

MEDICAL HOME DIGEST

DOUBLE ISSUE

NEWS FROM THE SAFETY NET MEDICAL HOME INITIATIVE

The Medical Home Digest is a newsletter devoted to keeping you informed about medical home transformation in the safety net. This newsletter is brought to you by the Safety Net Medical Home Initiative, which is sponsored by The Commonwealth Fund. Each issue highlights critical aspects of patient-centered care and PCMH transformation.

From the Principal Investigator



Jonathan Sugarman, MD, MPH
President & CEO, Qualis Health

The Center for Medicare and Medicaid Innovation (CMMI, or the Innovation Center), a new component of the Centers for Medicare & Medicaid Services (CMS) recently opened its doors and launched its website. CMMI was established by the Affordable Care Act (ACA), and is intended to identify, evaluate, and disseminate new models of care that support progress towards achievement of three aims- improving the individual experience of care, improving population health, and reducing per capita costs of health care.

The Innovation Center will fund a number of initiatives related to the patient-centered medical home. CMS is already participating in multi-payer medical home demonstration projects in eight states. CMMI estimates that about 1,200 medical homes serving almost one million Medicare beneficiaries will participate in the initiative.

Two other projects will be of great interest to many readers of the Medical Home Digest, as they focus primarily on safety net practices and populations.

January–April 2011
Quality Improvement Strategy/Enhanced Access

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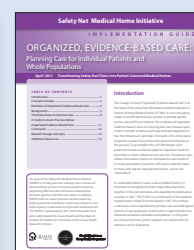
RESOURCES:



Quality Improvement Strategy 2



Care Coordination



Organized, Evidence-Based Care

In the near future, the Innovation Center plans to launch the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration. The demonstration project will include up to 500 FQHCs and will test the effectiveness of the medical home model in improving care while containing costs in community health centers. (More information about this demonstration project can be found at <http://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?itemid=CMS1230557>.)

Under another provision of the ACA to be overseen by CMS, state Medicaid programs can receive federal funds to help design and implement programs under which Medicaid enrollees with multiple chronic conditions can select “health homes.”

We believe that the success of participants in these medical home demonstration projects can be enhanced by the tools and approaches that have been designed and tested in the Safety Net Medical Home Initiative. This edition of the Medical Home Digest summarizes some of those approaches—selection of a cohesive and coherent quality improvement strategy, development and optimization of care delivery teams, and coordination of care among various settings—and provides examples of how they can be implemented.

Also, safety net practices wishing to quickly assess where they are in terms of “medical homeness” may wish to take a look at the PCMH-A tool described on page 18.

These and other tools can be accessed at www.qhmedicalhome.org. I encourage you to harvest the learning from the SNMHI, and to freely apply it in your own settings!

Safety Net Medical Home Initiative

This is a product of the Safety Net Medical Home Initiative, which is supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff. The Initiative also receives support from the Colorado Health Foundation, Jewish Healthcare Foundation, Northwest Health Foundation, The Boston Foundation, Blue Cross Blue Shield of Massachusetts Foundation, Partners Community Benefit Fund, Blue Cross of Idaho, and the Beth Israel Deaconess Medical Center. For more information about The Commonwealth Fund, refer to www.cmwf.org.

The objective of the Safety Net Medical Home Initiative is to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative is administered by Qualis Health and conducted in partnership with the MacColl Institute for Healthcare Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org/



**MacColl Institute at
Group Health Cooperative**

Transforming Safety Net Clinics into Patient-Centered Medical Homes

Quality Improvement Strategy Introduction



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Becoming a patient-centered medical home is hard work. It means making changes to people's jobs and how they relate to others in the practice, as well as uprooting practice systems with which people have grown comfortable. Change of this magnitude doesn't happen overnight or on command. Like good carpenters, successful practice organizations approach practice improvement with a strategy and plan; they

Choose and use a formal model for quality improvement. A sound QI plan includes a paradigm such as the PCMH Model that provides the logic and design for planning, testing, and making changes to the practice. The more specific the plan the better, which is why experts assembled for the SNMHI identified eight major change concepts, and several key changes under each change concept. But even a detailed plan is not very helpful without the tools to get the job done. The critical tools for quality improvement include an approach for identifying sound ideas for change, trying these ideas out while measuring their impact, and spreading those that are successful throughout the organization.

The most successful approaches to making changes to complex systems derive from industries other than healthcare. Those in broadest use (e.g., the Model for Improvement¹, LEAN thinking²) share common features:

- Improvement is a continuous process, not a project,
- Those involved in the process(es) under consideration participate in its improvement.
- Impacts, both positive and negative, of change are measured and made visible.
- Limited tests of changes assess their utility before implementing them more broadly.

The particular process change strategy selected appears to matter far less than the breadth and continuity of its use. Successful organizations institutionalize continuous quality improvement by encouraging QI and practice teams to meet regularly to review performance indicators and look for opportunities to do better and reduce redundancy and waste; they **ensure that patients, families, providers, and care team members are involved in quality improvement activities.** Even though larger organizations can charge specialized QI teams with these responsibilities, it appears to be best if essentially all front-line staff are involved in the QI process. Wise managers are also increasingly recognizing the value of obtaining patient and family member input, and are exploring different approaches to getting it, such as membership on QI committees, focus groups, and/or patient experience surveys: they **obtain feedback from patients/family about their healthcare experience and use this information for quality improvement.**



A trusted performance measurement system is a necessary component of any effective QI strategy. Successful organizations **establish and monitor metrics to evaluate improvement efforts and outcome, and ensure all staff members understand the metrics for success.** An effective performance measurement system will motivate providers to change, identify areas in need of improvement, and assess whether improvement efforts have been effective. To do so, measures should be clinically relevant and timely. For these reasons, the most effective measures derive from clinical data and not insurance claims. Performance measurement is just one of several critical functions (meaningful use) of an effective electronic medical record (EMR) system as laid out by the federal Office of the National Coordinator of Information Technology.³ A well-established EMR meeting meaningful use criteria is an important facilitator of care improvement and good care, but practices need to select and implement their EMR wisely to achieve the benefits.

