Key Activities List

Background and Description

The Safety Net Medical Home Initiative (SNMHI) developed a framework—The Change Concepts for Practice Transformation—to help guide primary care practices through the PCMH transformation process. It includes eight change concepts in four stages:

Laying the Foundation: Engaged Leadership and Quality Improvement Strategy.

Building Relationships: Empanelment and Continuous & Team-Based Healing Relationships.

Changing Care Delivery: Organized, Evidence-Based Care and Patient-Centered Interactions.

Reducing Barriers to Care: Enhanced Access and Care Coordination.



A "change concept" is a general idea used to stimulate specific, actionable steps that lead to improvement. Each SNMHI Change Concept includes three to five "key changes." These provide a practice undertaking PCMH transformation with more specific ideas for improvement. Each practice must decide how to implement these key changes in light of their organizational structure and context.

The "Key Activities Checklist" is an interactive tool (Excel®) to help practices and coaches track activity towards implementation of the 32 key changes.

This document, the "Key Activities List," is a simplified version of the tool and lists the key changes followed by ***key activities, or ideas for how to implement the key changes***, and examples of how some practice sites have tested these ideas. The Key Activities List is a useful discussion guide and planning tool and has been formatted for easy printing.

Adapted from: Safety Net Medical Home Initiative. Key Activities Checklist Tool. 2nd ed. Seattle, WA: Qualis Health and the MacColl Center for Health Care Innovation at the Group Health Research Institute, May 2013.

ENGAGED LEADERSHIP		
Key Changes	**Key Activities**	**Examples of Activities that Have Been Tested**
1a. Provide visible and sustained leadership to lead overall cultural change as well as specific strategies to improve quality and spread and sustain change.	Ensure executive and clinical leadership demonstrates "buy-in" to the PCMH model	· Educate, promote, and discuss the PCMH model frequently at a variety of organizational meetings, so that BOD members, providers, staff, and key partners are informed and activated · Incorporate PCMH goals into organizational compliance plan or link to incentive programs; if possible, redesign compensation or bonus structure to promote the PCMH model · Inform internal and external audiences about PCMH plans, innovations, and successes using a variety of formats, (e.g., clinic newsletters, local newspapers, etc.) · Be visible at provider and staff meetings to support the PCMH model and actively participate in PCMH/QI team meetings · Develop and implement a PCMH leadership committee, which may be composed of staff members from each care team or professional group (e.g., nurses, MAs, providers, etc.) · Set organizational priority to gain PCMH recognition by external entities, (e.g., NCQA, state certification, etc.) · Participate in regional, statewide, and national P4P programs · Integrate the PCMH model into the organizational mission and vision · Hire staff or volunteers to support PCMH, (e.g., QI /PCMH manager, "panel" manager, patient greeter.)
1b. Ensure that the PCMH transformation effort has the time and resources needed to be successful.	Identify a central PCMH implementation team that is made up of staff members representing a variety of roles, patients, and other stakeholders	· Develop management team "go and see" activities, (e.g., weekly executive team rounds, daily site management team rounds) · Discuss how the team will adapt to transitioning team members (i.e. departures, new additions); consider representation from every discipline · Include patients
	Ensure resources are available to staff for PCMH transformation	· Dedicate necessary resources to support measurement, to facilitate communication about the PCMH model, to support team building · Establish expectations with timelines for PCMH practice priorities · Assess QI training needs and act upon results · Send staff to trainings or conferences to learn about aspects to PCMH, (e.g., IHI Office Practice Summit)
1c. Ensure that the clinicians and other care team members have protected time to conduct activities beyond direct patient care that are consistent with medical home model.	Protect time for planning and time for reviewing data	· Allocate time for PCMH/QI planning · Develop "standard work" activities for site management teams which focus on process improvement and best practices, i.e. develop agreements on standard templates and consistent definitions across teams and/or sites · Share data with staff on a regular basis and allocate time for discussion · Schedule all meetings during the staff work hours instead of before or after clinic hours to allow the staff to attend and not add to their work day
	Engage team members in PCMH activities	· Use visual boards and team-specific data · PDSA binder in break room where staff can add ideas for change · Actively share best practices for PCMH implementation across teams and clinics · Provide opportunities for staff to identify opportunities for improvement and to define action plans, e.g. staff surveys, suggestion boxes · Restructure clinic leadership and accountabilities to guide transformation work
1d. Build the practice's values on creating a medical home for patients into staff hiring and training processes.	Modify new hire and orientation process to embed PCMH values	· Incorporate vision of PCMH into staff, provider, patient, and BOD member orientation · Develop staff training modules for PCMH · Modify job descriptions · Identify mentors to support new and existing employees in learning PCMH change concepts · Develop orientation materials to use with new e-learning platform · Send staff to trainings or conferences to learn about aspects to PCMH, (e.g., IHI Office Practice Summit)
	Engage all staff in marketing PCMH	· Collect and share stories of how PCMH has positively impacted patients and patient care (e.g., all staff meetings focused on "Telling Our Story")

