METRIC – An MC-FP Part IV Solution

This survey is not intended to be a “test” of your practice’s current environment. Rather, we hope it will help you begin thinking about the systems of care that you currently use, which of these are working well, and which could be improved. You will be able to compare your answers with those of others in steps 4 and 8; however, it is most useful to think of this survey as a self-assessment that can help you determine where to place your focus.

You may feel that some of the answers provided here are not mutually exclusive or do not reflect your practice precisely. Simply choose the response that most closely describes your practice environment.

**Organization of My Practice: Planned care is more effective if the office practice in which care is provided has clearly defined strategies and protocols.**

1. The way we seek to improve geriatric care in our practice (select one):
   - o is not well-organized; we are unable to consistently give patients the time, effort, and resources that are needed.
   - o focuses on problems as they emerge or become an emphasis of insurers, state efforts, or other outside influences.
   - o involves the use of protocols and practice tools.
   - o includes an overall improvement strategy that we use proactively to meet our practice goals.

**Community Linkages: Linkages between your practice and community resources play an important role in the management of your patients’ care.**

2. In our practice, (select one):
   - o we do not link geriatric patients to community resources as consistently as I would like.
   - o we give our geriatric patients the name and phone number of a community resource, and it is up to the patient to make contact.
   - o we have a staff person who is responsible for ensuring that doctors, practice staff, and our geriatric patients make maximum use of community resources.
   - o we have excellent community-wide coordination between our office and community agencies in caring for geriatric patients.

3. In our practice, partnerships with community organizations focusing on geriatrics (select one):
   - o do not exist.
   - o are being considered but have not yet been implemented.
   - o are formed to develop supportive programs and policies.
   - o are actively sought to develop formal supportive programs and policies across the entire system.

**Self-management Support: Effective self-management support can help patients and families cope with the challenges of aging. It can reduce complications and symptoms and improve patients’ overall sense of health and well-being.**

4. In our practice, self-management support for geriatric patients (select one):
   - o involves distribution of information (e.g., pamphlets, booklets).
   - o includes referral to self-management classes or educators.
   - o is provided by trained personnel in our practice who are designated to do self-management support.
   - o is provided by trained personnel in our practice who are trained in self-management skills and who see most of our geriatric patients.

5. In our practice, (select one):
   - o we do not consistently address self-management concerns of geriatric patients and their families or caregivers.
we address self-management concerns only of the specific patients who seem to need it.
we address self-management issues during each geriatric patient’s visit as part of the philosophy of the practice.
we have peer support groups in the practice or by referral to other well-established programs.
we systematically assess patients’ self-management needs, and we use peer support groups routinely.

6. In my practice, support for behavior change interventions (select one):
   o is not available.
   o is limited to the distribution of pamphlets, booklets, or other written information.
   o is available by referral to others who are skilled in this area.
   o is available from the physicians and staff of our practice, who use proven techniques to effect behavior change.
   o is available from the physicians and staff, who are trained in behavior change techniques and use these skills as an integral part of routine care.

**Decision Support:** Effective planned care programs ensure that physicians have access to evidence-based information necessary to care for patients to assist them in decision making. This might include evidence-based practice guidelines or protocols and other information sources that are readily available at the point of care.

7. In our practice, evidence-based guidelines (select one):
   o are not readily available at the time of patient visits.
   o are available in our practice, but are not easy to access rapidly.
   o are available and integrated into our charting system (e.g., flow sheets with embedded guidelines, personal digital assistants [PDAs]).
   o are available, supported by physician education, and integrated into care through reminders and other proven behavior change methods.

8. Our practice follows the following protocol for informing patients about guidelines (select one):
   o We do not regularly inform patients about guidelines.
   o We give patients guideline handouts if they ask for them.
   o We routinely give patients a copy of guidelines pertinent to their care.
   o We routinely give patients guidelines with personalized targets for them to achieve and with recommendations about how to achieve the targets.

**Delivery System Design:** Effective planned care usually requires changes in the way practices provide care for patients—that is, changes in your office systems and your way of doing daily business. Teamwork and follow-up are two important elements of effective chronic disease management.

9. In our practice, (select one):
   o I have to do almost everything if I want to be sure my geriatric patients receive the care they need.
   o although we don’t talk about “teams,” I do have competent staff to assist me in providing excellent care for our geriatric patients.
   o we have regular staff meetings in which we discuss specific issues to improve care of our geriatric patients.
   o we have a finely tuned “team,” in which everyone understands his or her role in caring for geriatric patients.

10. In our practice, patient follow-up (select one):
    o is scheduled by the patient or the practice as needed.
    o is scheduled by the practice in accordance with guidelines.
    o is ensured by always scheduling a return visit and contacting patients if they do not show.
    o is customized to patient needs, and we are very proactive in calling and/or emailing patients to check up on them between visits.

11. In our practice, planned visits for geriatric patients (select one):
    o are not used.
    o are used if patients are not doing well or need refills.
    o are implemented for certain patients. Reminder cards are used, but there is no long-term planning for regular visits. Checklists and flow sheets are used, in addition to other tools to ensure key elements of care are provided.
    o are used for all patients and include regular assessment, preventive interventions, and attention to self-management support.
    o are used systematically to optimize patient follow-up. In addition, missed elements of planned care are easily spotted through an alert system.
12. In our practice, coordination of care between our office and subspecialists (select one):
   o is not done well.
   o is done reasonably well, but depends mostly on written communication between our office and subspecialists, case managers, or disease management companies.
   o is done quite well, with adequate oral and written communication between our office, subspecialists, and other relevant providers.
   o is a high priority and includes active coordination between our office, subspecialists, and other relevant groups.

Clinical Information Systems:
Timely, useful information about individual patients and populations of patients with chronic conditions is a critical feature of effective programs, especially those that employ population-based approaches.

13. In our practice, a registry of geriatric patients (select one):
   o is not available.
   o is used to maintain patient information such as name, diagnosis, contact information, and date of last contact, either on paper or in a computer database.
   o is used to identify patients regarding specific clinical information (e.g., data collection for measuring/tracking, identifying patients for planned visits or group visits).
   o is tied to guidelines and provides prompts and reminders about needed services (e.g., lab and other testing), and/or is an integral function of our electronic health record.

14. Reminders to physicians and other team members (select one):
   o are not available.
   o include general reminders about geriatric patients based on birth date, but do not describe needed services at the time of encounter.
   o include indications of needed services for populations of patients through periodic reporting.
   o include specific information for the team about guideline adherence at the time of individual patient encounters.

15. In our practice, performance feedback regarding geriatric care (select one):
   o is not available.
   o is provided to the physicians at infrequent intervals and/or about a limited number of patients.
   o occurs at frequent enough intervals to monitor performance and is specific to each physician.
   o is timely and specific to each physician; we routinely review the reports and strive to remedy any deficiencies as rapidly as possible.

16. Specific treatment targets and goals (select one):
   o are not part of the chart in most cases.
   o are noted in each patient's chart.
   o are established collaboratively and include self-management as well as clinical goals.
   o are established collaboratively and include self-management as well as clinical goals. Individual treatment goals and targets are discussed and adjusted frequently, with input from patients.