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2. Pittsburgh Regional Healthcare Initiative puts new spin on improving healthcare quality. *Qual Lett Healthc Lead*. Nov 2002;14(11):2-11, 11.
3. Office of the National Coordinator for Health Information Technology, Department of Health Human Services. Health information technology: initial set of standards, implementation specifications, and certification criteria for electronic health record technology. Final rule. *Fed Regist*. Jul 28 2010;75(144):44589-44654.



OHSU Scapoose (Oregon)

Knowledge from the Field

Teams and Teamlets



Tom Bodenheimer, MD, FAAP; Professor of Family and Community Medicine at University of California, San Francisco

All primary care practices have a team. For a small private office, the team is the physician, medical assistant, and receptionist. For community health centers, out-patient department clinics, and multi-specialty groups the team is larger, including a variable mix of physicians, advanced practice clinicians, RNs, medical assistants, receptionists, health educators, pharmacists, social workers, and community health workers.

Whereas the team varies with the size and type of practice, one feature is constant as the central subunit of the team in almost all primary care settings: the clinician/ medical assistant dyad. (Clinician refers to physicians, physician assistants and nurse practitioners.) We call this dyad the “teamlet” – the small team that is sometimes part of a larger team.¹

The teamlet is a throwback to the past, the old days when a general practitioner and nurse were the only two people in a small practice. The GP and nurse worked together for many years, trusted each other, and were both trusted by the patient. The teamlet concept attempts to replicate this model in more complex modern primary care practices.

In a few studies, teamlets have been shown to improve care, medical assistant, and physician satisfaction. Compared with physician-alone care, physician/MA teamlets reduce depression symptoms, and the medical assistants are satisfied with their expanded role.² Physicians expressed enthusiasm for a teamlet project in which medical assistants provided counseling, phone monitoring, and home visits for patients with congestive heart failure.³ Family physicians working in teamlets with health coaches improved some cardiovascular risk reduction processes and outcomes compared with usual care.⁴

The first step in forming teamlets in private practices or community health centers is to pair each medical assistant with the same clinician. Of course, scheduling issues -- given the prevalence of part-time clinicians -- may make it difficult to have a perfect 1:1 relationship over time between a clinician and a MA. But it is essential to get as close to this relationship as possible. In so many practices, different clinicians work with different MAs on different days, which means that

- 1) the clinician and MA do not learn to trust one another,
- 2) the patients interact with too many people which is a barrier to the patient trusting both the clinician and the MA, and
- 3) there is little accountability, so that if the clinician asks the MA to do something and there is a different MA on different days, it is difficult to figure out who is responsible if something gets dropped.

In a few studies, teamlets have been shown to improve care, medical assistant, and physician satisfaction.

If the same clinician always (or almost always) works with the same MA, and they become a teamlet, then the MA can begin to assume some responsibility for the clinician's panel of patients. Perhaps the MA becomes responsible for colorectal cancer screening. She makes sure that every person in the teamlet's panel (not the clinician's panel, but the teamlet's panel) needing such screening receives it. Rather than being told to do one task after another, the MA is given responsibility for an entire area of work. If a patient's life is saved by early recognition of a colon cancer, it is the MA who saved that person's life. Both teamlet members, the clinician and the MA, feel responsible for the health of their panel of patients. The clinician and MA trust each other, and the patients trust them both.

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In the News

Improving Patient-Centered Communication: A Team Development Model



Larry Mauksch,
MEd., University
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What does it take to build and sustain a successful team? Research and practice, in specialty care and in primary care, demonstrate the critical importance of communication for successful team building. Training in effective communication can help build the effectiveness of primary care teams, while improving patient care and enhancing efficiency.

Many clinicians are overwhelmed by the need to meet productivity targets – and they wonder how they can communicate well with patients without taking more time than is available in the day. Research suggests that it would take a solo primary care provider (PCP) 24 hours a day to adequately address the acute, chronic, and preventive needs for a panel of 2,500 patients.¹⁻³ A closer look at the primary care visit explains this challenge. Primary care patients have an average of three to six concerns per visit. Half of adults have two or more chronic conditions and the majority of these patients lack the knowledge, confidence, and skills to manage their conditions.^{4,5} Over one quarter of patients in primary care suffer from one or more mental illness and the prevalence in vulnerable populations may be higher than 50%.⁶ The average adult has two behavioral risk factors such as smoking, alcohol abuse, sedentary lifestyle, or obesity.⁷

How can primary care providers address the complexities of their patient populations with limited time and resources? New research suggests that adopting two interdependent skill sets may help practice provide better care, enhance patient experience, and more effectively manage providers' time.