QUALITY IMPROVEMENT STRATEGY		
Key Changes	**Key Activities**	**Examples of Activities that Have Been Tested**
2a. Choose and use a formal model for quality improvement.	Adopt Lean, the Model for Improvement, PDSA or some equivalent as a QI Strategy	· Provide staff training on QI methodology (Lean or Model for Improvement or another, as indicated) · Incorporate QI methodology on a small scale in everyday work to accustom staff to QI · Include those who 'do the work' in work redesign process · Add a QI position or dedicated staff time to QI activities
2b. Establish and monitor metrics to evaluate routinely improvement efforts and outcomes; ensure all staff members understand metrics for success.	Determine quality measurement strategy for practice transformation	· Establish quality measures for practice transformation, (e.g., cycle time, third next available, etc.) · Identify a balanced set of measures (including clinical outcomes, practice transformation, etc.) tied to the strategic goals, that roll down to the team-level to define PCMH transformation · Establish data collection methods and ensure reliability and accuracy of the data · Set goals or compare quality measures with national or local benchmarks
	Use quality measurement results to drive improvements	· Review quality measures routinely with team members · Use run charts of each teams' performance to create "friendly competition" · Standardize quality measures across all teams · Create a system that supports full transparency of data · Develop a visual management system to drive improvements on monthly measures (e.g., data dashboards) · Develop comfort with using measurement in all improvement efforts, even small tests of change
2c. Ensure that patients, families, providers, and care team members are involved in quality improvement activities.	Include patient(s) on the QI/PCMH team or in the planning process	· Identify options for obtaining patient input on clinic processes in ways that are patient centered (not during normal business hours, etc.) · Inform patients of QI activities and have them "rate" how team is doing · Recruit patient to participate as a member of the PCMH or quality committee meeting · Include QI activities and feedback opportunities in satisfaction surveys
	Encourage staff and providers to engage in the improvement process	· Train all teams and staff in process improvement · Conduct and use information from staff satisfaction surveys · Invite all staff to join committees on topics that interest them or are in their particular expertise · Reward "quality champions" that are highly involved and encourage QI efforts
	Include staff from other organizations or departments in quality improvement activities	· Board member with FQHC committee is member of QI committee · Pull on coach or consultant assistance with QI activities · Conduct or participate in collaboratives or other shared learning opportunities with health centers doing similar work
2d. Optimize use of health information technology to meet Meaningful Use criteria.	Use population-based data to ensure all eligible care is provided and follow up as necessary	· Use EHR fields to serve as reminders for planned care · Customize EHR when needed (e.g., create care plan templates) · Ensure adequate technical support for improvement activities · Use population-based reports to support data collection and QI activities
	Use technology to support care delivery	· Develop a scorecard to use for huddles and outreach to drive improvement · Meet Meaningful Use criteria · Use decision support tools regularly
	Use supplemental technologies as needed (registry, etc.)	· Patient portal, secure messaging, patient disease registry (Kryptiq's Care Manager), e-signature · Adapt Excel and other spreadsheet/database software to support QI activities

EMPANELMENT		
Key Changes	**Key Activities**	**Examples of Activities that Have Been Tested**
3a. Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis.	Set and communicate organizational goals for establishing panels	· Leadership explores shared panels or requirements for part-time providers · Have part-time providers share a panel ensuring that patients have access to either provider every week · Conduct focus group for empanelment with leadership
	Develop initial reports linking patients and providers and review	· Create list of patients by provider or care team to be shared with and reviewed by other team members · Assure data are accurate/correct · Reach out to empanelled, but "missing" patients · Develop initial reports linking patients and providers; have providers review and validate · Use Mark Murray's 4 cut method to do a first pass of assigning patients · Consider how to assign families to ensure continuity · Bring together a multi-disciplinary team including providers
	Regularly review provider/team assignments and make modifications to level workload	· Assign nursing capacity to a team depending on how busy the provider is
	Determine protocols and/or policies for assigning new patients	· Develop system for querying unassigned patients regularly · Post visual cues of the protocol at the point of patient assignment (e.g. front desk) · Develop scripts for schedulers around assigning patients · Patients empanelled upon intake
	Standardize process for panel management, monitoring and maintenance	· Assign responsibility for ongoing maintenance · Determine policy for transfer of PCP, management of PCPs at capacity and new patient expectations · Develop process for un-empanelling a patient when they are no longer actively managed by the team · Schedule a monthly review with the panel manager using a visual management system to track huddles and review process
3b. Assess practice supply and demand, and balance patient load accordingly.	Apply risk-adjustment criteria	· Risk adjust by determining weights for age and gender · Weight panels by acuity and/or number of comorbidities · Risk adjust for cultural and/or social factors such as translation needs, transportation, homelessness, etc. · Use the patient acuity rubric
	Determine appropriate panel size for each provider	· Develop expectations for medical residents · Develop expectations re: FTE minimums for providers who will have panels
	Calculate supply (provider time) and demand (patient need)	· Define active and inactive patient categories · Classify patients as inactive or active · Calculate average patient utilization
	Make adjustments to ensure balanced patient loads for care teams	

