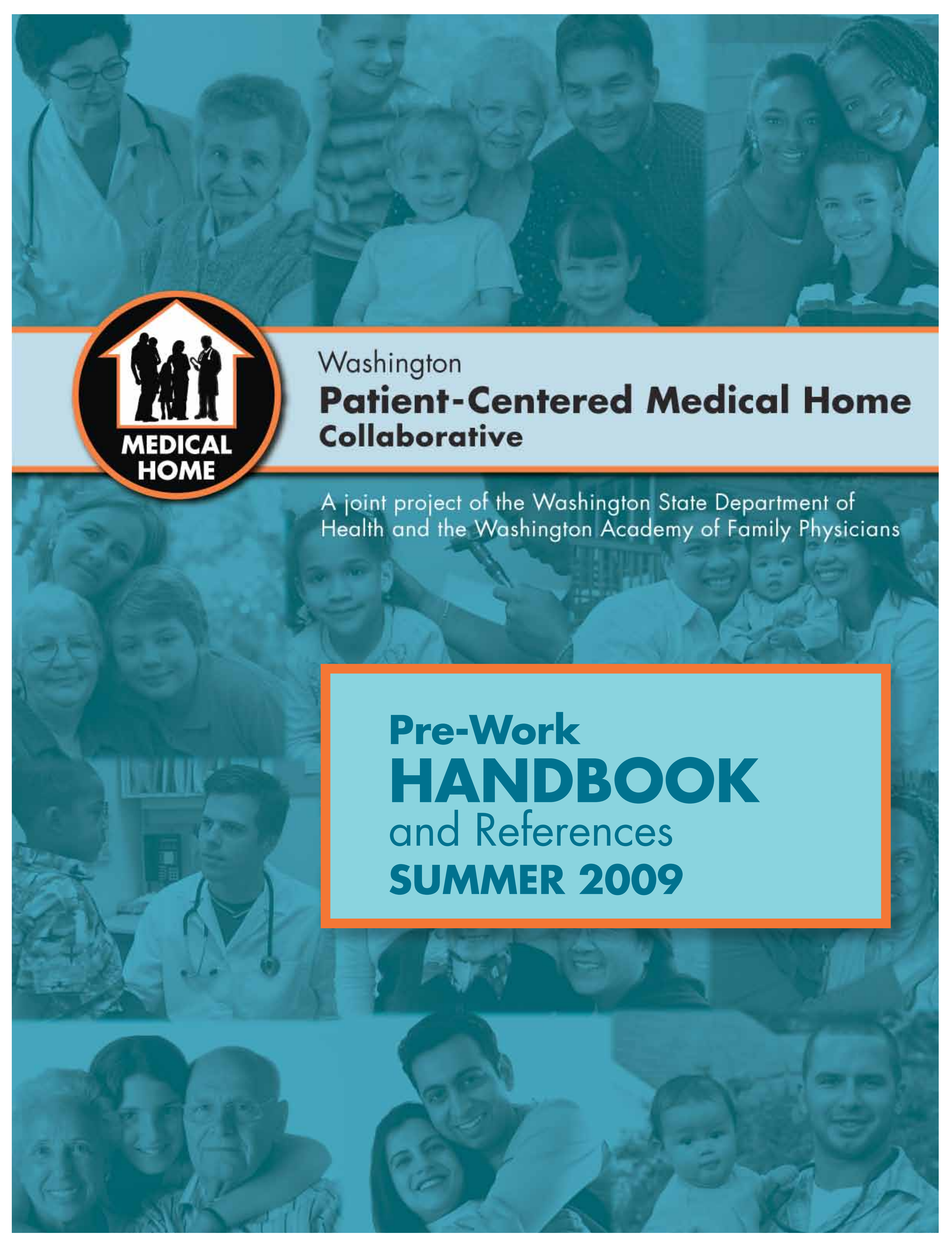
MEDICAL
HOME
Washington
Patient-Centered Medical Home
Collaborative
A joint project of the Washington State Department of
Health and the Washington Academy of Family Physicians
Pre-Work
HANDBOOK
and References
SUMMER 2009

Washington
Patient-Centered Medical Home Collaborative

A joint project of the Washington State Department of Health and the Washington Academy of Family Physicians

Pre-Work HANDBOOK and References SUMMER 2009

Sponsored by:

WELCOME

Welcome to the Washington Patient-Centered Medical Home Collaborative. The Patient-Centered Medical Home is an important step toward transforming your practice. As participants of this collaborative, you will contribute to an important development in health care history.

The Patient-Centered Medical Home promises to be the foundation of health care reform, bringing the art of healing and the science of medicine into the 21st century information age. Patient-centered medical homes will move beyond care based on episodes and visits to care based on authentic, lasting partnerships and teamwork.

The Washington Department of Health and the Washington Academy of Family Physicians are partners in this collaborative. Our goal is to also be partners with you, the clinics, in this exciting work. Your work is certain to make a lasting impact on the health of the people who live in Washington State.

Pat Justis

Manager, Medical Home Collaborative

Washington State Department of Health

www.doh.wa.gov

Leslie A. Oja

Director, Patient-Centered Medical Home-
Improving Performance in Practice

Washington Academy of Family Physicians

www.wafp.net

"The patient-centered medical home represents a pivotal turning point for the restoration of a healthy primary care foundation and better health for our nation."

Nutting, Miller, Crabtree, Jaen, Stewart & Stange

ACKNOWLEDGEMENTS

Many organizations and individuals contributed to the development of the Washington Patient-Centered Medical Home Collaborative (the Collaborative). We would like to recognize the following organizations and individuals for providing direction, funding, and expertise.

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Regence Blue Shield

Group Health Cooperative of Puget Sound

Molina Healthcare

Community Health Plan of Washington

Asuris Northwest Health

Kaiser Foundation

The Washington Academy of Family Physicians (WAFP) supports the Collaborative through funding provided by the American Board of Medical Specialties Improving Performance in Practice program and from the WAFP Foundation. WAFP is committed to assisting primary care practices in their effort to develop patient-centered medical home traits. The WAFP is a member-driven organization comprised of physicians who specialize in Family Medicine, and is the largest medicine specialty in the state.

Thanks to the Washington State Legislature, Governor Gregoire, and the Primary Care Coalition

Rep. Larry Seaquist (D-26) sponsored House Bill 2549-Patient-Centered Medical Home, that Governor Gregoire signed into law. Many members of the House and Senate, and the Governor were active in voicing their support for the development of patient-centered medical homes in Washington. The Primary Care Coalition was instrumental in bringing the issue to legislative action.

Thanks to other generous supporters:

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Puget Sound Health Alliance

University of Washington

Washington Health Information Collaborative

Washington, Wyoming, Alaska, Montana and Idaho Family Medicine Residency Training Programs (WWAMI)

Washington State Health Care Authority

Washington State Department of Social and Health Services

Qualis Health

Primary Care Coalition

Collaborative Advisory Committee

Acumentra Health
Aetna Healthcare
CIGNA Healthcare
Columbia United Providers
Community Health Plan
Department of Social and Health
Services
Evercare Washington
First Choice Health
Group Health Cooperative
Health Care Authority
Molina Healthcare
Kaiser Health Foundation
National Initiative for Children's
Healthcare Quality
Northwest Physicians Network
Premera Blue Cross
Primary Care Coalition
Public Health of Seattle/King County
Puget Sound Health Alliance
Qualis Health
Regence BlueShield
University of Washington
Washington Academy of Family
Physicians
Washington Association of
Community and Migrant Health
Centers
Washington Chapter American
Academy of Pediatrics

With Appreciation

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DEDICATION

The Summer Handbook of the Washington Patient-Centered Medical Home Collaborative is dedicated to the children with special health care needs who first inspired physicians, families and health workers to improve care delivery to create a level of primary care called a *patient and family-centered medical home*. May those children , who are now adults, be well and thrive.

How to use the handbook

Section 1: The Essentials

The first section focuses on the information your team needs for the collaborative activities prior to the first learning session. The change package, team instructions for activities and information on measures can be found here.

Section 2: References

The second section includes references to use anytime, as you wish or not.

> **"...go forward with curiosity, wondering where this experiment will lead."**
>
> **Pema Chodron**

About our partnership

The Washington State Department of Health and Washington Academy of Family Physicians are pleased to be working together on this collaborative. Each organization brings a realm of expertise that complements the other. If you have any questions about who is responsible for what, please feel free to ask Pat Justis (patricia.justis@doh.wa.gov) or Leslie Oja (leslie@wafp.net.

National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home Standards

The Washington Patient-Centered Medical Home Collaborative is not directly focused on preparation for NCQA Patient-Centered Medical Home Standards. We can, however, offer information and resources that will help practices pursue national certification. The measures section, in particular, has specific information related to standards. We expect the NCQA standards to continue to evolve and reflect input from across the nation.

CALENDAR

Site Visit A
July-September, 2009

Learning Session 1
September 29-30, 2009

Site Visit B
October 2009-March 2010

Learning Session 2
March 29-30, 2010

Site Visit C
April –September 2010

Learning Session 3
September 27-28, 2010

Site Visit D
October 2010-March 2011

Learning Session 4
March 28, 2011

Site Visit E
April –September 2011

Outcomes Congress
September 26, 2011

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Section 2 - Reference

Separate document

"…I argue for a radical transfer of power and a bolder meaning of 'patient-centered care' whether in a medical home or in the current cathedral of care: the hospital."

Donald Berwick

A New Definition

"My proposed definition of 'patient-centered care' is this:

The experience (to the extent the informed, individual patient desires it) of transparency, individualization, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances and relationships in health care."

Donald Berwick

The three rules

Notice what works.

If what you are doing does not work, do something else.

If what you are doing works, do more of it.

The three rules for Solution-Focused Therapy have strong relevance and utility for quality improvement and the Washington Patient-Centered Medical Home Collaborative.

SECTION I

PART 1 - CHARTER
PART 2 - TEAM ACTIVITIES
PART 3 - MEASURES

"Most current practice models are designed to enhance physician workflow. The patient-centered medical home should be designed to enhance the patient experience. This shift requires a transformation, not an incremental change."