In 2008, my inter-disciplinary team conducted a literature review to determine how communication skills might enhance quality of care and help manage time. We used findings from this literature review to develop a model⁸ that names specific skills that promote

efficiency and patient-centered communication. While the articles we read focused on physician communication, the skills we describe are relevant to the work of all primary care team members. For example, all team members need to use relationship development skills—empathy, eye contact, humor, reflective listening—to foster patient trust and patient engagement in self-care.

The most potent time management skill that we identified is collaborative agenda setting.⁹ Planning the use of time at the very beginning of a visit helps the patient and team agree on realistic goals. Identifying concerns at the outset of an encounter decreases the probability that last minute “oh by the way” concerns will prolong visits. Instead the final phase of the visit can be used to co-create a feasible plan. Shared decision-making about the plan decreases the use of extra resources and referrals and improves outcomes.¹⁰ Patients often have unspoken concerns and fears and drop cues. When a team member picks up on these cues visits are not as long.¹¹ And your team may have addressed the most important reason for the patient visit.

Unfortunately, many physicians and medical assistants may not be trained to use these and other communication skills. Nor have they considered how teams can share the use of these skills to enhance quality and effectively manage time. While some people are better communicators than others, few people can describe their communication patterns in specific terms. The knowledge feels intuitive. Yet there are skills that all team members within a practice can learn and implement to improve patient-team communication, thereby improving clinic efficiency, provider satisfaction, and patient experience.

What follows is a step-by-step training protocol to build ‘teamness’ through learning to name and demonstrate communication skills that enhance quality and efficiency within the office practice setting

Planning the use of time at the very beginning of a visit helps the patient and team agree on realistic goals.

Step 1: Learn the vocabulary of effective communication. Some colleagues and I from several US medical schools conducted a review¹² of the common communication assessment tools. Next, my team at the University of Washington used this review to combine the best features of the various tools to develop the “[Patient-Centered Observation Form \(PCOF\)](#).” A unique feature of the PCOF is that it is designed to train the user as well as structure feedback to the person being observed. By studying the PCOF and taking a 30-35 minute online training, one can learn terms to describe an assortment of communication skills. This allows you to develop an observer self. This free training program is available at: <https://catalyst.uw.edu/webq/survey/mauksch/122514>

Step 2: Observe and reflect on how you and others in your practice communicate. Use the PCOF to rate the communication others on your team while seeing real patients. Have others rate you. This exercise accomplishes two goals. By watching others and hearing feedback from others you become more self-aware and skilled. You begin to ask, how can my team can work together to make sure that the core skills on the PCOF are always part of the patient’s experience? If the team can answer “yes” to the following questions then the visit was likely a success.

1. Have we made a connection with this patient?
2. Have we confirmed what is most important to this patient today? (And what is important to us?)
3. Do we understand the patient’s view on today’s health concerns?
4. Does the plan make sense to the patient and to us?
5. Is the patient confident in being able to carry out the plan?



Community Health Centers of Lane County (Oregon)

a. Observation set up: Begin with the Teamlet¹³ (PCP and medical assistant) observing each other with the same patients. Plan a half-day clinic with fewer patients—say one patient for the first hour and the rest every 45 minutes. The visit starts with the medical assistant working with the patient and being observed by the physician. Then the PCP takes over and the medical assistant remains and observes.

b. Informing patients. “We are both going to be with you for the entire visit watching each other to figure out ways to provide the best care to our patients. So first I will watch [insert MA’s name] work with you. And, then she will watch me. And when we are done if you have suggestions we would love to hear them.” If appropriate, the medical assistant can leave during sensitive exams.

c. Use the form: Attached to this article are copies of a physician and nurse/medical assistant version of the PCOF. Once the interview starts, the observer looks at the form rather than at the patient. This way the observer avoids visually engaging the patient and upstaging the interaction between the patient and the other team member. Make notes about behaviors, ideas, quotes, and choose either A, B, or C for each row on the PCOF. Resist giving the person you are observing the benefit of the doubt. If you do not see the behavior, don’t record it.



Community Health Center, Inc. (Oregon) during their daily huddle.

Step 3: Debrief and plan for improvement.

a. Debrief using the PCOF: When the patient has left, take time to discuss your impressions, ideas, and learning with one another. Consider the following principles in giving feedback. Describe specific behaviors. Avoid being judgmental. Be curious and respectful. Provide feedback about behaviors that the person can change. Avoid only describing ways to improve skills, also paying attention to skills that are present and useful. The chances are that the person you are observing may not be aware of what s/he does well.

b. Share ideas: How can responsibility be shifted from the PCP to the medical assistant? How do “teamlet” members communicate with one another about agenda topics, patient cues, about important tasks? A few tips: Avoid creating rigid rules about who performs certain communication functions. In many cases, skill overlap is normal and helpful. For example, while the medical assistant may begin agenda setting, the physician should still ask, “is there something else?” Patients may forget to mention an important topic. At the end of the visit the PCP may confirm the plan but the MA may come in and ask the patient to explain the plan (“teachback” method) and then print an after visit summary.

This team observation exercise is about experimentation and learning.

c. Share between teamlets: Once all the practice teamlets have finished a half day of observation, take time to share learning. This way everyone benefits from one another’s learning and creativity.

d. Try new skills and new team processes: Make some decisions about what to change in how your teamlet provides care. Set goals, try new approaches, and expect revision as you learn.

c. Meet regularly: Teams that grow and function effectively meet regularly to share and problem solve. Other people on the team such as nurses, receptionists, pharmacists, counselors, and care managers can observe the teamlet see patients and provide feedback. And they can observe one another and help each other improve the patient experience and clinic efficiency.