EMPANELMENT (CONTINUED)		
Key Changes	**Key Activities**	**Examples of Activities that Have Been Tested**
3c. Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need.	Develop capacity to build panel reports that support outreach activities	· Designate and train a panel manager · Identify IT resources to build report templates · Identify services that may be useful to examine, (e.g., preventive care, medication management, appropriate and timely chronic care)
	Analyze panels by sub-population or patients or visit type	· Analyze patients by disease type, provider and nurse-provider team and compare each to clinic as a whole
	Proactively reach out to patients to address needs identified in the panel data	· Use a registry system or panel reports to identify patients who need a follow-up call · Designate role/responsibility for doing follow-up calls with patients · Leverage EHR functionality to generate automated letters to patients re: routine follow up care (e.g. immunizations, well child checks) · Utilize patient portal and secure messaging for outreach · Develop a clinical outreach procedure for routine preventive and DM visit follow-up · Use a Heijunka Board and other visual management tools to monitor daily performance on measures
	Educate patients about the importance of continuity	· Incorporate inpatient orientation · Routinely stress importance of ongoing relationship with specific clinician · Utilize scripting for scheduling/reception staff

CONTINUOUS & TEAM-BASED HEALING RELATIONSHIPS		
Key Changes	**Key Activities**	**Examples of Activities that Have Been Tested**
4a. Establish and provide organizational support for care delivery teams that are accountable for the patient population/panel.	Developing staff buy-in for changing roles and responsibilities	· Visible support from clinical leadership to support PCMH teamness · Provide training for all staff/providers on the PCMH · Rewriting job descriptions to support PCMH · PCMH measures presented at staff meetings where leadership are present · Leadership delivers regular, consistent messaging about PCMH and medical home progress, (e.g., updates at meetings on a regular basis across the entire organization, in newsletters, etc.) · Follow patients or simulate the patient experience as a way to engage staff in thinking about new roles · Use senior leadership meetings to identify and include "champions" from staff when implementing training or changing care team roles · Hold monthly all-team meetings to inform, recognize, reward and appreciate staff
	Ensure teams have time to meet regularly	· Allocate time for team huddles to ensure the care team is prepared for each visit · Hold quarterly department meetings to discuss PCMH goals · Ensure that people at all levels have the opportunity to meet as a PCMH or QI team to plan and organize changes that affect the clinic systems · Build time into daily work, pre- and post-session, for teams to meet at an established time · Hold routine "problem-solving" meetings · Co-location of care team members supports ability to meet and communicate
	Identify who should be on the care team	· Use volunteers, ancillary staff (e.g., pharmacy) or others to support care delivery teams · Include behavioral health and health educator(s) in teams · Assign everyone in the health center to at least one care team · Solicit staff suggestions for role changes · Pilot new care team structures with one or two care teams then spread to others · Use patient panels to identify the ideal care team structure/staffing model
	Develop a staffing plan that addresses staff turnover or staff leave	· Have clear job descriptions · Develop workflows to ensure continuous cross-training
4b. Link patients to a provider and care team so both patients and provider/care teams recognize each other as partners in care.	Make the care teams visible and apparent to patients	· Send out letters and business cards describing each team · Use color-coded badges · Place pictures of care teams in lobby/waiting areas · Create a bulletin board describing teams with photos, team names, and member names · Develop business cards identifying the teams with the nurses being the primary contact · Provide patients with a formal check-in that indicates the members of their care team (the provider the patient is seeing today, the RN/MA and other team members participating in their care. Include phone numbers and instructions re: with whom the patient should follow up with questions) · Update the phone menu to route patients directly to their care team
	Inform patients about the PCMH model	· Create educational/marketing materials · Hang PCMH posters in the waiting room · Share information at check-in · Ensure that materials will be understood by patients of all ethnicities and backgrounds · Play a video describing the PCMH (e.g. Emmi solutions video used by TransforMed) in the waiting room · Test site-based health councils