Nutting, Miller, Crabtree, Jaen, Stewart & Stange

PART 1

Washington Patient-Centered Medical Home Collaborative

CHARTER

MISSION

To implement patient-centered medical homes in a variety of primary care clinics and improve the care of patients/families using the collaborative methodology.

GOALS

1. Develop an implementation model for patient-centered medical home which:
   - Improves health outcomes for patients
   - Improves the patient and family's experience of care
   - Improves primary care team satisfaction
2. Examine overall health care utilization and costs impacted by medical home implementation.

What is a change package?

A *change package* is a cohesive set of *change concepts*. The Institute for Healthcare Improvement (IHI) used the term change concept to refer to a general, scientifically grounded idea for a change. A change concept can stimulate many different ideas for specific process changes across a variety of healthcare settings.

Each "Breakthrough Collaborative," organized by IHI or other organizations uses a change package to guide the improvement work and drive the learning sessions. The change package for the Washington Patient-Centered Medical Home Collaborative was created by an expert panel in Seattle in October 2008. Primary care practices participated in focus groups to comment on the change package and changes were made to reflect their suggestions.

At the conclusion of the collaborative, after the Outcomes Congress, the change package may be refined to reflect the lessons learned during the two years of work.

CHANGE PACKAGE

Engaged Leadership

1. Provide visible and sustained leadership to lead culture change and specific quality improvement strategies.
2. Ensure that providers and other care team members have protected time and a method to proactively manage at-risk patient populations.
3. Integrate patient-centered medical home values and practices for patients/families into staff hiring and training processes.

Quality Improvement Strategy

1. Use a model for quality improvement.
2. Clearly establish and monitor metrics to evaluate improvement efforts and outcomes; ensure that all team members understand the metrics for success.
3. Obtain feedback from patients/family about their healthcare experience and use information for quality improvement.
4. Establish a quality improvement team that includes patients/families to meet regularly and guide the effort.

Patient-Centered Interactions

1. Integrate self-management support at every visit through goal setting and action planning.
2. Empower patients/family to expand their role in decision-making, care plan creation, health-related behaviors and self-management.
3. Show respect for patient/family values and expressed needs.
4. Communicate effectively with patients/families in a culturally appropriate manner, with a language and at a level that the patient/family understands.
5. Test results and cared plans are communicated to patients/families.

Organized Evidence-Based Care

1. The practice has access to evidence-based care guidelines.
2. Use point-of-care reminders based on clinical guidelines.
3. Conduct planned care for complex patients with one or more chronic diseases.
4. Prepare for productive interactions by ensuring up-to-date information is available at the time of each visit.

Continuous and Team-Based Healing Relationships

1. Clearly link each patient to a provider and care team so that both patient and provider/care team know and recognize each other as partners in care.
2. Clearly define roles and distribute tasks among care team members to reflect the skills, abilities and credentials of team members.
3. Cross-train care team members to maximize flexibility and assure that patients' needs are met.

Enhanced Access

1. Care options are patient/family-centered and accessible to all patients, regardless of abilities and skills.
2. Promote and expand access to assure established patients have 24-hour 7-day continuous access to their provider or care teams via phone, e-mail, or in-person visits.

Population Management

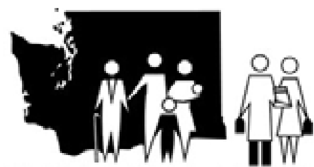
1. Assure all patients are linked to a provider/care team.
2. Balance the patient load across the providers in the office while honoring patient preferences.
3. Optimize use of health information technology to:
   a. Schedule appointments and monitor access to care on a continual basis.
   b. Understand and define your patient population, including language, race/ethnicity, and disabilities.
   c. Define and track care for individual patients and sub populations, including referrals and abnormal lab/imaging results.
   d. Provide patient-specific educational materials and reminders.

Care Coordination

1. Proactively track and support patients as they go to and from specialty care, the hospital, and the emergency department.
2. Link patients with community resources to facilitate referrals and respond to patient/family needs.
3. Integrate specialty and behavioral health into care protocols; establish two-way communication with an array of specialists to meet patient/family needs.

Patient-Centered Medical Home Improving Performance In Practice

A project of Washington Academy of Family Physicians and The American Board of Medical Specialties



Washington Academy of Family Physicians was awarded a grant to work with primary care practices on a state-based, quality improvement initiative funded in large part by the Robert Wood Johnson Foundation and the WAFP Foundation.

Quality Improvement Coaches for Improving Performance In Practice will assist participating practices in transformation efforts through training, organizational tools, and materials utilization, as well as on-site coaching.

These coaches will help each practice manage the development and implementation of changes necessary to implement their goals.

The objectives of the program align with the broader goals of the Washington Patient-Centered Medical Home Collaborative:

1. Use a Registry to identify patients with diabetes/asthma prior to the visit.
2. Use a condition-specific decision support tool (e.g., a visit planner).
3. Create a customized flow diagram and protocols to standardize the care process.

In 2009 the Washington program will focus on diabetes care in its partnership sponsoring the Washington Patient-Centered Medical Home Collaborative.

The Patient-Center Medical Home-Improving Performance in Practice program and national professional organizations will work closely with payers, health systems and public health organizations to align resources and efforts to support the work. Physicians who complete the IPIP program will meet a component of their maintenance of certification requirements.

Improving Performance in Practice (IPIP)

Participating States

Colorado
Michigan
Minnesota
North Carolina
Pennsylvania
Wisconsin
Washington

ON THE WEB

www.IPIPProgram.org

PART 2

TEAM ACTIVITIES

Pre-Learning Session 1

Team Activities

Look for the

To identify tasks to complete before the first learning session, September 29-30, 2009.

The day-to-day leader of the team should make sure all worksheets and documents from team activities come to Learning Session 1.

Forming the Team

A strong team is crucial to the success of your improvement effort. Choose your team members based on their knowledge of and passion for the systems and processes you will improve. A good size for a team is three to six members. You may create a larger team to meet at your clinic than attends the learning sessions.

There are four defined roles within the team, each expected to fulfill a set of responsibilities. Depending on the size of a clinic, one individual may fill more than one role on the collaborative team. Larger organizations may have both a Senior leader and a System leader. In a smaller setting there are fewer layers of leadership.

The same three core team members are required to attend all the learning sessions; the Clinical Champion and Day-to-Day Leader are essential, and all clinics need to send a third core member. At Learning Sessions 1 and 3 we would like your Senior Leader or your System Leader to participate in a leadership track. Leaders often come to the Outcomes Congress to celebrate the team's work.

Due to the space available and budget for this project we must set a team maximum of six people to attend the learning sessions. Though we require the core team of three to be consistent for all learning sessions, you may elect to vary the other three who attend, if you plan to use the six member maximum. You may choose to have a larger team working on the quality improvements within your clinic.

Team Role Descriptions

Role	Description
SENIOR LEADER (Sponsor) or System Leader *Typical organizational role:* **Executive medical director or clinical director**	• Authority to allocate the time and resources needed to achieve the team's aim. • Administrative authority over all areas affected by team's changes or direct authority over the systems affected by team's changes. • Will facilitate spread of successful changes through the organization or throughout the department or service area. • Champions the team's work to other leaders in the organization. • Makes sure the team stays aware of other changes in the organization that can affect their work.
CLINICAL CHAMPION or PRIMARY PROVIDER *Typical organizational role:* **Usually a physician, but may be a nurse practitioner, or other healthcare provider**	• A practicing provider, an opinion leader, and respected by peers. • Thoroughly understands the subject matter and processes of care. • Good working relationship with colleagues and day-to-day leader. • Displays the energy and desire to drive improvements.

Team Role Descriptions, continued

Role	Description
Day-to-Day Leader *Typical organizational role:* **Quality improvement manager, nurse, or health educator**	• Coordinates the project, ensuring that cycles of change are tested, implemented, and documented. • Coordinates communication between the team and Collaborative leadership. • Oversees data collection and reporting. • Works effectively with the clinical champion. • Understands how changes will affect systems. • Has the time to keep the project moving forward; this role usually requires 0.25 FTE or more.
Other Team Members	• Any staff with process knowledge involved in developing ideas to test, as well as testing and implementing changes.

"It is important to protect regular time to reflect and learn as a practice."

- Nutting

EXPECTATIONS:
Primary Practice Teams

Timeline of expected activities

ACTIVITY	TIMELINE
Perform pre-work activities (described in Team Activity section) Select a core team with a minimum of three members to attend all learning sessions and site visits: • The team must include the clinical champion and a day to day leader • One clinical care provider such as a nurse or medical assistant. • A third person of the clinic's choice. • Three team members are considered the minimum for the core team. Learning sessions may be attended by a maximum of six members. (The three core members plus a maximum of three others.) • We request that the three member core team stay constant for the two year period of the project. • The other three optional "spots" may be rotated (or not) as you balance the need for continuity with the need to spread learning in your practice.	**July-September 2009** **Select team: July 2009**
Regularly communicate about the improvement project to the rest of your clinic and organization to gain acceptance for your team's improvements and later spread learning from the Collaborative to other staff in the organization. Regular reporting to the team's senior leader and or system leader to maintain visible support for the improvements.	**July 2009-September 2011**

EXPECTATIONS:
Primary Practice Teams

Timeline of expected activities

ACTIVITY	TIMELINE
Load a registry or the registry functions of an Electronic Health Record (EHR) with a population equal to one full time provider's panel plus all clinic patients with diabetes.	**July 2009-December 2009**
Develop data collection methods and queries for registry or the registry functions of an Electronic Health Record (EHR).	**July 2009-September 2009**
Develop a bulletin board or storyboard display (see next page) at the clinic so that all staff and providers are familiar with the aim of the project and the data is visible.	*No storyboards at Learning Session 1* **March 29-30, 2010** — **Learning Session 2** **September 27-28, 2010** — **Learning Session 3** **March 28, 2011** — **Learning Session 4** **September 26, 2011** — **Outcomes Congress**
Plan, design, and implement plan-do-study-act (PDSA) improvement cycles to meet the team's aim.	**October 2009-September 2011**
Collect and display data at the clinic to reflect the team's learning and results.	**October 2009-September 2011**
Regular reporting to Collaborative leadership, based on the schedule provided at Learning Session 1. These reports provide a record for progress and can benefit other participant teams.	**October 2009-September 2011**

EXPECTATIONS:
Primary Practice Teams

Timeline of expected activities

ACTIVITY	TIMELINE
Share information, challenges and lessons with other Collaborative participants, during and between learning sessions.	**July 2009-September 2011**
Directly communicate any concerns, questions or requests to your team's assigned coach. If unresolved, please contact a Collaborative manager: Pat Justis, 360-236-3793 patricia.justis@doh.wa.gov Leslie Oja, 425-747-3100 leslie@wafp.net	**June 2009-September 2011**

What is a storyboard?