Potential pitfalls.

Hierarchical thinking: The traditional medical hierarchy can result in medical assistants or other team members feeling hesitant to share observations and ideas.¹⁴ Physicians may feel the pressure to be the expert. Remember that everyone on the team can contribute to improving care. When medical assistants and other team members feel heard, team effectiveness and morale should increase.

Seeing too many patients: Avoid succumbing to volume pressures. Protect time for feedback and learning.

Conclusion

Practice is essential for mastery. This communication model helps teams succeed because it offers a structured way to observe and share, with the eventual goal of redefining the visit to most efficiently and effectively provide care. Team members reinforce skill in one another. My experience and accumulating evidence from clinics and organizations who use this model is that patient and team member satisfaction increases and anxiety about time management is reduced. Although improvements in the quality of patient care outcomes will require more study, this model provides a structured method to improve communication with patients and between team members, reduce hierarchical barriers, and improve efficiency. Establishing a shared language about communication skills helps each clinic create its own unique culture of high quality care.¹⁵

Editorial support provided by Sharon Eloranta, MD, Qualis Health.

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Improving Patient-Centered Communications: A Team Development Model

University of Washington Family Medicine Patient Centered Observation Form

Trainee name _____ Observer _____ Obsrvn# _____ Date _____

*Directions: Mark one box per row. Circling behaviors may help. Competent skill use is in the right two columns.
Record important provider or patient comments and verbal or non-verbal cues in the notes sections. Use this form to
enhance your learning, vocabulary, and self-awareness. If requested, use this form to guide verbal feedback to
someone you observe.*

Skill Name <i>Skill Level: Best practice description</i>	Provider Centered Biomedical Focus	Patient Centered Biopsychosocial Focus
Establishes Rapport <ul style="list-style-type: none"> Introduces self; Warm greeting; Acknowledges all in the room by name Uses eye contact; Humor or non medical interaction; 	<input type="checkbox"/> 1a. Uses 0-1 elements	<input type="checkbox"/> 1b. Uses 2 elements. <input type="checkbox"/> 1c. Uses ≥ 3 elements.
Notes:		
Maintains a relationship Throughout the Visit <ul style="list-style-type: none"> Demonstrates empathy; Listens well using continuer phrases and by repeating important verbal content; Demonstrates mindfulness through curiosity, self-reflection, and presence; 	<input type="checkbox"/> 2a. No evidence of empathy or verbal listening behavior. Disease and biomedically focused.	<input type="checkbox"/> 2b. Evidence of empathy OR listening well OR evidence of mindfulness. <input type="checkbox"/> 2c. Demonstrates two of the following: verbal or non-verbal empathy; listening skills; or mindfulness.
Notes:		
Collaborative upfront agenda setting <ul style="list-style-type: none"> ≥ 1 additional elicitations ("something else?") Acknowledges pre-visit info from the MA or EHR. Confirms what is most important to patient? 	<input type="checkbox"/> 3a. Uses 0-1 elements	<input type="checkbox"/> 3b. Uses 2 elements. <input type="checkbox"/> 3c. Uses ≥ 3 elements.
Note patient concerns here:		
Maintains Efficiency <ul style="list-style-type: none"> Shared thinking about priorities, structure, and problem solving. Tracks multiple topics and is organized 	<input type="checkbox"/> 4a. No shared thinking about visit structure. Drawn off topic, or unorganized visit structure.	<input type="checkbox"/> 4b. Shared thinking about priorities, visit structure, or problem solving. Simple agenda, organized interview. <input type="checkbox"/> 4c. Shared thinking about priorities, structure, and problem solving. Tracks multiple topics; is organized.
Notes:		
Gathering Information <ul style="list-style-type: none"> Uses open-ended questions <u>along</u> with closed questions. Uses reflecting, clarifying, or summarizing statements 	<input type="checkbox"/> 5a. Uses 0 to 1 open-ended questions. No reflecting, clarifying, or summary statements.	<input type="checkbox"/> 5b. Uses 2 or more open-ended questions OR uses one reflecting, clarifying or summary statement. <input type="checkbox"/> 5c. Uses 2 or more open-ended question AND more than one reflecting, clarifying, or summarizing statement.
Notes:		
Assessing Patient's Perspective on Health <ul style="list-style-type: none"> Investigates patient verbal and non-verbal cues. Initiates exploration of patient beliefs and contextual influences: family, cultural, spiritual. Number patient verbal / non-verbal cues ____	<input type="checkbox"/> 6a. Does not acknowledge patient cues or explore patient beliefs, concerns and feelings. Does not explore contextual influences: family, cultural, or spiritual.	<input type="checkbox"/> 6b. Acknowledges verbal / non-verbal cues about feelings or beliefs OR Responds to contextual influences described by the patient. <input type="checkbox"/> 6c. Investigates patient verbal / non-verbal cues OR Initiates exploration of patient beliefs and contextual influences such as family, cultural, and spiritual issues.
Notes:		