CONTINUOUS & TEAM-BASED HEALING RELATIONSHIPS (CONTINUED)		
Key Changes	**Key Activities**	**Examples of Activities that Have Been Tested**
4c. Ensure that patients are able to see their provider or care team whenever possible.	Use reports to identify the frequency with which patients see their provider/care team	· Routinely measure the percentage of visits/appointments that are scheduled with the patient's own primary care provider (PCP)/care team · Measure the percentage of visits that are not scheduled with the patient's own PCP/care team at times when the patient's own PCP/care team was available · Use Heijunka Board as visual management tool to ensure that work is done each day · Educate patients/community and staff members who schedule appointments about the importance of continuity and the relationship with the care team
	Establish processes to ensure that the patient gets all preventive, chronic and other appropriate care	· Develop scripts or prioritization 'rules' for use by front desk staff · Assign staff to call patients who are overdue for care/outreach · Introduce preventive care screenings into MA and CA workflow when rooming patients · Update EHR documentation forms to include visual reminder cues for preventive care
4d. Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.	Define team roles	· Develop standard work for all roles and train for this · Modify the role of the front desk staff to include patient reminders · Modify the role of the MAs/LPNs to include setting up planned care visits or preventive care visits · Modify the role of RNs to include complex care management, oversight of MAs, and/or inpatient stay liaison · Support providers (MD, DO, NP, PA) in delegating tasks best accomplished by other team members · Hold "roles retreat" collaborative to identify who can do what, and how to shift the work · Develop new team roles and job descriptions based on results of the collaborative · Hold "roles retreat" all day seminar to share new team roles, responsibilities and accountabilities with staff · Develop annual review structures that reward work as a member of a care team
	Ensure team is prepared for each visit	· Assign specific team member to 'prep' or 'scrub' the chart before the visit · Use team huddles to improve communication · Use pre-visit checklists · Reception team members make sure all referral notes, etc. are in clinic prior to visit · QI nurse is responsible for ER reports, hospital f/u · Leadership works with providers to ensure team coverage every day especially during vacations · Identify appropriate levels of IT support to develop patient lists for planned care and outreach
	Identify training needs	· Ensure each team member has competencies or an ongoing training plan to complete the assigned role, especially if the new role involves an increase in patient care and management
	Conduct ongoing training for staff	· Conduct monthly tutorials to help staff better use EHR · Build-in improving care as part of daily work · Develop role of MA champion to continually mentor new and existing MAs and ensure that they are consistently using their new skills that they learned in training · Use existing training sessions and conferences from national organizations (e.g., NACHC, IHI, Kaiser, etc.) to train staff · Include new providers in PCMH learning sessions held at the regional or state level · Provide training on team communication and conflict management · Modify and use existing curricula, (e.g., SNMHI MA Training Curriculum available here: Implementation-Guide-Supplement-Team-Based-Care.pdf

ORGANIZED, EVIDENCE-BASED CARE		
Key Changes	**Key Activities**	**Examples of Activities that Have Been Tested**
5a. Use planned care according to patient need.	Proactively contact patients in need of chronic or preventive care services	· Have MA, front desk staff, or others use lists of patients due or overdue for services (preventive or planned care) and call to come in for a visit or remind of services due from external providers (e.g. mammogram)
	Use team huddles to review necessary care to provide to patients	· Identify a schedule for team huddles and dedicate that time · Dedicate staff to review charts prior to the huddle to identify patient needs · Use HIT to produce dashboards, reports or alerts when patients are in need of care · Match the schedules of the team members so that everyone can be present
	Implement processes to assure evidence-based care is provided	· Create a policy for nurse visits for patients needing additional follow-up for chronic disease management · Use standing orders for predictable planned care activities (e.g., HbA1c tests, retinal eye exams, LDL, etc.)
	Implement workflows for planned care	· Clearly identify activities and roles surrounding planned care (e.g., Who does outreach? Who sets, documents and follows up with patients on self-management goals?)
	Engage patients in the development of care plans	· Use agenda setting and action planning tools, and/or include patient goals and plans in visit summary printed for patient to take home. · Leverage EHR to create "report cards" for patients that demonstrate progress towards meeting self-management goals (e.g., a run chart that shows change in HbA1c over time)
5b. Identify high risk patients and ensure they are receiving appropriate care and case management services.	Identify high risk patients for care management	· Use tested algorithms · Retrieve data from hospitals, payers, etc. · Use patient registries · Document risk status in EHR (e.g., add level of risk to problem list)
	Work with patients to develop shared care plans	· Train team members to use action planning tools · Train staff in techniques such as motivational interviewing and 'teach back' to engage patients in care planning
	Implement a chronic disease management program	· Use the services of a diabetes educator · Institute protocols for chronic diseases · Implement standing orders for behavioral health and medication management consults for patients with chronic conditions · Implement routine education and planned visit training for care team staff, including pharmacists · Implement RN medication refill protocol
	Develop standard work flows and processes for identifying patients for care management	· Use process mapping tools · Design clinic's information infrastructure to internally track and manage referrals/transitions including specialist consults, hospitalizations, ET visits and community agency referrals · Assess patient's clinical, insurance and logistical needs · Identify patients with barriers to referrals/transitions and help patients address them · Schedule weekly team meetings (with care manager, physician, consulting psychiatrist (if applicable), and other relevant care team members) to review highest risk patients
	Develop standard work of care manager	· Locate and tailor job descriptions for care management · Revisit team roles and adjust them to care management · Establish protocols for managing panels of high risk patients
	Build capacity for RNs and care managers	· Move tasks from RNs to MAs, front desk staff, patient navigators, others as appropriate based on certification, training and skill set