Storyboards use simple, clear statements and graphics to describe the quality improvement work of a team. A storyboard can be used at any point during the team's work, and focuses on themes that are relevant to a particular stage of work, audience or communication goal. Typical elements on a storyboard include:

- Aim statement
- Description of a problem, current situation or opportunity
- Descriptions of improvement tests or PDSA cycles
- Data to display the result of the test
- A summary of challenges
- Accomplishments or lessons learned
- Next steps to sustain and or spread the change

Team Membership Worksheet

Please complete and return to your assigned coach by July 31. We realize some of you documented your team on your enrollment application, but other clinics did not, so we would like to confirm team membership for all participants. Descriptions of the roles may be found on the document entitled *Forming the team* on page 13. Please remember, one person may play multiple roles but you need a minimum of three team members.

CORE TEAM
Will attend all learning sessions and site visits

Clinical Champion

Name:
Position in clinic:
E-mail:
Phone:

Day-to-Day Leader

Name:
Position in clinic:
E-mail:
Phone:

Team Member

Name:
Position in clinic:
E-mail:
Phone:

Senior Leader/System Leader

Name:
Position:
E-mail:
Phone:

Name:
Position:
E-mail:
Phone:

Other team members or interested supporters within your organization you would like to include:

Name:
Position in clinic:
E-mail:
Phone:

Name:
Position in clinic:
E-mail:
Phone:

Name:
Position in clinic:
E-mail:
Phone:

Please circle an estimate of how many team members you will send to learning sessions (minimum of 3, maximum of 6):

3 4 5 6

Please note:

Details about learning session registration, location, lodging, team stipends, CME credits, transportation, and reporting will be available soon.

Pre-Learning Session 1 Team Checklist

Read through Forming a team, then complete the team worksheet, and send to your coach by July 31.*

Organize your team and commit to a regular meeting time.
Clarify roles and responsibilities.

Meet with your senior and or system leader(s) to agree on two-way communication strategies. Negotiate which decisions the team can make and which decisions need to be made by senior leaders.

Prepare your electronic registry and or electronic medical record for two populations. First assure the equivalent of one full time provider's panel of patients are abstracted into your information system; (assumes patients are assigned to the panel) and second, all patients with diabetes who receive care at your clinic site, for all providers.

Assess your Health Information Technology (HIT).
Determine what it will take to build the data collection, data reporting and data analysis processes and who will take responsibility for the tasks.

Develop queries for the measures to make reporting as easy as possible later.

* Previously sent via e-mail and discussed in initial informed consent appointments

Pre-Learning Session 1
Team Checklist

Communicate to the relevant parts of your organization to let them know about the Washington Patient-Centered Medical Home Collaborative. Make communication a regular agenda item for your team meetings.

Complete the assessments your team decides are useful

Know your purpose

Know your patients

Know your people

Know your patterns

Know your processes

Decide on a method for keeping the team's documents all together in a master file electronically and or in hard copy. You will want all the team records easy to access. Appoint a team historian or archivist to keep things together, especially if note keeping is shared by all members.

Read, explore Web sites, talk as a team, and call or e-mail other clinics. Consider the possibilities. Dream about the ideal patient-centered medical home.

Work as a team to synthesize some themes or headlines from your completed assessments of people, patterns, process and patients to brainstorm possible project aim statements under each theme in the change package.

The acceptance of your team's improvements will be directly linked to the effectiveness and persistence of your communication efforts.

The Microsystems Framework

Microsystems is a model to describe and improve the clinical office setting for health care, developed tested and refined in the Dartmouth-Hitchcock Health System in New Hampshire.

These methods can be adapted to a wide variety of clinical settings, large and small, urban and rural, community-based and academic.

Some teams enrolled in the collaborative have already had some exposure to the Clinical Micro-systems concepts and practices. You are welcome to draw on any previous assessments you may have completed, as long as you update the information to reflect your current situation. We believe the assessments are much stronger when completed by the entire team rather than by one individual.

If members of your team have differing percep-tions, that is healthy and fertile ground for more dialogue.

"Clinical microsystems are the front-line units that provide most health care to most people. They are the places where patients, families and care teams meet. Microsystems also include support staff, processes, tech-nology and recurring patterns of informa-tion, behavior and results. Central to every clinical microsystem is the patient.

The microsystem is the place where:

- Care is made.
- Quality, safety, reliability, efficiency and in-novation are made.
- Staff morale and patient satisfaction are made."

- Outpatient/Primary Care Greenbook, page 2

"All health care professionals— and we believe all front line clinical and support staff are professionals—have 2 jobs.

Job 1 is to provide care.

Job 2 is to improve care."

- Outpatient/Primary Care Greenbook, page 2

The Five Ps:

Know Your Purpose
Know Your Patients
Know Your Professionals
Know Your Processes
Know Your Patterns

Credit

Materials for this section are excerpted from the Outpatient/Primary Care Greenbook, 2001, copyrighted by Trustees of Dartmouth College, Godfrey, Nelson, Batalden, Institute for Health-care Improvement, Adapted from the original version, Dartmouth-Hitchcock, Version 2, February 2005.

"Dartmouth-Hitchcock Medical Center and the developers of this workbook are pleased to grant use of these materials without charge, providing that recognition is given for their development, that any alterations to the documents for local suitability and acceptance are shared in advance, and that the uses are limited to **their own use and not for re-sale."**

Set Your Pace

The Clinical Microsystems materials and specifically, the Greenbook tools, can be described as a well stocked pantry, a shop full of well designed tools, or fertile soil. Pick your metaphor.

Every clinic and each participant primary practice team has different circumstances and a different thirst and tolerance for quality improvement work. We hope you view quality improvement as integral to your work, and not extra. If it feels like busywork and does not carry important meaning, then something needs to be changed.

The pace and scope of the quality improvement work you do are vitally important and must be adjusted as you go. Take on too big of a project and it will become overwhelming. Put the bar too low and the improvement will not inspire and inject energy and passion into your team.

We will make tools and resources available. We may even offer suggestions for you to consider. The work, however, is always yours to decide.

PICK YOUR TOOLS

We have excerpted a small number of assessment tools from the Clinical Microsystems Greenbook for outpatient primary care. On the next page we offer the "Primary Practice Profile" as well as a selection of tools from the Greenbook. Your team may select and use different tools than the one we include here. Complete the tools that seem the most useful to your team and that will help you have the best data to drive project selection. Visit the Clinical Microsystems web site to locate the Outpatient-Primary Care Greenbook and explore the wide selection of assessment tools.

Please note:

We put the tools in PDF form to retain all original layout. You can find the forms in Word files suitable for electronic edits on the Clinical Microsystems Web site.

www.clinicalmicrosystem.org

Primary Care Practice Profile

A. Purpose:
Why does your practice exist?

Site Name:	Site Contact:	Date:
Practice Manager:	MD Lead:	Nurse Lead:

B. Know Your Patients: Take a close look into your practice, create a "high-level" picture of the PATIENT POPULATION that you serve. Who are they? What resources do they use? How do the patients view the care they receive?

Est. Age Distribution of Patients:	**%**
Birth-10 years	
11-18 years	
19-45 years	
46-64 years	
65-79 years	
80 + years	
% Females	
Est. # (unique) pts. In Practice	
Disease Specific Health Outcomes, pg 24	
Diabetes HgA1c =	
Hypertension B/P =	
LDL <100 =	

List Your Top 10 Diagnoses/Conditions		**Top Referrals (e.g. GI Cardiology)**
1.	6.	
2.	7.	
3.	8.	
4.	9.	
5.	10.	

Patients who are frequent users of your practice and their reasons for seeking frequent interactions and visits	**Other Clinical microsystems you interact with regularly as you provide care for patients (e.g. OR, VNA)**

Patient Satisfaction Scores	% Excellent
Experience via phone	
Length of time to get your appointment	
Saw who patient wanted to see	
Satisfaction with personal manner	
Time spent with person today	

Pt Population Census: Do these numbers change by season? (Y/N)	**#**	**Y/N**
Patients seen in a day		
Patients seen in last week		
New patients in last month		
Disenrolling patients in last month		
Encounters per provider per year		

Out of Practice Visits	
Condition Sensitive Hospital Rate	
Emergency Room Visit Rate	

****Complete "Through the Eyes of Your Patient", pg 9***

C. Know Your Professionals: Use the following template to create a comprehensive picture of your practice. Who does what and when? Is the right person doing the right activity? Are roles being optimized? Are all roles who contribute to the patient experience listed? What hours are you open for business? How many and what is the duration of your appointment types? How many exam rooms do you currently have? What is the morale of your staff?

Current Staff	**FTEs**	**Comment/ Function**	**3rd Next Available**		**Cycle Time**
Enter names below totals Use separate sheet if needed			PE	Follow-up	Range
MD Total					
NP/PAs Total					
RNs Total					
LPNs Total					
LNA/MAs Total					
Secretaries Total					
Others:					

Do you use Float Pool? ____ Yes ____ No
Do you use On-Call? ____ Yes ____ No

Days of Operation	**Hours**
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Do you offer the following? Check all that apply.