Improving Patient-Centered Communications: A Team Development Model

University of Washington Family Medicine Patient Centered Observation Form

Trainee name	Observer	Obsrvn#	Date
Skill Name Skill Level: <i>Best practice description</i>	Provider Centered Biomedical Focus		Patient Centered Biopsychosocial Focus
Electronic Medical Record Use <ul style="list-style-type: none"> Transparently describes use of EMR to pt. Maintains eye contact with patient during majority of interview. Positions monitor to be viewed by patient Points to screen 	<input type="checkbox"/> 7a. Uses 0 or 1 of the four elements.	<input type="checkbox"/> 7b. Uses 2 elements	<input type="checkbox"/> 7c. Uses 3 or 4 elements
Notes:			
Physical Exam <i>Not present in every interview</i> <ul style="list-style-type: none"> Prepares patient before all physical exam actions. Describes all exam findings 	<input type="checkbox"/> 8a. Does not prepare the patient before the exam or describe findings after the exam.	<input type="checkbox"/> 8b. Prepares patient for 1-3 exam actions AND describes 1-3 findings.	<input type="checkbox"/> 8c. Prepares patient before > 3 physical exam actions AND Describes > 3 findings.
Notes:			
Sharing Information <ul style="list-style-type: none"> Uses language familiar to the patient. Summaries cover biopsychosocial concerns. Invites Q/A 	<input type="checkbox"/> 9a. Summaries dominated by biomedical focus. Significant use of medical jargon. No opportunity for patient Q/A.	<input type="checkbox"/> 9b. Uses language the patient can understand AND one of the following: Summarizes patient's biomedical concerns OR Invites Q/A.	<input type="checkbox"/> 9c. Uses language the patient can understand AND summaries cover biopsychosocial concerns AND invites Q/A.
Notes:			
Behavior Change Discussions <i>Not present in every interview</i> <ul style="list-style-type: none"> Explores patient knowledge about behaviors that compromise health. Explores pros and cons of changing and not changing health habits. Creates a plan aligned with patient's readiness 	<input type="checkbox"/> 10a. Does not address behavior change OR lectures patient about health behaviors OR imposes a plan with no assessment of patient's readiness.	<input type="checkbox"/> 10b. Responds to patient concerns about behavior change AND one of the following: Describes only the pros of change OR the cons of not changing OR offers behavior change advice with patient permission.	<input type="checkbox"/> 10c. Explores patient knowledge about behaviors that compromise health, explores pros and cons of changing and not changing health habits AND creates a plan aligned with patient's readiness.
Notes:			
Co-creating a plan Informed Decision Making <ul style="list-style-type: none"> Physician shares evidence(when available) behind recommendations Examines pros and cons and uncertainties of all viable options Shared Decision Making <ul style="list-style-type: none"> Physician offers plan respecting biomedical, psychological and social goals and values. Physician asks for patient input and if needed, modifies plan in response to patient concerns 	<input type="checkbox"/> 11a. No informed decision making <input type="checkbox"/> 12a. Physician states plan and does not ask for patient input.	<input type="checkbox"/> 11b. Discusses one of the following: evidence; pros and cons of options; alternatives; uncertainties. <input type="checkbox"/> 12b. Physician offers plan respecting patient's biomedical goals and values AND physician asks for input on plan, if needed, modifies plan in response to concerns.	<input type="checkbox"/> 11c. Discusses > 1 of the following: evidence, pros and cons of options; alternatives; uncertainties. <input type="checkbox"/> 12c. Physician offers plan respecting patient's biopsychosocial goals and values and physician asks for input and, if needed, modifies plan in response to patient concerns.
Notes:			
Closure and Follow-up <ul style="list-style-type: none"> Asks for questions about today's topics. Prints After Visit Summary; uses Teachback. Teachback = Asking the patient to explain their understanding of the plan 	<input type="checkbox"/> 13a. No request for questions. Does not provide written summary of plans. Does not use Teachback.	<input type="checkbox"/> 13b. Asks for questions OR one of the following: provides written summary OR uses Teachback.	<input type="checkbox"/> 13c. Asks for questions about today's topics, provides written summary and uses Teachback.
Notes:			

Improving Patient-Centered Communications: A Team Development Model

Patient Centered Observation Form:

MA/Nurse

Trainee name _____ Observer _____ Obsrvn# _____ Date _____

Directions: Make notes using row headings to help organize your observations. Record important MA/Nurse behaviors and comments, patient comments, verbal or non verbal cues, and your thoughts and questions.

Check one box per numbered row, e.g., either 1a or 1b or 1c; then either 2a or 2b or 2c, etc.

Desired behaviors are in columns to the right of the wider line.

Use this form to enhance your own learning and awareness and, if requested, to guide feedback.