ORGANIZED, EVIDENCE-BASED CARE (CONTINUED)		
Key Changes	**Key Activities**	**Examples of Activities that Have Been Tested**
5c. Use point-of-care reminders based on clinical guidelines.	Integrate comprehensive, guideline-based information on prevention or chronic illness treatment into care protocols and/or reminders	· Implement new templates for provider decision support, (e.g., pediatric asthma and spirometry use, COPD, aspirin use for cardiovascular disease) · Implement standing orders for nurses or MAs, (e.g., vaccinations, diabetes, etc.) · Include point of care reminders for self-management goal setting and review of progress towards achievement of goals
5d. Enable planned interactions with patients by making up-to-date information available to providers and the care team prior to the visit.	Use a summary report or pre-visit worksheet with most recent lab work, vitals and preventive care	· Include patient goals and experiences since last visit through the use of visit preparation forms with patients before the visit

PATIENT-CENTERED INTERACTIONS		
Key Changes	**Key Activities**	**Examples of Activities that Have Been Tested**
6a. Respect patient and family values and expressed needs.	Prioritize patient experience	· Form a patient advisory council to meet on a quarterly basis with leadership and board members · Establish a committee or assign accountability to address and improve patient experience · Include patient representative(s) on committee to address patient experience · Include patient experience as a standing agenda item at leadership meetings · Routinely conduct patient satisfaction surveys · Share survey results with staff and providers and identify changes that could lead to improvement
	Elicit patients' expectations for the visit/appointment	· Ask patients to write their expectations on a worksheet · Use a questionnaire, agenda setting tools, etc. · Have MA/front desk staff ask patient and document in medical record · Use of pre-visit tools, (e.g., CareOregon visit preparation tool, to ensure that all information about evidence-based preventive and chronic care needs is available)
6b. Encourage patients to expand their role in decision-making, health-related behaviors and self-management.	Educate care team members on all available patient engagement tools	· Place patient engagement education materials, including videos, in lobby/waiting area · Request patients bring medications or medication lists at every visit · Use decision aids to engage patients in treatment choices or preferences · Improve EHR patient education materials and decision aids to better support both staff and patients · Enlist pharmacy residents to educate patients on treatment and alternatives for their condition at the same time the pharmacist is reviewing medications · Train staff and providers in patient-centered communication, e.g. use of Mauksch's Patient-Centered Observation Form
	Actively engage patients in their care	· Standardize the use of health promotion materials, starting with disease management materials · Placed shared decision-making stock boxes which hold decision aids in each exam room · Train staff and providers to respond to patient expectations · Train staff and providers to use decision aids · Train staff and providers on behaviors/techniques for conveying patient-centeredness
6c. Communicate with patients in a culturally appropriate manner, in a language and at a level that the patient understands.	Identify the language/health literacy needs of patient population	· Collect 'preferred language for the visit' data from patients and document in EHR · Host focus groups to gain in-depth patient feedback on the clarity of clinic communications · Use available tools to identify and respond to the approximate health literacy levels of patient population · Use focus groups to determine how to best approach language and cultural needs including literacy
	Communicate with patients and families in a way that best serves their needs	· Offer programs, (e.g., group visits, health workshops, patient orientation, etc.) in the languages of populations served · Modify patient education and communication materials to support patients' literacy levels and languages · Use appropriately-trained interpreter in any visit where the patient's preferred language is other than English · Assess best/sustainable process for patient interpretation needs - in person/telephone - and develop supportive workflows · Hire bi-or multi-lingual staff (including ASL) to assist patients in non-clinical matters · Post information and directional signage in multiple languages reflective of patient population in the waiting room · Offer foreign language training to providers and staff (e.g., Rosetta Stone to train providers and staff in Spanish) · Establish process to ensure translators are available for patients who need/benefit from this support · Utilize available technologies including text, secure messaging, and patient portal
	Ensure providers and staff are responsive to the varied needs of a multi-cultural patient population	· Train staff in important issues of health disparities, health literacy, and communicating effectively with patients · Train providers and staff in how to work effectively with trained medical interpreters · Train providers and staff in techniques for culturally-sensitive care · Match patients with providers / care teams with similar cultural backgrounds when possible · Strive to match patients with providers that have a strong background in understanding health disparities as well as providing culturally specific care; (e.g., empanel all Spanish-speaking patients to a Spanish-speaking, bi-lingual provider)