- ☐ Group Visit
- ☐ E-mail
- ☐ Web site
- ☐ RN Clinics
- ☐ Phone Follow-up
- ☐ Phone Care Management
- ☐ Disease Registries
- ☐ Protocols/Guidelines

Appoint. Type	**Duration**	**Comment:**

Staff Satisfaction Scores		**%**
How stressful is the practice?	% Not Satisfied	
Would you recommend it as a good place to work?	% Strongly Agree	

***Each staff member should complete the Personal Skills Assessment and "The Activity Survey", pgs 13-15**

D. Know Your Processes: How do things get done in the microsystem? Who does what? What are the step-by-step processes? How long does the care process take? Where are the delays? What are the "between" microsystems hand-offs?

1. **Track cycle time for patients from the time they check in until they leave the office using the Patient Cycle Time Tool. List ranges of time per provider on this table, pg 16/17**
2. **Complete the Core and Supporting Process Assessment Tool, pg 18**

E. Know Your Patterns: What patterns are present but not acknowledged in your microsystem? What is the leadership and social pattern? How often does the microsystem meet to discuss patient care? Are patients and families involved? What are your results and outcomes?

- Does every member of the practice meet regularly as a team?
- How frequently?
- Do the members of the practice regularly review and discuss safety and reliability issues?
- What have you successfully changed?
- What are you most proud of?
- What is your financial picture?
- What is the most significant pattern of variation?

***Complete "Metrics that Matter", pgs 23-24**

Know Your Purpose

"Start with Purpose. Why does your practice exist?
Raise this question to EVERYONE in your practice to create the best statement of purpose that everyone can buy into."

From page 4
Outpatient/Primary Care Greenbook

Options for writing a purpose statement

- Ask team members to make word lists or simple sentences and then work to combine the common ideas.
- Write an open letter to the patients in the practice, and explain the reasons your team is working to build more elements of a patient-centered medical home.
- As a variation, write an oath to your patients, making an ethical promise about your purpose in relationship to their needs and what you will be for them in times of enormous vulnerability or suffering.
- Work together on a visual representation of the clinic's purpose using any and all media; drawing, painting, collage of found images, fingerpaints, etc.
- Everyone composes written questions about the practice's purpose and drops the questions into a "hat." Take turns pulling out a question and answering, building on the themes for the purpose statement on a common flip chart or white board as the conversation progresses.
- The team divides up the entire clinic and asks every person who works there in any role, "Why does this practice exist? "

Bring all the answers together to create a common statement.

Know Your Patients X

Patients

- Gain insight into how your patients experience your practice. One simple way to understand the patient experience is to experience the care. Members of the staff should do a "Walk Through" in your practice. Try to make this experience as real as possible, this form can be used to document the experience. You can also capture the patient experience by making an audio or videotape.

Through the Eyes of Your Patients

Tips for making the "Walk Through" most productive:

1. Determine with your staff where the starting point and ending points should be, taking into consideration making the appointment, the actual office visit process, follow-up and other processes.
2. Two members of the staff should role play with each playing a role: patient and partner/family member.
3. Set aside a reasonable amount of time to experience the patient journey. Consider doing multiple experiences along the patient journey at different times.
4. Make it real. Include time with registration, lab tests, new patient, follow-up and physicals. Sit where the patient sits. Wear what the patient wears. Make a realistic paper trail including chart, lab reports and follow-up.
5. During the experience note both positive and negative experiences, as well as any surprises. What was frustrating? What was gratifying? What was confusing? Again, an audio or video tape can be helpful.
6. Debrief your staff on what you did and what you learned.

Date: ______________

Walk Through Begins When: _________________

Staff Members: ______________________________

Ends When: __________________________________

Positives	Negatives	Surprises	Frustrating/Confusing	Gratifying

Know Your Professionals

Professionals

- Development of each member in the practice is a key to success for staff and the microsystem. The Personal Skills Assessment tool helps determine the education and training needs of staff. All staff members complete this survey and then discuss the action plan with leadership and other staff. A plan is developed to help members achieve goals so they can become the best they can be.
- This tool provides guidance for individual development plans along with assessing the “group” needs to plan larger learning and training sessions.

Primary Care Practice Resources—Personal Skills Assessment

Name ______________________ Unit: ______________________

Role: ______________________ Date: ______________________

Clinical Competencies:											
Please create your list of clinical competencies and eva	**Want to Learn**	**Never Use**			**Occasionally**				**Frequently**		
	❑	1	2	3	4	5	6	7	8	9	10

Clinical Information Systems (CIS):											
What features and functions do you use?	**Want to Learn**	**Never Use**			**Occasionally**				**Frequently**		
Provider/On Call Schedule	❑	1	2	3	4	5	6	7	8	9	10
Patient Demographics	❑	1	2	3	4	5	6	7	8	9	10
Lab Results	❑	1	2	3	4	5	6	7	8	9	10
Pathology	❑	1	2	3	4	5	6	7	8	9	10
Problem List	❑	1	2	3	4	5	6	7	8	9	10
Electronic Health Record (EHR)											
Review Reports/Notes	❑	1	2	3	4	5	6	7	8	9	10
Documentation	❑	1	2	3	4	5	6	7	8	9	10
Direct Entry	❑	1	2	3	4	5	6	7	8	9	10
Note Templates	❑	1	2	3	4	5	6	7	8	9	10
Medication Lists	❑	1	2	3	4	5	6	7	8	9	10
Medication Ordering											
Action Taken on Surgical Pathology											
Insurance Status	❑	1	2	3	4	5	6	7	8	9	10
Durable Power of Attorney	❑	1	2	3	4	5	6	7	8	9	10
Radiology	❑	1	2	3	4	5	6	7	8	9	10
OR Schedules	❑	1	2	3	4	5	6	7	8	9	10

NOTE: CIS refers to hospital or clinic-based systems used for such functions as checking in patients, electronic medical records, accessing lab and x-ray information. Customize your list of CIS features to determine skills needed by various staff members to optimize their roles.

Technical Skills:											
Please rate the following on how often you use them.	**Want to Learn**	**Never Use**			**Occasionally**				**Frequently**		
CIS*	❑	1	2	3	4	5	6	7	8	9	10

Know Your Professionals, continued

Primary Care Practice Resources—Personal Skills Assessment page 2

Name ______________________________ Unit: ______________________________

Technical Skills cont'd:

Please rate the following on how often you use them.	Want to Learn	Never Use			Occasionally				Frequently		
Central Dictation	❑	1	2	3	4	5	6	7	8	9	10
Word Processing (e.g. Word)	❑	1	2	3	4	5	6	7	8	9	10
Spreadsheet (e.g. Excel)	❑	1	2	3	4	5	6	7	8	9	10
Presentation (e.g. Power Point)	❑	1	2	3	4	5	6	7	8	9	10
Database (e.g. Access or File Maker Pro)	❑	1	2	3	4	5	6	7	8	9	10
Patient Database/Statistics	❑	1	2	3	4	5	6	7	8	9	10
Internet/Intranet	❑	1	2	3	4	5	6	7	8	9	10
Printer Access	❑	1	2	3	4	5	6	7	8	9	10
Fax	❑	1	2	3	4	5	6	7	8	9	10
Copier	❑	1	2	3	4	5	6	7	8	9	10
Telephone System	❑	1	2	3	4	5	6	7	8	9	10
Voice Mail	❑	1	2	3	4	5	6	7	8	9	10
Pagers	❑	1	2	3	4	5	6	7	8	9	10
Tube System	❑	1	2	3	4	5	6	7	8	9	10
	❑	1	2	3	4	5	6	7	8	9	10

Meeting & Interpersonal Skills:	Want to Learn	Never Use			Occasionally				Frequently		
What skills do you currently use?	❑	1	2	3	4	5	6	7	8	9	10
Effective Meeting Skills (brainstorm/multi-vote)	❑	1	2	3	4	5	6	7	8	9	10
Timed Agendas	❑	1	2	3	4	5	6	7	8	9	10
Role Assignments During Meetings	❑	1	2	3	4	5	6	7	8	9	10
Delegation	❑	1	2	3	4	5	6	7	8	9	10
Problem Solving	❑	1	2	3	4	5	6	7	8	9	10
Patient Advocacy Process	❑	1	2	3	4	5	6	7	8	9	10
Open and Effective Communication	❑	1	2	3	4	5	6	7	8	9	10
Feedback – provide and receive	❑	1	2	3	4	5	6	7	8	9	10
Managing Conflict/Negotiation	❑	1	2	3	4	5	6	7	8	9	10
Emotional/Spiritual Support	❑	1	2	3	4	5	6	7	8	9	10

Improvement Skills and Knowledge:	Want to Learn	Never Use			Occasionally				Frequently		
What improvement tools do you currently use?											
Flowcharts/Process Mapping	❑	1	2	3	4	5	6	7	8	9	10
Trend Charts	❑	1	2	3	4	5	6	7	8	9	10
Control Charts	❑	1	2	3	4	5	6	7	8	9	10
Plan/Do/Study/Act (PDSA) Improvement Model	❑	1	2	3	4	5	6	7	8	9	10
Aim Statements	❑	1	2	3	4	5	6	7	8	9	10

Know Your Processes

Processes

- Beginning to have all staff understand the processes of care and services in the practice is a key to developing a common understanding and focus for improvement. Start with the high level process of a patient entering your practice by using the Patient Cycle Time tool. You can assign someone to track all visits for a week to get a sample, or the cycle time tool can be initiated for all visits in a one week period with many people contributing to the collection and completion of this worksheet.
- Typically, other processes will be uncovered to measure and you can create time tracking worksheets like this template to measure other cycle times.

Primary Care Practice Patient Cycle Time

Day: ____________ **Date:** ____________

Scheduled Appointment Tim ____________ **Provider you are Seeing Toc** ____________

Time	
	1. Time you checked in.
	2. Time you sat in the waiting room.
	3. Time staff came to get you.
	4. Time staff member left you in exam room.
	5. Time provider came in room.
	6. Time provider left the room.
	7. Time you left the exam room.
	8. Time you arrived at check out.
	9. Time you left practice.

Comments:

Know Your Processes

Processes

- Beginning to have all staff understand the processes of care and services in the practice is a key to developing a common understanding and focus for improvement. Start with the high level process of a patient entering your practice by using the Patient Cycle Time tool. You can assign someone to track all visits for a week to get a sample, or the cycle time tool can be initiated for all visits in a one week period with many people contributing to the collection and completion of this worksheet.
- Typically, other processes will be uncovered to measure and you can create time tracking worksheets like this template to measure other cycle times.