Element	MA/Nurse Centered Biomedical Focus	Patient Centered Biopsychosocial Focus
Establishes Rapport	<input type="checkbox"/> 1a. Uses 0-1 of the following: Introduces self; eye contact; warm greeting; non medical interaction; humor, acknowledges all in room by name	<input type="checkbox"/> 1b. Uses 2 of the following: Introduces self; eye contact; warm greeting; non medical interaction; humor, acknowledges all in room by name
		<input type="checkbox"/> 1c. Uses ≥ 3 of the following: introduces self; eye contact; warm greeting; non-medical interaction; humor; acknowledges all in room by name
Maintaining Relationship	<input type="checkbox"/> 2a. No evidence of empathy <input type="checkbox"/> 3a. No verbal listening behavior <input type="checkbox"/> 4a. No evidence of mindfulness: disease focused, distracted and not person focused.	<input type="checkbox"/> 2b. Conveys empathy non-verbally <input type="checkbox"/> 3b. Uses continuer phrase(eg, um hmm) or repeats patient's phrases <input type="checkbox"/> 4b. Mild evidence of mindfulness: curiosity or presence or reflection.
		<input type="checkbox"/> 2c. Conveys empathy non-verbally and verbally. <input type="checkbox"/> 3c. Uses continuer phrases and repeats important verbal content <input type="checkbox"/> 4c. Demonstrates mindfulness: curiosity, reflection, and presence.
Establishes Agenda- with or without pre-visit form or ePlanning	<input type="checkbox"/> 5a. No elicitations, form use or use of ePlanning, dove into other tasks <input type="checkbox"/> 6a. Does not confirm what is most important to the patient.	<input type="checkbox"/> 5b. Uses form or ePlanning or 1 additional upfront elicitation, patient may indicate completion. <input type="checkbox"/> 6b. Confirms what is most important to the patient OR explains how concerns will be shared with the MD
	NAME THE PROBLEMS RAISED BY PATIENT OR MA/Nurse:	
Basics: Vitals, Checks: Meds, paperwork	<input type="checkbox"/> 7a. Collects vitals but does not share results <input type="checkbox"/> 8a. Does not ask about paper work or med refills	<input type="checkbox"/> 7b. Collects vitals and shares one result. <input type="checkbox"/> 8b. Asks about paperwork OR med refills
		<input type="checkbox"/> 7c. Collects vitals and shares more than one result <input type="checkbox"/> 8c. Asks about paperwork AND med refills
Patient Activation (encourages pt to bring up important issues) _____ # of clues	<input type="checkbox"/> 9a. Does not acknowledge patient cues <input type="checkbox"/> 10a. Does not ask if patient has questions <input type="checkbox"/> 11a. Does not acknowledge patient beliefs, concerns and feelings.	<input type="checkbox"/> 9b. Acknowledges verbal OR non verbal cues <input type="checkbox"/> 10b. Asks if patient has questions but does not encourage patient to address them with provider <input type="checkbox"/> 11b. Responds to context cues: family, cultural, spiritual.
		<input type="checkbox"/> 9c. Acknowledges patient verbal AND non verbal cues. <input type="checkbox"/> 10c. Encourages patient to bring up questions with provider. <input type="checkbox"/> 11c. Initiates exploration of contextual influences: family, cultural, spiritual.

Improving Patient-Centered Communications: A Team Development Model

Patient Centered Observation Form:

MA/Nurse

Trainee name		Observer		Obsrvn#	Date
Element	MA/Nurse Centered Biomedical Focus	Patient Centered Biopsychosocial Focus			
Use of Electronic Health Record	<input type="checkbox"/> 12a. Does not describe use of EMR to patient <input type="checkbox"/> 13a. No eye contact with patient during interview <input type="checkbox"/> 14a. Positions the monitor so it is NOT easily viewed by patient, does not point to screen	<input type="checkbox"/> 12b. Transparently describes use of EMR to patient once <input type="checkbox"/> 13b. Uses eye contact with patient during critical portions of interview <input type="checkbox"/> 14b. Positions the monitor so it is easily viewed by patient OR points to screen	<input type="checkbox"/> 12c. Transparently describes use of EMR to patient more than once <input type="checkbox"/> 13c. Maintains eye contact with patient during majority of interview <input type="checkbox"/> 14c. Positions the monitor so it is easily viewed by patient, AND points to screen		
Behavior Change Discussions NOT PRESENT IN EVERY INTERVIEW	<input type="checkbox"/> 15a. Does not address health behavior change issues or lectures patient about health behaviors. <input type="checkbox"/> 16a. Uses scare tactic tone(guilt) <input type="checkbox"/> 17a. Imposes a plan that was not aligned with patient's readiness.	<input type="checkbox"/> 15b. Responds to patient concerns about health behavior change. <input type="checkbox"/> 16b. Describes only the pros of change or the cons of not changing <input type="checkbox"/> 17b Offers advice to patient with patient permission and general interest	<input type="checkbox"/> 15c. Explores patient knowledge about behaviors that compromise health. <input type="checkbox"/> 16c.Explores balanced view of pros and cons of changing and not changing. <input type="checkbox"/> 17c. Helps patient create a plan aligned with patient's readiness.		
Closure Follow-up and System Navigation	<input type="checkbox"/> 18a. No request for questions about today's topic and no summary of plans <input type="checkbox"/> 19a. Does not print an after visit summary or offer to print an AVS or use "Teachback" <input type="checkbox"/> 20a. Does not inquire about system navigation concerns or offer suggestions	<input type="checkbox"/> 18b. Asks for questions on today's topics OR summarized plans. <input type="checkbox"/> 19b. Prints an AVS but does not check for understanding or use "Teachback" <input type="checkbox"/> 20b. Offer suggestions and directions about system navigation, eg, directions, getting appointments,	<input type="checkbox"/> 18c. Asks for questions about today's topics and summarized plans <input type="checkbox"/> 19c. Prints an AVS and confirms patient understanding or uses "Teachback" <input type="checkbox"/> 20c Offers suggestions and directions about system navigation and facilitates communication between primary care and other health care settings or community agencies		

In the News

Enhanced Access: Providing the Care Patients Need, When They Need It

This article provides highlights from the [Enhanced Access Implementation Guide](#), released in December 2010.