PATIENT-CENTERED INTERACTIONS (CONTINUED)		
Key Changes	**Key Activities**	**Examples of Activities that Have Been Tested**
6d. Provide self-management support at every visit through goal setting and action planning.	Train staff and providers on self-management support	· Train staff and providers on why self-management support is key to engaging patients as partners in their care · Train providers and staff in how to effectively use self-management support techniques to engage with patients · Establish roles and responsibilities for team members and the use of self-management goal-setting · By implementing systems to support, ensure communication among staff about patient self-management support, (e.g., establish documentation methods for patient self-management goals)
	Ensure self-management support at every visit	· Designate role/responsibility to address goals at every patient visit · Make sure all team members know patient goals and follow-up so they can support them as appropriate · Use self-management goal setting forms in the patient visit · Use available support tools as appropriate, (e.g., PSPC Asthma Intervention, CINA materials, etc.) · Use a health educator if available · Utilize behavioral health to address self-management support where appropriate
	Use validated communication strategies for goal-setting with patients	· Train appropriate staff on how to initiate self-management goal conversations with patients · Train staff and providers in the use of motivational interviewing techniques
	Establish a system to follow-up on self-management goal-setting	· Use a registry system to identify patients who need a follow-up call · Designate role/responsibility for doing follow-up calls with patients · Share information on applicable community services that will help patients achieve their SM goals · Use templates and reminder systems in EHR · Provide a list of community resources for patients (e.g., farmer's market lists, places for free yoga sessions, free meals, etc.) and also a wellness fair that occurs once per month for patients wanting to improving their health · Develop scripts or other training resources to support other staff roles in follow-up, (e.g., patient navigator)
6e. Obtain feedback from patients/families about their healthcare experience and use this information for quality improvement.	Capture patients' satisfaction with care	· Use validated patient satisfaction or experience surveys that are appropriate to population language and literacy level · Present patient satisfaction survey results to staff during a clinic-wide staff meeting to discuss ways to improve operations to increase ratings
	Understand patients' experiences with care	· Conduct waiting room interviews (e.g., ask patients if they were satisfied with the care they received and if all their questions were answered at the time of the visit) · Conduct 'secret shopper' testing, see the Secret Shopper Exercise · Observe, document and analyze patient flow through an office visit · Do 'walkthroughs' with various staff members

