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Appendix A to:

Fernald D, Hall T, Mongomery L, et al. Colorado Residency PCMH Project: Results from a 6-Year Transformation Effort. Fam Med. 2019;51 [epub ahead of print]. doi: FamMed.2019.928558.

APPENDIX A

Practice PCMH Monitor Items Subscales

1. Quality Improvement Process (alpha = 0.8909)
    a. QI teams and process provided with necessary time & resources
    b. Staff participation in and contributions to improvement process recognized and rewarded
    c. QI team meets regularly (at least twice a month)
    d. Meetings well-organized - agendas, meeting summaries, prepared leaders and members
    e. QI team uses QI tools – AIMs, process mapping, PDSA
    f. QI team members do assignments and tasks, with good team accountability
    g. QI team functions at a high level with a sustainable, reflective QI process that deals effectively with challenges and conflict
    h. System implemented for including patient input and perspectives in ongoing improvement activities (such as, patient advisory groups or patients on QI teams)
2. Team-based Care (alpha = 0.8131)
    a. Culture of shared leadership created, with everyone sharing responsibility for change and improvement in the practice
    b. Staff actively and regularly involved in team meetings

c. Team members have defined roles that optimally makes use of their training and skill sets

d. Protocols and standing orders implemented to better distribute workload throughout the team

e. Cross training developed and role barriers removed to improve response to patient needs

3. Data and Population Management (alpha = 0.9095)

a. Identify clinically important conditions for initial collection of quality measures

b. Registry & specific measures chosen

c. Workflow for maintaining registry data reliably implemented

d. Measures reported monthly internally and to project

e. Registry data are used to identify specified populations of patients (with initial focus on identified clinically significant conditions)

f. Patients with care or outcomes falling outside of acceptable range identified for more intensive care

g. Patient recall system designed and implemented to bring in patients for needed care

h. Flow sheet using registry data used for point of care decision support by care team

4. Self-management Support and Care Coordination (alpha = 0.8651)

a. Care management system used to assist in care of patients needing additional assistance, mobilization of community resources, and/or contact between visits

b. Patients actively linked with community resources to assist with their self-management goals

c. Patients are provided with tools and resources to help them engage in the management of their health between office visits

d. Practice teams use proactive communication for planned, between-visit patient interactions

e. Local referral sources and community resources identified and information aggregated in central location for clinicians and staff to access

f. Care coordinator used for subset of clinical population to ensure patient connectivity to outside providers and community resources

5. Continuity of Care (alpha = 0.7610)

a. Every patient is assigned a personal physician, with a small care team to serve as back-up when the personal physician is unavailable

b. The practice has a system to insure that patients are able to see their own clinician as often as possible, including tracking the percentage of patient visits that are with the patient's own chosen personal clinician

c. Patients can reliably make an appointment with their personal physician or a care team member within defined and acceptable time periods

d. Shared care plans developed collaboratively with patients and families and then regularly reviewed to assess and monitor patient progress in accomplishing goals

e. Team huddles used to discuss patient load for the day and plan for treatment, follow up and identification of team members involved in patient's care