The goal of the Enhanced Access Change Concept is to ensure that patients and family members can get healthcare when and how they need it. This includes expanding a patient's options for interacting with their healthcare team beyond in-person visits to include after hours care, phone calls, e-mails, and other services. Enhanced Access can include extended visits, same day visits, or multiple provider visits. A key component of enhanced access is obtaining care from your care team on evenings, week-ends or holidays without going to the emergency department. Beyond the expectation of off-hours coverage, Enhanced Access considers a patient's health insurance coverage to be a shared responsibility addressed between the patient and a member of the care team. Helping patients attain and understand health insurance coverage is a fundamental part of the PCMH model.

Achieving Enhanced Access, like many of the PCMH Change Concepts for Practice Transformation requires a fundamental

change in how providers and staff work. The implementation guide provides methods and examples for steps to improve clinic access including increasing clinic capacity; working more efficiently; simplifying appointment types; implementing simplified patient scheduling; aligning capacity with demand; creating contingency plans; and reducing no-shows. In addition to increasing clinic access, there are also suggestions for how to decrease unnecessary demand to better serve both patients and providers. Clinica Family Health Services (Colorado) started offering group visits in order to increase patient access to care. Cambridge Health Alliance's Revere Family Health Center (Massachusetts) adopted three strategies to help enhance access: a new patient orientation, advanced access scheduling, and shared medical appointments.

The PCMH model also expects patients to have 24/7 access to care. Ideally, this would mean that a care team would provide 24/7 access to their established panel of patients; this is a challenging standard. The guide walks the readers through bare-minimum standards of care and makes recommendations on how providers and care teams can work to provide their patients with excellent and patient-centered access.

The Initiative is on the forefront of best practices in the safety net, and a number of sites have identified innovative ways to ensure patients attain health insurance coverage. SNMHI best practices include having dedicated and trained staff; separating the registration visit from the first appointment; providing a new patient orientation; and providing a specialized insurance enrollment position in the front office.

Improved and enhanced access allows care team members and all clinical staff to focus on clinical care, population health, and improving the efficiency of their practice in other ways.

Table 1. Benefits and Outcomes Associated with Enhanced Access

Stakeholder	Benefits / Outcomes
Patients and Families	Convenience Get to see their provider of choice Problems addressed in a timely manner
Providers	Greater continuity Less chaos and more control Better satisfaction
Clinics	Potential increase in RVU billing Reduced no-show Improved staff satisfaction Fewer patient complaints
Communities	Reduced emergency department use Reduced hospitalization rates

Source: Safety Net Medical Home Initiative. Moore LG, Powell J. Enhanced Access Implementation Guide: Providing the Care Patients Need, When They Need It. 1st ed. Burton T, ed. Seattle, WA: Qualis Health and the MacColl Institute for Healthcare Innovation at the Group Health Research Institute; December 2010.

Knowledge from the Field

Rural Clinic Links Patients, Resources through Close Community Connections

Providers at Yuma Clinic in rural Yuma, Colorado treat about 1,000 patients per month on average. Yuma is located in the northeastern corner of Colorado and has around 3,200 residents. Serving a patient population that is about 40% Hispanic with a significant number of elderly, the Yuma clinic has close ties to its small community and the local hospital which helps for prioritizing care coordination.

Yuma Clinic, like many rural providers, faces obstacles associated with its setting that can hinder PCMH transformation.

Assembling a care team is more challenging due to shortages of providers, as is access to care. There are challenges associated with treating all type of patients because you may be “the only shop in town,” and transient patients like migrant workers have little information about their history and previous care received.

Teri Mekelburg, R.N., says successful follow up and coordination of treatment after receiving care at the clinic is easier in a small community. The provider and nurse work together to make sure referrals are done to home health care, or other community resources with the help of a Community Health Worker who is employed by the hospital.

“Our community health worker does local outreach, and working through a grant for “Heart Healthy Solutions”, she offers weight management classes and glucose and lipid screenings as a free service. Last year she conducted screenings on 300-400 patients,” says Mekelburg.

Mekelburg adds that when patients are discharged from the Yuma hospital, co-located with the Yuma clinic, the hospital discharge planner coordinates with community resources and



with the clinic so that a patient’s care team is notified of any emergency department use, for example.

“It’s nice because there is no dropping the ball between the hospitalist and primary care provider as happens in larger facilities...The [hospital] discharge planner would make a plan for patients to follow up with their PCP here. The same thing goes for the ED. If a doctor wants to see a patient again, then they will make an appointment at the time of discharge.”

A county-employed ombudsman is also available to assist patients with resources for care. “If we have someone who needs help with insurance or Medicare Part D sign up, our ombudsman conducts referrals to special services, including help with long term care options,” says Mekelburg.

Mekelburg adds, “We also have very low nurse turnover; so our nurses, who know the resources well, and the community health worker can work together to coordinate care between clinic, hospital, and home for the best patient outcome.”

Resource Alert

SNMHI Summit 2011: Learn · Share · Transform

In March, the SNMHI held its first national meeting in Boston, MA. The meeting included 200 team members from the Initiative's 65 participating clinics. Over the course of the two day Summit, each clinic presented its work on one or more of the Change Concepts for Practice Transformation.

"Very thought-provoking. I continue to feel energized by information taken away from the Summit."

National experts from academia, policy, and the front lines of the safety net delivery system also spoke passionately about the value of patient-centered care and shared their own experiences and strategies for driving improvement.

The goal of the Summit was to provide SNMHI practice teams the opportunity to share their practice transformation successes with one another and to learn from each other's challenges. One participant enthusiastically reinforced the value of shared learning, noting "There was not a single group there that did not have something interesting to share and a compelling story to tell." PCMH transformation is not easy; every clinic reported opportunities for improvement. One participant noted "our center is not unique. Other CHCs across the country face similar challenges and are finding successful approaches to implementing the PCMH." Another participant noted: "all regions are having great successes, and share similar struggles."