Primary Care Practice Patient Cycle Time—Academic Example

Type of Visit: ____________________ **Day** ______________ **Date** __________________

Scheduled Appointment Ti ____________ **Provider you are Seeing T** ____________

Time

[ ] **1. Time you checked in.**

[ ] **2. Time you sat in the waiting room.**

[ ] **3. Time staff came to get you.**

[ ] **4. Time staff member left you in exam room.**

[ ] **5. Time provider came in room. If the provider left the room more than once, please note the times**

	1	2	3
Time Left			
Time Returned			

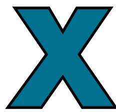
[ ] **6. Time provider left the room.**

[ ] **7. Time you left the exam room.**

[ ] **8. Time you arrived at check out.**

[ ] **9. Time you left practice.**

Know Your Processes
Another option



Processes

- Review, adapt and distribute the Core and Supporting Processes evaluation form to ALL practice staff. Be sure the list is accurate for your practice and then ask staff to evaluate the CURRENT state of these processes. Rate each process by putting a tally mark under the heading which most closely matches your understanding of the process. Also mark if the process is a source of patient complaints.
  Tally the results to give the Lead Team an idea as to where to begin to focus improvement from the staff perspective.
- **Steps for Improvement:** Explore improvements for each process based on the outcomes of this assessment tool. Each of the processes below should be flowcharted in its' current state. Once you have flowcharted the current state of your processes and determined your Change Ideas, use the PDSA Cycle Worksheet to run tests of change and to measure.

Primary Care Practice Know Your Processes Core and Supporting Processes							
Processes	**Works Well**	**Small Problem**	**Real Problem**	**Totally Broken**	**Cannot Rate**	**We're Working On It**	**Source of Patient Complaint**
Answering Phones							
Appointment System							
Messaging							
Scheduling Procedures							
Order Diagnostic Testing							
Reporting Diagnostic Test Results							
Prescription Renewal							
Making Referrals							
Pre-authorization for Services							
Billing/Coding							
Phone Advice							
Assignment of Patients to Your Practice							
Orientation of Patients to Your Practice							
New Patient Work-ups							
Minor Procedures							
Education for Patients/Families							
Prevention Assessment/Activities							
Chronic Disease Management							
Palliative Care							

Patterns

- Patterns are present in our daily work and we may or may not be aware of them. Patterns can offer hints and clues to our work that inform us of possible improvement ideas. The Unplanned Activity Tracking Card is a tool you can ask staff to carry to track patterns of interruptions, waits and delays in the process of providing smooth and uninterrupted patient care. Start with any group in the staff. Give each staff member a card to carry during a shift, to mark each time an interruption occurs when direct patient care is delayed or interrupted. The tracking cards should then be tallied by each person and within each group to review possible process and system redesign opportunities. Noticing patterns of unplanned activities can alert staff to possible improvements.
- This collection tool can be adapted for any role in the Primary Care Practice to discover interruptions in work flow. Circles in the example indicate processes to further evaluate for possible improvements.

Primary Care Practice Unplanned Activity Tracking Card

Unplanned Activity Tracking		**Unplanned Activity Tracking**	
Name: ______		Name: ______	
Date: ______ Time: ______		Date: ______ Time: ______	
Place a tally mark for each occurrence of an unplanned activity	**Total**	**Place a tally mark for each occurrence of an unplanned activity**	**Total**
Interruptions		Interruptions	
• Phone		• Phone IIII IIII IIII	15
• Secretary		• Secretary	
• RN		• RN IIII IIII	10
• Provider		• Provider	
Hospital Admissions		Hospital Admissions IIII IIII II	12
Patient Phone Calls		Patient Phone Calls	
Pages		Pages IIII IIII IIII IIII	20
Missing Equipment		Missing Equipment	
Missing Supplies		Missing Supplies IIII	5
Missing Chart: Same Day Patient		Missing Chart: Same Day Patient	
Missing Chart: Patient		Missing Chart: Patient IIII IIII	10
Missing Test Results		Missing Test Results	
Other		Other	○
			○

Know your patterns X

Patterns

- Patterns can be found through tracking the volumes and types of telephone calls. Review the categories on the telephone tracking list to ensure they reflect the general categories of calls your practice receives. Ask clerical staff to track the telephone calls over the course of a week to find the patterns of each type of call and the volume peaks and valleys.
- Put a tally mark each time one of the phone calls is for one of the listed categories. Total the calls for each day and then total the calls in each category for the week. Note the changes in volume by the day of the week and am/pm.

Primary Care Practice Telephone Tracking Log

Week of ________	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday		Week Total
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	
Appointment for Today															
Total															
Appointment for Tomorrow															
Total															
Appointment for Future															
Total															
Test Results															
Total															
Nurse Care															
Total															
Prescription Refill															
Total															
Referral Information															
Total															
Need Information															
Total															
Message for Provider															
Total															
Talk with Provider															
Total															
DAY TOTAL															

Bonus tool:
Important team skill

Huddle Sheet

- What can we proactively anticipate and plan for in our work day/week? At the beginning of the day, hold a review of the day, review of the coming week and review of the next week. Frequency of daily review is dependent on the situation, but a mid-day review is also helpful.
- This worksheet can be modified to add more detail to the content and purpose of the huddles.

Huddle Sheet
Practice: ____________________ Date: __________   **Aim:** Enable the practice to proactively anticipate and plan actions based on patient need and available resources, and contingency planning.
Follow-ups from Yesterday
"Heads up" for Today: (include special patient needs, sick calls, staff flexibility, contingency plans)
Meetings:
Review of Tomorrow and Proactive Planning
Meetings:

Developing a SMART Goal Statement

In previous collaboratives the term "aim statement" has been used. The specific formula for how to write the statement felt like a burden to some. We have decided to use the well known term SMART goal, in combination with the more general vision of work you can develop as a part of the "Know your Purpose" activity. (See page 26)
SMART is an acronym that stands for Specific-Measurable-Achievable-Realistic-Timely.

In this collaborative we encourage SMART goal statements that are a concise, written statement describing what the team expects to improve. The goal statement provides guidance for the team's specific efforts. To ensure support for your team's work, it is important to align your statement with your organizations' strategic goals and to involve senior leadership.

State the goal clearly and include numerical goals.

Teams make better progress when they have a specific goal. Numerical targets clarify the statement, create tension for change, and direct measurement. Teams typically set numerical goals that are 10-50% above their current baseline numbers and, as these goals are reached, set new goals, called 'stretching' goals.

Involve senior leaders.

Senior leaders can help align the goal statement with the organization's strategic goals. A senior leader must also provide support personnel and resources.

Base your goal on data or organizational needs.

Examine existing data within your organization. Refer to the change package and focus on issues that matter at your clinic. Personalize the goal statements to fit your organization.

Chunk it up.

When possible, it is often better to break up a large system into parts to improve, to take segments of a long complex process. Link the successes rather than flailing with an improvement plan too large in scope.

Identify the species.

If the existing process is stable and well known, you can make incremental improvement. If no process exists, or the one that does is nearly random because everyone has developed their own "work around", you need to plan or redesign a new process, rather than improve an existing process design.

Examples:

The lousy goal statement matching game

Draw a line between the lousy goal statement and the described flaw.

Answers at bottom of next page

A. Improve self-management practices.

B. Have some patients using the open access schedule by December.

C. 50 percent of all referrals to Orthopedics will go well.

D. Send out mammogram reminders to women over 60 within three months.

E. Use language interpretation services whenever needed.

1. No target population, no degree of improvement, no time line.
2. Lacks specific description of what "go well" means.
3. How many patients, and use the schedule to do what? Any patient, or is there a target population?
4. The population is named, and the time goal, but not what degree of improvement this represents.
5. Too broad, no definition of what improvement means, no time, no degree of improvement, lacks most details.

Improved Goal Statements Examples

"50 percent of patients with a diagnosis of asthma will have documented self-management goals within the next 3 months."

Or if you do not yet know what your baseline data is you may say:

"The percentage of patients with a diagnosis of asthma with a documented self-management goal will be 10% above baseline within the next 3 months."

The mammogram reminder postcard will go out by December 2009 to 100% of panel patient females over 50 who lack a documented baseline mammogram."

According to the Center for Evaluative Clinical Sciences at Dartmouth,

U.S. states that rely more on primary care have:

- lower Medicare spending (inpatient reimbursements and Part B payments),
- lower resource inputs (hospital beds, ICU beds, total physician labor, primary care labor, and medical specialist labor),
- lower utilization rates (physician visits, days in ICUs, days in the hospital, and fewer patients seeing 10 or more physicians), and
- better quality of care (fewer ICU deaths and a higher composite quality score).

Dartmouth Atlas of Health Care, Variation among States in the Management of Severe Chronic Illness, 2006

The lousy aim statement matching game

Answers

A-5 B-3 C-2 D-4 E-1

Team Activity: Brainstorming SMART Goal Statements X

Before the first learning session, your team will complete several assessments:

Know your purpose
Know your patients
Know your people
Know your processes
Know your patterns

Use the information from your assessments , the change package and material in the quality improvement section to create a list of possible project aim statements. Apply brainstorming rules to generate a list without editing at first, thinking divergently about all the possibilities. Each aim statement idea needs to link to the change package.
Work as a team to prioritize your list. Come to the first learning session in September with at least three and no more than ten ideas for possible SMART goal statements. Work to refine the statements so they are focused, measurable and include time targets.

SMART GOALS

Specific
Measurable
Attainable
Realistic
Timely

Team Worksheet:
SMART Goal Statements Brainstorm

Team name:

Clinic:

Team members:

SMART Goal Brainstorm

SMART Goal Brainstorm, continued

PART 3
MEASURES

Measures

In perspective

The Washington Patient-Centered Medical Home Collaborative will include measures focused on the descriptive statistics used for quality improvement, as well as more rigorous data methods used for evaluation of the medical home model. Some measures may serve both purposes.