ENHANCED ACCESS		
Key Changes	**Key Activities**	**Examples of Activities that Have Been Tested**
7a. Promote and expand access by ensuring that established patients have 24/7 continuous access to their care teams via phone email or in-person visits.	Offer extended hours to meet patient needs	· Shift operating hours to better meet the needs of patients, particularly for different ethnic groups · Stagger provider and staff schedules to improve coverage/increase hours · Open weekends and evenings · Open early for people needing lab tests · Open for lunch-hour appointments · Ensure patients know about and understand after-hours care
	Implement after-hours on-call coverage	For each of the activities listed below, it is assumed that each includes access to patient's medical records remotely: · Use a cell phone that is shared or rotated among providers after hours · Have residents take call or establish an "on-call resident" role · Contract with after-hours call agency with rotating provider call schedule on pager · Use a provider or RN on-call coverage rotation schedule
	Use technology to improve after-hours care	· Implement secure patient portals to allow communication between patients and provider teams via email · Provide remote access for providers on-call or off-site to access EHR/medical records
7b. Provide scheduling options that are patient- and family-centered and accessible to all patients.	Accommodate walk-in and same-day appointments	· Make open access an organizational priority · Review the principles of open access scheduling with all staff · Establish an Urgent Care Clinic that links patients back to their own provider/care team · Evolve away from urgent care providers and to adequate levels of same day access for all empanelled providers
	Expand access during regular business hours by trying different types of visits	· Assess and test the feasibility of group visits, shared medical appointments or other alternatives to the traditional 1:1 visit, (e.g., as seen in Centering Pregnancy, Reclaiming Your Health group visits) · Assess and test the feasibility of increasing services provided on-site, (e.g. pharmacy, behavioral health services, etc.) · Identify ways to support "max-packing" visits or provide other necessary/recommended services (preventive exams, chronic care tests, etc.) when patients are in the office · Offer pharmacy visits and/or nurse visits · Review schedules for patients who could be seen by non-provider staff and establish a system for providing non-provider visits · Review schedules for patients whose visits could be done by phone and establish a system for providing telephone visits · Offer pharmacotherapy clinic once a week
	Expand in-person access during regular business hours by using staff in new ways.	· Conduct provider-directed nurse visits · Offer nurse or med-level provider visits without appointment all day including lunch hours · Use students to run vaccination clinics · Use pharmacy and medical residents in new ways · Use RNs as physician extenders
	Improve telephone systems to assure that patient questions are answered quickly	· Use scripts and training to allow front desk staff, MAs, etc. to answer some of the questions previously addressed by RNs · Evaluate existing telephone systems including patient input and redesign accordingly · Incorporate a triage system · Establish a standardized workflow for telephone calls including information collection · Establish policies and protocols for addressing voice mails and other messages · Assign a dedicated MA/RN to answer clinical questions · Solicit patient input on how to improve telephone systems · Float MA carries cell phone for direct access to daily patient questions; screens/responds/and forwards as needed

ENHANCED ACCESS (CONTINUED)		
Key Changes	**Key Activities**	**Examples of Activities that Have Been Tested**
7b. Provide scheduling options that are patient- and family-centered and accessible to all patients. **(continued)**	Improve processes to reduce no show rates	· Standardize scheduling templates · Make reminder calls to patients who are high-risk for not showing up for appointments · Communicate no-show policy for all patients with two or more no-shows and have them sign a behavior contract
	Evaluate access using data collection	· Have a systematic approach for managers and teams to review schedules, (e.g., monthly, to assess access continuity) · Calculate supply of providers and compare to patient demand including requests (e.g., phone calls) for appointments that are not able to be filled same day · Monitor telephone abandonment rates to determine which changes result in improvements · Regularly review dashboard of access measures such as average days to third next available appointment, no show rate, wait and cycle times, resolution on first call, etc.
7c. Help patients attain and understand health insurance coverage.	Design a program to assist patients in enrolling in available health plans including Medicaid or Medicare Part D	· Establish a new patient orientation program that addresses all coverage opportunities and is repeated annually · Have a pharmacist available daily to meet with patients and select plan based on output from www.medicare.gov · Establish a financial advocate position to assist patients in enrollment · Have a social worker , financial counselor, or outreach worker address health insurance coverage · Partner with community organizations (e.g., SHINE) to provide Medicare Part D Support
	Identify resources for uninsured patients	· Use social worker or patient navigator to refer patients to options within the community

CARE COORDINATION		
Key Changes	**Key Activities**	**Examples of Activities that Have Been Tested**
8a. Link patients with community resources to facilitate referrals and respond to social service needs.	Establish accountability by deciding as a primary care clinic to improve care coordination	· Develop a quality improvement plan specific to collaborating with community health care facilities, specialists, and other community resources to implement changes and measure progress · Post provider-specific data publicly re: care coordination activities, (e.g., percentage of referrals completed and results communicated in a timely fashion) · Use reports and/or visual boards with care coordination results at the team level · To ensure that all information is available to the team when needed and has been communicated with patients, incorporate information on referrals and results into planned care structure/daily huddle
	Identify, develop and maintain relationships with key specialist groups, hospitals and community organizations	· Complete internal needs assessment to determine key partnership needs · Have medical director and/or executive director meet with community hospital representatives to champion relationship building efforts · Work with specialty groups to establish bi-directional communication systems for referrals and scheduling · Practice engages with community agencies to improve access and use of social services for patients
	Develop agreements with these key groups, hospitals and agencies	· Initiate conversations with key consultants and community resources · Develop verbal or written agreements that include referral or transition guidelines, expectations, and consultation or transition processes · Establish written agreement with hospitalists
	Develop systems that support the safe transition of patients	· Ensure the information and medication changes are communicated to all parties · Use RN care manager, referral coordinator and others and/or care transitions program to ensure patients are supported as they move across healthcare and community facilities · Receive data from and work with health plan CCMs to manage patient care · Staff hospital inpatient service exclusively with patient's PCPs and PCP partners, providing immediate familiarity in inpatient setting · Conduct home visits by nurse practitioner and pharmacist · Identify care team member responsible for managing patient care transitions or integrate transition of care responsibilities across care team member roles · Establish clinical guidelines for contact within 48 hours of discharge with patients after a transition of care experience, e.g., ED or hospital discharge or discharge from other healthcare setting
8b. Integrate behavioral health and specialty care into care delivery through co-location or referral agreements.	Improve collaboration between primary care and mental health teams	· Embed an LCSW, behaviorist, and/or family practice mental health NP on care teams as feasible and create a system for 'warm hand-offs' to these providers · Use volunteer specialists to see uninsured · Collaborate with and establish a formal agreement with a community mental health agency · Use a psychiatrist or PMHNP for medications management for high acuity and provide time to consult with PCPs managing lower acuity · Engage providers in identifying high risk patients who would benefit from extra monitoring or outreach from behavioral health · Create a process between PCP and behavioral health specialist for shared care plans and setting self-management goals with patients
	Improve collaboration between primary care and specialty care	· Establish a specialty care network at local hospital · Tap into Volunteer Physicians Network or other community resource affiliated with specialty care · Integrate patient self-management goals into shared care plan · Use bi-directional communication and a shared care plan between PCP and specialty providers