All presentations and storyboards are available on the [SNMHI website](#).

"Our organization is pioneering the path for other community health centers."



Patient-Centered Medical Home Assessment (PCMH-A) Tool Marks One Year

The Patient-Centered Medical Home-Assessment (PCMH-A), developed by the MacColl Institute for Healthcare Innovation, Group Health Cooperative, is both a self-assessment and teaching tool for teams intended to help them identify their current level of 'medical homeness' based on their implementation of the 8 Change Concepts for Practice Transformation. In March 2011, the Safety Net Medical Home Initiative celebrated one year using the PCMH-A tool to understand and track practice transformation.

- [Empanelment](#)
- [Continuous & Team-based Healing Relationships](#)
- [Patient-centered Interactions](#)
- [Engaged Leadership](#)
- [Quality Improvement \(QI\) Strategy](#)
- [Enhanced Access](#)
- [Care Coordination](#)
- [Organized, Evidence-based Care](#)

The tool is publicly available to help teams assess their medical home capacity and scores teams in each of the 8 domains on medical home activities. The [PCMH-A](#) is an interactive, self-scoring PDF that can be downloaded, completed, saved and shared.

PART 1: EMPANELMENT

1a. Determine and understand which patients should be empanelled in the medical home, and which require temporary, supplemental, or additional services.
 1b. Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self management status, community and family need.
 1c. Understand patient supply and demand and balance patient load accordingly.
 1d. Enable feedback to team and for external reporting on processes of care and population outcomes.

Components	Level D	Level C	Level B	Level A
1. Patients	...are not assigned to specific practice panels.	...are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes.	...are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes.	...are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.
Score	1 2 3	4 5 6	7 8 9	10 11 12
2. Registry or panel-level data	...are not available to assess or manage care for practice populations.	...are available to assess and manage care for practice populations, but only on an ad hoc basis.	...are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states.	...are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states.
Score	1 2 3	4 5 6	7 8 9	10 11 12
3. Registries on individual patients	...are not available to practice teams for pre-visit planning or patient outreach.	...are available to practice teams but are not routinely used for pre-visit planning or patient outreach.	...are available to practice teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states.	...are available to practice teams and routinely used 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
4. Reports on care processes or outcomes	...are not routinely available to practice teams.	...are available to practice teams but are not routinely used for pre-visit planning or patient outreach.	...are available to practice teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states.	...are available to practice teams and routinely used 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

PART 3: PATIENT-CENTERED INTERACTIONS

3a. Assess and respect patient and family values and expressed needs.
 3b. Encourage patients to expand their role in decision-making, health related behaviors, and self management.
 3c. Assure communication with their patients in a culturally appropriate manner in a language and at a level that the patient understands.
 3d. Provide self management support through collaborative goal setting and patient action planning.

Components	Level D	Level C	Level B	Level A
8. Assessing patient and family values and preferences	...is not done.	...is done, but not used in planning and organizing care.	...is done and providers incorporate it in planning and organizing care on an ad hoc basis.	...is systematically done and incorporated in planning and organizing care.
Score	1 2 3	4 5 6	7 8 9	10 11 12
9. Involving patients in decision-making and care	...is not a priority.	...is accomplished by provision of patient education materials or referrals to classes.	...is supported and documented by practice teams.	...is systematically supported by practice teams trained in decision making techniques.
Score	1 2 3	4 5 6	7 8 9	10 11 12
10. 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 (such as closing the loop) 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
11. Self-management support	...is limited to the distribution of information (pamphlets, booklets).	...is accomplished by referral to self-management classes or educators.	...is provided by goal setting and action planning with members of the practice team.	...is provided by members of the practice team trained in patient empowerment and problem-solving methodologies.
Score	1 2 3	4 5 6	7 8 9	10 11 12
12. The principles of patient-centered care	...are included in the	...are included in the	...are included in the	...are included in the
Score	1 2 3	4 5 6	7 8 9	10 11 12

PART 7: CARE COORDINATION

7a. Link patients with community resources to facilitate referrals and respond to social service needs.
 7b. Have referral protocols and agreements in place with an array of specialists to meet patients' needs.
 7c. Proactively track and support patients as they go to and from specialty care, the hospitals and the emergency department.
 7d. Follow-up with patients within a few days of an emergency room visit or hospital discharge.
 7e. Test referrals and care plans are communicated to patients.

Components	Level D	Level C	Level B	Level A
24. 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 the organization with which the practice has a referral protocol or agreement.
Score	1 2 3	4 5 6	7 8 9	10 11 12
25. 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 the organization with which the practice has a referral protocol or agreement.
Score	1 2 3	4 5 6	7 8 9	10 11 12
26. Patients in need of specialty care, hospital care, or supportive community-based resources	...cannot reliably obtain needed referrals to partners with whom the practice has a relationship.	...obtain needed referrals to partners with whom the practice has a relationship.	...obtain needed referrals to partners with whom the practice has a relationship and relevant information is communicated in advance.	...obtain needed referrals to partners with whom the practice has a relationship, relevant information is communicated in advance, and timely follow-up after the visit occurs.
Score	1 2 3	4 5 6	7 8 9	10 11 12

PART 7: CARE COORDINATION CONTINUED ON PAGE 9

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