One of the key questions of the model for improvement is, “how will you know that a change is an improvement? “

The Washington Patient-Centered Medical Home Collaborative is about meaningful improvements to primary care from the perspectives of patients, patient’s families, physicians and the team of care providers. Measures are the tools we use to evaluate the degree of improvement.

There is a saying in quality improvement work:

Data = facts.

Information = data that responds to useful questions.

The Washington Patient-Centered Medical Home Collaborative measures are focused on useful information to compel improvement action.

WARNING

Not every change is an improvement.

Defining a Provider Panel and Assigning Patients to Providers

Each clinic participating in the Washington Patient-Centered Medical Home Collaborative will include for reporting, at a minimum, the equivalent of the complete patient panel of a full-time primary care provider.

The clinic is responsible for assigning the panel of patients to the Collaborative participating provider.

If a clinic already has a process in place for assigning patients to a provider, they may continue to utilize that method.

We offer a framework (Murray, 2007) to assist with the identification of active patients of the Clinical Champions and other participating providers to abstract into a registry and or Electronic Health Record (EHR) for the Collaborative.

First, identify your active patients. An active patient is one who had two encounters with different dates of service in your clinic during the previous 2 years. An encounter may include a face-to-face visit, laboratory visits, medication refill requests, eVisits (patient visits conducted through e-mail and/or other teleconferencing-like method), phone visits, visit reminder efforts, and inactive patient contact efforts.

Clinics may assign patients by asking the patient to identify their primary care provider.

Use the following "four-cut" method for attributing or assigning active patients:

1. Patients who have seen only one provider for all visits are assigned to that provider.
2. Patients who have seen more than one provider are assigned to the provider that they see most often.
3. The remaining patients who have seen multiple providers the same number of times are assigned to the provider who performed their most recent physical or health check.
4. The remaining patients who have seen multiple providers the same number of times but have not had a recent exam are assigned to the provider they saw last.

REFERENCE

Murray, M., Davies, M., & Boushon, B. (2007, April). Panel Size: How Many Patients Can One Doctor Manage? Family Practice Management, 44-51.

The Collaborative core team will be responsible for completing the following tasks for clinical data baseline reporting prior to January 1, 2010:

- The entire patient panel (ALL patients equivalent to a full time provider) must be abstracted into the registry or EHR.

- All patients with diabetes seen in the clinic (regardless of provider) must be abstracted into the registry or EHR. **Note: this is an update from the information provided in the informed consent visits or phone appointments.**

- The clinic must have a method for identifying and 'tagging' all active patients entered into the registry/EHR up until January 1, 2010. These 'tagged' patients constitute the panel of patients that will be reported on throughout the collaborative. Patients may be entered into the registry/EHR after January 1, 2010, but those patients will not be 'tagged' for reporting.

- In CDEMS, we have set up a dummy diagnosis for medical home that we will use to tag the panel of patients. Every patient in the registry is assigned the *medical home diagnosis* until January 1, 2010. This will allow reporting on this panel population throughout the Collaborative without increasing denominators.

- All required clinical data elements must be captured in and reported out of the practice registry/EHR by January 1, 2010. This will constitute the baseline data for the Collaborative. Please refer to the measures for the required clinical data elements.

Abstraction Guidelines

Populating your EHR or registry through patient data abstraction can be time consuming and difficult. If this is a pre-work task that your clinic must undertake, we recommend that you start the process as soon as possible. The goal is to have the entire panel (described above) abstracted into your reporting system (EHR or registry) and "tagged" by January 1, 2010, for your first baseline data report.

You will abstract and load two populations:

- all patients with diabetes in the clinic as identified by diagnostic code,
- all patients in the clinical champion's panel.

You have the option to include patients from other providers at your clinic site in your patient cohort for reporting as long as the provider is involved in medical home improvements. In the case of a Clinical Champion with a part-time clinical load, additional patients are required to reach a total number of patients equal to a full time provider panel.

In order to meet National Committee for Quality Assurance Physician Practice Connections for Patient-Centered Medical Home (NCQA PPC-PCMH®) standards for medical home recognition, the clinic's electronic data system should include specific searchable demographic patient information and clinical patient information. In order to align your clinic with these requirements, we recommend that you ensure the following information is included for every patient during the abstraction process.

The searchable data fields are as follows:

Demographic Patient Information

18 Data Fields

- Name
- Date of Birth
- Gender
- Marital Status
- Language Preference
- Voluntarily self-identified race/ethnicity
- Address
- Telephone (primary contact number)
- E-mail address
- Internal ID (internal tracking/chart numbers)
- External ID
- Emergency Contact Information
- Current and past diagnoses
- Dates of previous clinical visits
- Billing codes for services
- Legal Guardian
- Health Insurance Coverage
- Patient/Family preferred method of communication

Clinical Patient Information

11 Data Fields

- Status of age-appropriate preventive services (immunizations, screenings, counseling)
- Allergies and adverse reactions
- Blood pressure
- Height
- Weight
- Body Mass Index (BMI) calculated (For pediatrics – BMI is percentile plotted on growth chart)
- Laboratory test results
- Presence of imaging results
- Presence of pathology reports
- Presence of advance directives
- Head circumference for patients <2 years

Additional notes

Refer to the NCQA Web site for an overview of all the scoring elements for NCQA Physician Practice Connections-Patient Centered Medical Home recognition. For NCQA PPC-PCMH® scoring, 100% is allotted if 12 of 18 demographic data fields are searchable, and 9 of 11 clinical data fields are searchable. This is NOT a must-pass element but it will help you score higher.

www.ncqa.org

Measure Categories

Measuring performance during the collaborative will enable your team to evaluate the effects of the changes you make; however, performance measurement is not an end in itself. Measurement should accelerate improvement, not slow it down. There are five categories of measurement that we will use to evaluate the collaborative, and that you will use to drive your individual quality improvement work.

1. Degree of Medical Home Implementation

The Medical Home Index: This is a survey measure that defines, describes, and quantifies activities related to the organization and delivery of primary care. Your core team will be given time at learning sessions to complete the survey as a group effort, providing a systems-level perspective from clinical and non-clinical staff.

2. Provider/Staff Satisfaction

Primary Care Staff Satisfaction Survey: This is a survey measure applicable to clinical and non-clinical staff. The core team will be given time at learning sessions to complete the survey.

3. Patient Experience

Patient Assessment Survey: Experiences with Your Regular Doctor. This survey will be administered to a sample of patients several times throughout the collaborative. **It is important that all practices adopt this survey to measure patient experience for the duration of the collaborative to ensure data aggregation across clinics.** This survey will only be administered to patients that have been attributed to the collaborative participating provider and have been "tagged" for clinical measurement reporting (see Defining a Provider Panel and Attribution). Collaborative staff will coordinate with you to assure that patients who are tagged "medical home" do not receive duplicate surveys.

4. Clinical Measures

Please refer to the next section.

5. Cost/Utilization Evaluation from Claims Data:

This arm of the evaluation will largely take place behind the scenes and will involve the joint effort of the University of Washington Department of Health Services, Group Health Center for Health Studies, Puget Sound Health Alliance, Washington State Health Care Authority, Washington Department of Health, Washington Academy of Family Physicians, and several health plans.

Required Clinical Measures

Patient-wide measures were chosen to evaluate the practice-wide impact of implementing a medical home and to drive quality improvement efforts on all patients. In addition to the required patient-wide measures, **all participants are asked to report on their clinic's entire population of patients with diabetes. Please note this is a change to the information you may have received in your informed consent appointment.**

Compliance with the National Committee for Quality Assurance Physician Practice Connections for Patient-Centered Medical Home (NCQA PPC-PCMH®)standards is optional for Collaborative participants. Information on eligibility is included for reference only.

A must-pass element of NCQA PPC-PCMH® recognition is the adoption of evidence-based guidelines for three conditions. The preferred way to document this for NCQA is by entering and tracking evidence-based guidelines for a condition in an EHR or registry. All collaborative participants will be doing this for some prevention measures and diabetes. By the end of the collaborative, clinics should be reporting on three or more clinically important conditions. Throughout the collaborative, we will ask clinics to report the conditions currently being tracked and any data elements being tracked by condition.

In order to support your efforts to track three or more conditions, DOH will provide data matrices by July 31, 2009, for several conditions that have been the focus of other medical home initiatives and/or NCQA PPC-PCMH recognition, and that represent evidence-based guidelines. Practices may choose the conditions most important and amendable to their own setting and resources, and are free to report as many or as few measures under the matrix that are useful to their setting and quality improvement (QI) efforts. Collaborative staff will measure the number of practice teams tracking three or more conditions.

Clinics are required to report on the diabetes measures monthly. Other measures will be reported less frequently. All clinics should be ready for the first baseline measure by January 1, 2010.