CARE COORDINATION (CONTINUED)		
Key Changes	**Key Activities**	**Examples of Activities that Have Been Tested**
8c. Track and support patients when they obtain services outside the practice.	Develop and implement an information transfer system	· Investigate potential of shared EHR or web-based e-referral system; if not available, set up other standardized information flow process · Review ED discharge records to assure timely follow-up care is provided · Design a communication method between hospital and primary care (texting, faxing, etc.) · Participate in ED diversion project with community partners to understand patterns related to high-utilizers of the ED or patients using the ED for primary care during regular clinic hours · Use CareEverywhere with other systems that use EPIC EHR · Determine appropriate model for the practice's integration of behavioral health, e.g., co-location of services, embedded behavioral health services or community based collaboration model · Test and implement "warm hand-offs" between PCP, patient and mental health/behavioral health staff
	Develop an internal tracking system	· Design the clinic's information infrastructure to internally track and manage referrals/transitions · Utilize EHR functionality for referral tracking
	Implement e-prescribing	· Utilize EHR functionality for e-prescribing
	Organize practice team to support patients and families	· Delegate/hire and train staff to coordinate referrals and transitions of care and patient centered communication · Assess patients' insurance and logistical needs · Identify patients with barriers to referrals/transitions and help patients address them · Assign accountability and timeframe for follow-up post referral or transition · Use Outreach Specialist and Referral Coordinator to assist patients
8d. Follow up with patients within a few days of an emergency room visit or hospital discharge.	Identify patients seen in the ED or discharged from hospital	· Review Emergency Department discharge records to assure timely follow-up care is provided · Design a communication method between hospital and primary care (testing, faxing, etc.) · Use patient navigator, health assistant or others to capture lists of patients' hospitalized or with ED visit · Share health center EHR access with local Emergency Department and admissions staff
	Develop workflows for ED follow-up visits	· Identify and integrate into care team the staff responsible for internal tracking and management of referrals/transitions · Assign roles and accountability for ED follow-up visits · Establish definitions of 'avoidable' vs. 'unavoidable' ED visits and workflows for follow-up of each type
	Use data to identify ED visit patterns	· Participate in ED diversion project with community partners to understand patterns related to high-utilizers of the ED or patients using the ED for primary care during regular clinic hour · Focus on patients who have both medical and psychiatric issues as subpopulation · Track "high flyers," number of patient follow-ups and number of times patient outreach is performed
8e. Communicate test results and care plans to patients.	Identify workflows for assuring results are communicated in a timely fashion	· Assign accountable staff the responsibility of tracking tests · Assign accountable staff the responsibility of communicating and explaining test results to patients in a timely manner · Modify procedures for conducting tests

This list was adapted from the Key Activities Checklist tool created by Qualis Health and the MacColl Center for Health Care Innovation; practice coaches from the Safety Net Medical Home Initiative's Regional Coordinating Centers (Colorado Community Health Network, Idaho Primary Care Association, Massachusetts League of Community Health Centers, CareOregon, Oregon Primary Care Association, Oregon Rural Practice-based Research Network, and the Pittsburgh Regional Health Initiative); and sites participating in the Safety Net Medical Home Initiative. We thank all for their significant contributions to this tool. For more information on SNMHI Regional Coordinating Centers and sites, please visit: https://cchn.org/.

The interactive Key Activities Checklist is available here: Key Activities Checklist

Safety Net Medical Home Initiative

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

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