Prevention Measures: Patient-wide

Measure	Statistic	Type
	Pediatrics: Patient Age 0-17 Years	
% pediatric patients with up-to-date well child visits at age 1 year	NUMERATOR: # of active pediatric patients aged 1 year (age 12-23 months at the time of the report) who have four or more documented well-child visits[i]. DENOMINATOR: Active patients age 1 year (12-23 months at the time of the report)[ii].	Process
% pediatric patients (age 4 to 17) with up-to-date well child visits	NUMERATOR: # of active pediatric patients age 4-17 years (at the time of the report) with a documented well child visit[iii] in the previous two years. DENOMINATOR: Active patients age 4 -17 years at the time of the report.	Process
	Adults: Patient Age 18-64 Years	
% adult patients assessed for smoking	NUMERATOR: # of active patients aged >=18 who had tobacco use status documented at the most recent visit within the previous year DENOMINATOR: Active patients age >=18	Process
% adult smokers with a documented cessation intervention	NUMERATOR: # of active patients aged >=18 who self-report being a current tobacco user that received a cessation intervention at the most recent visit within the previous year. Cessation intervention may include smoking cessation counseling (eg, clinician advice to quit, referral to quit-line or other cessation service, educational materials, etc.) and/or pharmacologic therapy. DENOMINATOR: Active patients >=18 who self-reported being a current tobacco user.	Process
Cancer Screening : Cervical	NUMERATOR: # of active female patients age 21-64 who received one or more pap tests during the previous 3 years. *Patients are included in the numerator if any of the following apply: Active, female patients who have had a total hysterectomy (removal of the uterus and cervix) or have any other documented medical contraindication. DENOMINATOR: Active female patients age = 21-64.	Process
Cancer Screening: Colon	NUMERATOR: # of active adult patients age 50-75 who received one or more of the following screening tests: *Fecal occult blood test (FOBT) in the previous year *Fecal immunochemical test (FIT) in the previous year *Flexible sigmoidoscopy during the previous five years *Double contrast barium enema during the previous five years *Colonoscopy during the previous ten years DENOMINATOR: Active patients age 50-75	Process

Measure	Statistic	Type
Geriatrics: Patient Age 65+ Years		
% geriatric patients assessed for the presence of an advanced directive	NUMERATOR: # of active patients aged >=65 with documentation that advanced care planning was discussed in the previous year. DENOMINATOR: Active patients age >=65	Process
% geriatric patients taking 15 or more medications	NUMERATOR: # of active patients aged >=65 with 15 or more medications on their 'active medications list' [iv] [v] DENOMINATOR: Active patients age >=65	Outcome

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[i] Well Child Visits are defined by the 2008 American Academy of Pediatrics (AAP) and *Bright Futures: Recommendations for Preventive Pediatric Health Care* (brightfutures.aap.org). At a minimum, all well child visits up to age 3 should include history; length/height and weight measurements; physical examination; sensory screening; and developmental and behavioral assessments

[ii] The medical home 'tag' will not be included when abstracting the report for the well child measures. Patients that are active and are within the specified age range *at the time of the report* will be included in the measure.

[iii] At a minimum, all well child visits from age 4-17 should include history; height and weight; calculated BMI; blood pressure; physical examination; and developmental and behavioral assessments.

[iv] Evidence suggests that a lower threshold than 15 medications is warranted for this outcome measure, however the American Society of Consultant Pharmacists suggest that this type of measure with a lower threshold may reduce access to needed medications. Studies have shown that this threshold is sensitive to quality improvement efforts in medication review and reconciliation.

[v] Farrell, Hill, Hawkins, & Newman. (2003). Clinic for identifying and addressing polypharmacy. *Am J Health-Sys Pharm*. 60, 1830, 1834-35.

Diabetes Measures

for Improving Performance in Practice (IPIP)

Diabetes Measures[i]

Measure	Statistic	Type	Target
Diabetes: Patient Age 18-75 Years			
% patients with diabetes with blood pressure documented less than 130/80 mm Hg	NUMERATOR: # of active patients with diabetes with the most recent systolic blood pressure measurement less than 130 mm Hg and a diastolic blood pressure less than 80 mm Hg documented during the previous year. *If there is no valid blood pressure level within the last year or if the result for the most recent blood pressure is not available, the level is considered to be more than or equal to 130/80 mm Hg and the patient is *NOT* included in the numerator. DENOMINATOR: Active patients with diabetes age 18-75	Outcome	>70%
% patients with diabetes with most recent LDL documented less than 100 mg/dl	NUMERATOR: # of active patients with diabetes with the most recent LDL-C level less than 100 mg/dl documented during the previous year. *If there is no valid LDL-C level within the last year or if the result for the most recent LDL-C level is not available, the level is considered to be more than or equal to 100mg/dL and the patient is *NOT* included in the numerator. DENOMINATOR: Active patients with diabetes age 18-75	Outcome	>70%
% patients with diabetes with most recent A1C >9.0%	NUMERATOR: # of active patients with diabetes with the most recent HbA1C value more than 9.0% documented during the previous year. *If there is no HbA1c level documented during the previous year, the level is considered to be more than 9.0% (i.e., no test is counted as poor HbA1c control) and they are included in the numerator. DENOMINATOR: Active patients with diabetes age 18-75	Outcome	<5%
% patients with diabetes who received a dilated eye exam	NUMERATOR: # of active patients with diabetes who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the previous year or a documented negative result during the previous 2 years.[ii] DENOMINATOR: Active patients with diabetes age 18-75	Process	>80%
% patients with diabetes tested for nephropathy or	NUMERATOR: # of active patients with diabetes who were screened for nephropathy during the previous year OR	Process	>90%

Measure	Statistic	Type	Target
already under treatment	have evidence of treatment for nephropathy. Screening tests include: *24-hour urine for microalbumin *Timed urine for microalbumin *Spot urine for micoralbumin *Microalbumin/creatinine ratio Evidence of treatment for nephropathy includes[iii]: *Nephrologist visit documented in the previous year *A positive microalbumin test in the previous year *Evidence of active ACE/ARB therapy *Any of the following diagnoses: diabetic nephropathy, end-stage renal disease (ESRD), chronic renal failure (CRF), renal insufficiency, acute renal failure (ARF), or dialysis (including hemodialysis and peritoneal dialysis). DENOMINATOR: Active patients with diabetes age 18-75		
% patients with diabetes with a current foot exam	NUMERATOR: # of active patients with diabetes who received a foot exam, defined in any manner (visual inspection, sensory exam with monofilament, or pulse exam) during the previous year. Indication of a test result and date must be documented. *_Include_ the following active diabetes patients in the numerator: • Patients with bilateral foot amputation. • Foot exams done by a podiatrist and documented in the medical record/registry. DENOMINATOR: Active patients with diabetes age 18-75	Process	>90%

[i] The adult smoking assessment and intervention measures should also be included in the diabetes monthly report (for the diabetic patient population)

[ii] Documentation in the medical record of a retinal eye exam must include: A note or letter from an ophthalmologist, optometrist or other health care professional summarizing the date on which the procedure was performed and the results of a retinal evaluation performed by an eye-care professional; or a chart or photograph of retinal abnormalities. If fundus photography was used in the exam, there must be documentation in the medical record indicating the date on which the procedure was performed and evidence that an eye care professional reviewed the results. Alternatively, results must be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist, or a note, which may be prepared by a primary care provider, indicating the date on which the procedure was performed, and that an ophthalmoscopic exam was completed by an eye-care professional, with the results of the exam.

[iii] Evidence of diagnosis of or treatment for nephropathy: CPT Codes 36800, 36810, 36815, 36818, 36820, 36821, 50300, 50320 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90945, 90947, 90989, 90993, 90997, 90999, 99512; ICD-9-CM Codes 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6, 250.4, 403, 404, 405.01, 405.11, 405.91, 581.81, 582.9, 583.81, 584-586, 588, 753.0, 753.1, 791.0; V-Codes V42.0, V45.1, V56; UB-92 Revenue Codes 0800-0804, 0809, 0820-0825, 0829-0835, 0839-0845, 0849-0855, 0859-0882, 0889; DRGs 316, 317

PART 4
KEY RESOURCES

"There are many ways to create a patient-centered medical home (PCMH) and many different forms a PCMH can take. Either over-specification or prescribing the pathway to achieving it can be counterproductive, frustrate practice participants and exacerbate change fatigue. Respect the practice's responsibility for its own destiny. Practices may need assistance, but decisions of what and how to change must be theirs. Facilitation, consultation coaching, learning sessions and use of web resources, all have roles. Practices must remain full partners in their learning and development process."

Nutting, Miller, Crabtree, Jaen, Stewart, & Stange

Most valuable resource:

THE PARTICIPANT TEAMS

Central Washington Community Health
1806 West Lincoln Avenue
Yakima, WA 98902
509-574-6137

Columbia Valley Community Health
600 Orland Avenue
Wenatchee, WA 98801
509-661-3620

Cornerstone Family Physicians
5920 100th St. SW 26 A
Lakewood, WA 98499
253-588-0756

Covington Primary Care
16850 SE 272 St.
Covington, WA 98042
425-228-3440

Edmonds Family Medicine
7315 212th St. SW Suite 101
Edmonds, WA 98026
425-670-3554

Evergreen Medical Group-
Canyon Park
1909 214th St. SE Suite 110
Bothell, WA 98221
425-488-4988

Evergreen Medical Group-
Redmond
8299 161st Ave NE Suite 101
Redmond, WA 98052
425-881-8813

Fall City Medical Clinic
PO Box 1015
Fall City, WA 98024
425-222-0800

Family Care Network
709 W. Orchard Drive, Suite 4
Bellingham, WA 98225
360-318-8800

Family Medicine of Southwest Washington
PO Box 1600
Vancouver, WA 98668
360-514-7550

Harborview Family Medicine Clinic
325 Ninth Ave
Seattle, WA 98104
206-744-8274

Harborview Medical Center
Adult Medicine Clinic
325 Ninth Ave
Seattle, WA 98104
206-744-5865

Healthpoint
955 Powell Avenue SW
Renton, WA 98057
425-203-0473

Inter Island Medical Center
550 Spring Street
Friday Harbor, WA 98250
(360) 378-2141 ext 23

International Community Health Services
PO Box 3007
Seattle, WA 98114-3007
206-788-3650

Lakeside Family Physicians
3707 Providence Point Drive SE Suite G
Issaquah, WA 98029
425-369-1342

Madigan Family Medicine Clinic
Madigan Army Medical Center
Tacoma, WA 98431
(253) 968-2065

Mark Reed Healthcare Clinic
322 South Birch Street
McCleary, WA 98557
360-495-3500

Matthew White,MD
5920 100th St. SW #30
Lakewood, WA 98499
253-584-1700

Olympic Physicians, PLCC
237 Professional Way
Shelton, WA 98584
360-426-2500

Olympic Primary Care
1010 Sheridan
Port Townsend, WA 98368
360-379-8031

Overlake Medical Clinics-
The Bellevue Clinic
1135 116th Ave NE Suite 110
Bellevue, WA 09004
425-289-3100

Pacific Medical Center
1200 12th Ave S
Seattle, WA 98144
206-621-4360

The PolyClinic
1145 Broadway
Seattle, WA 98122
206 860-5458

Port Orchard Medical Clinic
451 Sedgewick Suite 110
Port Orchard, WA 98367
360-874-5900

Providence Physicians Group-Monroe
14692 179th Ave SE Suite 100
Monroe, WA
360-794-7994

Providence St. Peter Family Medicine
525 Lilly Rd NE
Olympia, WA 98506
360-493-4001

Rockwood Cheney
400 E 5th Ave
Spokane, WA 99202
509-838-2531

Rockwood Medical Lake
400 E 5th Ave
Spokane, WA 99202
509-838-2531

SeaMar Community Health Center
1813 Sumner Ave.
Aberdeen, WA 98520
360-538-1293

Swedish Community Health
5300 Tallman Ave. NW 4 East
Seattle, WA 98107
206-297-5100

Tacoma Family Medicine
521 Martin Luther King Jr. Way
Tacoma, WA 98405
253-403-2980

University of Washington
Physicians Network
Kent-Des Moines
PO Box 359410
Seattle, WA 98195-9410
206-329-8976

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Washington State Department of Health
Chronic Disease Prevention Unit
PO Box 47855
Tumwater, WA 98504

Physical address
111 Israel Rd. SE
Tumwater, WA 98501

Collaborative Clinical Chairs

Adults
Bertha (Berdi) Safford, M.D.

Dr. Safford is Medical Director for Quality Performance for Family Care Network, a 52 family physician group without walls in Whatcom County, Washington. She is a board-certified family physician who also continues her part-time family practice. Prior to becoming medical director for Family Care Network, she served for twelve years as Whatcom County Medical Director of Group Health Cooperative of Puget Sound, implementing Group Health's quality improvement process in the network model. She is on the faculty of the American Academy of Family Physicians Practice Enhancement Forum.

Dr. Safford's primary interest is improving quality of care. Her community was one of the 7 national recipients of the Robert Wood Johnson Foundation "Pursuing Perfection" healthcare grants. Her private practice in Ferndale was the grant pilot site for idealized practice redesign. Prior to this, she led Family Care Network's successful completion of the Institute for Healthcare Improvement's 13-month Breakthrough Series on Chronic Illness, demonstrating measurable improvement in the outcomes of diabetic patients. She was a member of the American Academy of Family Physicians Commission on Health Care Services from 1993-1998, and chaired the commission in 1999. She also served on the Academy's Commission on Quality and Scope of Practice from 2001 - 2004. Dr. Safford was selected Washington's Family Physician of the Year in 2003.

Geriatrics
Martin (Marty) Levine, M.D.

Dr. Levine is a family physician, geriatrician, and medical center chief at Group Health's Northgate Medical Center. He has a primary care medical practice that focuses on older adults. He has been involved in efforts to improve primary care through quality improvement, research and policy.

Pediatrics
James (Jim) W. Stout, M.D., M.P.H.

Jim is a Professor of Pediatrics and Adjunct Professor of Health Services at the University of Washington School of Public Health. Jim is a cofounder of the National Initiative for Children's Healthcare Quality (NICHQ), a non-profit organization headquartered in Boston. He also leads a quality improvement program, Interactive Medical Training Resources (iMTR) based at the University of Washington's Child Health Institute, which currently focuses on online spirometry training.

Jim has a long-standing interest in improving asthma care. Jim is also a pediatrician at the Odessa Brown Children's Clinic, a satellite of Seattle Children's, where he directs their Asthma Clinic, and provides direction for its QI programs. Through these organizations, he works on a variety of local and national projects with the united goal of improving the quality of children's healthcare.

Faculty

Jim Davis, M.D.

Jim Davis recently joined the University of Washington Department of Family Medicine in November 2008 as professor and Chair. His goals include increasing the number of medical students selecting Family Medicine as their career path, promoting health policy to stimulate primary care workforce development in the WWAMI* region, facilitating new models of care such as the patient centered medical home and other innovations to improve delivery of primary care, and research that informs and enhances medical practice.

Jim received his BA from Lafayette College, Easton Pa.; MD from the George Washington University; and completed his Family Practice residency at the University of Wisconsin-Madison where he also served as Chief Resident. After residency, he completed a 2-year fellowship at the UW-Madison funded in part by a Fellowship in Medical Education from the National Fund for Medical Education. Jim completed an MS in Preventive Medicine and was a Kellogg Foundation Fellow in Administrative Medicine. He joined the UW-Madison Family Medicine (UW DFM) faculty in 1980.

During his time at the University of Wisconsin, Jim served in a variety of leadership roles including associate director, and later director, of St. Mary's (now Wingra) Family Medical Center where he maintained a full spectrum family medicine practice. Jim then helped create the research division for the UW DFM and served as its first director from 1983-88.

He then shifted his energies to the medical school and helped create a first and second year course entitled Clinical Medicine and Practice and served as course director until 1997. During this time, Jim created and taught a required graduate school course entitled "Quality of Health Care: Evaluation and Improvement" in the UW Physician Executive program in Administrative Medicine.

He then served as Vice Chair for Clinical Operations until assuming the role of Madison Campus Director and Associate Chair of the UW DFM in 2000. In 2004 he became Vice Chair of the department and later served as Interim Chair from 2006-2008. In 2004 he was voted into the medical staff succession of University of Wisconsin Hospital and Clinics as secretary–treasurer, Vice President, and finally President before leaving for his new position at the University of Washington.

Nationally, Jim has served on several committees of the National board of Medical examiners including the original Computer Based Examination (CBX) Development Committee and Part 3 Committee. He has been active in the North American Primary Care Research Group (NAPCRG) and the Society of Teachers of Family Medicine including serving as Chair of the Research Committee and member of the Board, and most recently is a member of the Legislative Affairs Committee of the Association of Departments of Family Medicine (ADFM).

Among his awards, he has been the recipient of the Dean's Teaching Award at UW-Madison School of Medicine and most recently he was awarded a prestigious Robert Wood Johnson Health Policy Fellowship in 2008.

*** The WWAMI region is:**

Washington
Wyoming
Alaska
Montana
Idaho

Faculty

Jeff Hummel, M.D.

For over 30 years Dr. Hummel has combined primary care practice in varied settings, including rural Eastern Washington, staff-model HMO, and a fee-for-service academic neighborhood clinic system, with a strong background in clinical informatics and quality improvement.

He worked for 11 years as the Medical Director for MEDEX Northwest, the Physician Assistant training program at the University of Washington, and piloted the concept of multi-disciplinary teams at Group Health in the 1990s. At the UW he spent 10 years developing reporting strategies for obtaining useful clinical information out of the back-end of EHRs for a number of clinical conditions including, diabetes, asthma, hypertension and anticoagulation.

For the past 4 years he has been working with the Qualis Health prevention team on the CMS quality improvement agenda spanning the full spectrum of Medical Homes activities and designing methods for workflow analysis using Lean principles to improve efficiency in such essential ambulatory care processes as medication reconciliation, immunizations, results tracking, and cancer screening in an EHR environment. He is also a consultant for Outlook Associates, Inc., for Medical Homes projects in Kansas and Missouri.

Larry Mauksch, M.Ed.

Larry Mauksch has spent the last 28 years training medical students, residents, mental health interns, and practicing physicians in interviewing skills, team development, and the diagnosis and management of mental disorders in primary care. He is the past chair of the Collaborative Family Health Care Association and a former chair of the Society of Teachers of Family Medicine Group on Physician Patient Interaction.

Mr. Mauksch's areas of research include examining educational strategies to enhance team and clinician communication to improve patient satisfaction, health outcomes and efficiency and ways to successfully integrate behavioral health and primary care services. He is the principle investigator of the Paired Observation and Video Editing (POVE) project, to disseminate an intensive training in communication skills to nine medical schools. Between 1998 and 2007 Mr. Mauksch served as a consultant, trainer and principle investigator developing and studying a collaborative care system in a primary care clinic serving only uninsured, low income adults. He is a consultant and trainer for several large health care organizations, helping them develop more effective and efficient patient centered systems of care.

Faculty

L. Gordon Moore, M.D.

L. Gordon Moore, M.D., is a national leader in improving health care in primary care and medical office practices. He leads the Ideal Medical Practices project (www.IdealMedicalPractices.org) where practicing physicians are demonstrating improved experience of care and clinical outcomes for the patients they serve. He is a faculty member of the Institute for Healthcare Improvement in the domain of office practice redesign, and is a Clinical Associate Professor with the University of Rochester Departments of Family Medicine and Community and Preventive Medicine.

Dr. Moore received his MD from the University of Rochester School of Medicine & Dentistry in 1990, served as intern, resident and chief resident at Highland Hospital with the U. of R's Department of Family Medicine, then accepted a salaried position with Highland. He has pursued his interest in quality and process improvement since his residency. He has participated in guideline and protocol initiatives, process redesign workshops, working with office practices from solo independent practices to large hospital based specialty clinics, from community health centers to private and academic practices. The organizing principle guiding his work is that a high performing health system is based on effective primary care. Effective primary care is based on a set of unambiguous design principles – eliminating barriers to care, organizing care around both the individual patient and the population served, supporting effective primary care through comprehensive policy and payment reform.

Dr. Moore is a recent transplant to Seattle WA with his wife Jana Carlisle and their three children .

Edward Wagner, M.D., M.P.H.,F.A.C.P.

Edward H. Wagner, M.D., M.P.H., F.A.C.P., is a general internist/epidemiologist and Director of MacColl Institute for Healthcare Innovation at the Center for Health Studies, Group Health Cooperative. His research and quality improvement work focus on improving the care of seniors and others with chronic illness. Since 1998, he has directed "Improving Chronic Illness Care", a national program of the Robert Wood Johnson Foundation.

He and his MacColl Institute colleagues developed the Chronic Care Model (CCM). The CCM now serves as the foundation for improving ambulatory care for many organizations nationally and internationally. He has written two books and more than 250 publications. He is a member of the Institute of Medicine of the National Academies. Dr. Wagner was the recipient of the 2007 NCQA Health Quality Award and the 2007 Picker Institute Award for Excellence in Patient-Centered care.

More to come...

Regular faculty will be joined by collaborative clinical chairs, adjunct instructors from the sponsoring organizations, quality improvement coaches, guest faculty from the participating clinics, and topic experts invited to teach at specific learning sessions. Learning session materials will offer biographical notes on all instructors for the particular session.

To suggest a topic or instructor for a learning session or monthly learing activity, send your ideas to:

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(360) 236-3793