The UCSF Double Helix Curriculum:
Transformation of High-Performing Primary Care in Education

Overview of the 10 Building Blocks of Primary Care: An experiential workshop

Facilitator Guide

- **Time:** 2-4 hours; 45-60min (if break into groups of 2-3 and each discusses one building block. Reserve ~30 min to discuss as a group).
- **Audience:**
  Residents or faculty who work in the same primary care clinic
- **Objectives:**

To provide an overview of the 10 building blocks of high performing primary care.
By the end of the session, participants will be able to:

  - Name the 10 building blocks of high performing primary care
  - Describe the utility of the 10 building blocks model
  - Discuss their own clinics' path on the road to achieving high performing primary care

- **Procedures:**

  1) Hand out a copy of the Building Blocks of Primary Care Assessment tool to each participant (see link or attached PDF)

  2) Divide the audience into groups of 3-5

  3) Give the small groups 10 minutes to read the metrics for Block 1 of the Building Blocks Assessment and discuss where they believe their clinic sits on the spectrum for each sub-measure in Block 1

  4) After 10 minutes, call the groups back together

  5) Have each group report its scores for each sub-measure and record them publically on a whiteboard, chalkboard, or screen

  6) Identify areas of discrepancy. For any metric where there is a >3 point spread between groups, ask each group to describe why they chose the number they did.

  7) Facilitate discussion to understand how different group members are experiencing clinic differently, defining the building blocks differently, or prioritizing different aspects of the clinic system.

  8) Repeat this procedure for blocks 2-10

  9) For each block, allot 10 minutes for small group discussion/score assignment, 5 minutes for score reporting, and 10 minutes for large group discussion. This will take 4 hours for all 10 building blocks.

  10) If you have only 2 hours, or if you have a particularly engaged group with robust discussions, consider focusing in on the blocks that are most difficulty to grasp, most challenging for your clinic, or most poorly utilized by the audience. These might include:

      Block 1: Engaged Leadership
      Block 2: Data Driven Improvement
      Block 4: Team Based Care
      Block 5: Patient-Team Partnership
      Block 6: Population Management

Diana Coffa, MD
Education Team
UCSF Family & Community Medicine Department at Zuckerberg San Francisco General Hospital

The 10 Building Blocks of Primary Care
Building Blocks of Primary Care Assessment (BBPCA)

Background and Description

The Building Blocks of Primary Care Assessment is designed to assess the organizational change of a primary care practice as measured against the 10 Building Blocks of High Performing Primary Care. The BBPCA incorporates all of the original items from the PCMH-A, reorganized into the framework of the 10 Building Blocks, and it includes a number of supplemental questions to examine areas not addressed by the PCMH-A.

Instructions

For each row, mark the number that best corresponds to the level of care that is currently provided at your site. The rows in this form present key aspects of patient-centered care. Each aspect is divided into levels showing various stages in development toward a patient-centered medical home. The states are represented by points that range from 1 to 12, with higher point values indicate that the actions described in that box are more fully implemented. To get the most out of the BBPCA, we recommend that you form a multidisciplinary team of management, clinicians, front line staff, and patients. Ask each person to complete the assessment individually, and then meet to discuss your answers. When you complete your assessment, ask the group to identify key areas in which they feel that they can grow.

UCSF Center for Excellence in Primary Care

The Center for Excellence in Primary Care (CEPC) identifies, develops, tests, and disseminates promising innovations in primary care to improve the patient experience, enhance population health and health equity, reduce the cost of care, and restore joy and satisfaction in the practice of primary care.

Acknowledgments

This survey is derived from a public version of The Patient Centered Medical Home Assessment created for use in the Safety Net Medical Home Initiative by the MacColl Center for Health Care Innovation at Group Health Cooperative of Puget Sound. For additional information, please visit **http://www.safetynetmedicalhome.org/**

The UCSF Center for Excellence in Primary Care would like to acknowledge the following individuals for their contribution to this work:

Rachel Willard-Grace, MPH; Kate Dubé; Kevin Grumbach, MD; Thomas Bodenheimer, MD, MPH.

UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

BUILDING BLOCKS OF PRIMARY CARE ASSESSMENT (BBPCA)

DIRECTIONS FOR COMPLETING THE SURVEY

This survey is designed to assess the organizational change of a primary care practice as measured against the 10 Building Blocks of High Performing Primary Care. The instrument is a modification of the Patient-Centered Medical Home Assessment Tool (PCMH-A), developed by the MacColl Center for Health Care Innovation (see below). The BBPCA incorporates all of the original items from the PCMH-A, reorganized into the framework of the 10 Building Blocks, and it includes a number of supplemental questions to examine areas not addressed by the PCMH-A.

1. **Answer each question from the perspective of one physical site (e.g., a practice, clinic).**

   Please provide name of your site

2. **For each row, mark the number that best corresponds to the level of care that is currently provided at your site. The rows in this form present key aspects of patient-centered care. Each aspect is divided into levels showing various stages in development toward a patient-centered medical home. The stages are represented by points that range from 1 to 12. The higher point values indicate that the actions described in that box are more fully implemented.**

3. **Save a copy for yourself by clicking here**

4. **Print a copy for yourself by clicking here**

ACKNOWLEGEMENT: This survey is derived from a public version of The Patient Centered Medical Home Assessment created for use in the Safety Net Medical Home Initiative by the MacColl Center for Health Care Innovation at Group Health Cooperative of Puget Sound. For additional information, please visit http://www.safetynetmedicalhome.org/

Block 1: Engaged leadership

Components	Level D	Level C	Level B	Level A
1. Executive leaders	…are focused on short-term business priorities.	…visibly support and create an infrastructure for quality improvement, but do not commit resources.	…allocate resources and actively reward quality improvement initiatives.	…support continuous learning throughout the organization, review and act upon quality data, and have a long-term strategy and funding commitment to explore, implement and spread quality improvement initiatives.
Score	1 2 3	4 5 6	7 8 9	10 11 12
2. Clinical leaders	…intermittently focus on improving quality.	…have developed a vision for quality improvement, but no consistent process for getting there.	…are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving.	…consistently champion and engage clinical teams in improving patient experience of care and clinical outcomes.
Score	1 2 3	4 5 6	7 8 9	10 11 12
3. The responsibility for conducting quality improvement activities	…is not assigned by leadership to any specific group.	…is assigned to a group without committed resources.	…is assigned to an organized quality improvement group who receive dedicated resources.	…is shared by all staff, from leadership to team members, and is made explicit through protected time to meet and specific resources to engage in QI.
Score	1 2 3	4 5 6	7 8 9	10 11 12
4. Quality improvement activities	…are not organized or supported consistently.	…are conducted on an ad hoc basis in reaction to specific problems.	…are based on a proven improvement strategy in reaction to specific problems.	…are based on a proven improvement strategy and used continuously in meeting organizational goals.
Score	1 2 3	4 5 6	7 8 9	10 11 12
5. Quality improvement activities are conducted by	…a centralized committee or department.	…topic specific QI committees.	…all practice teams supported by a QI infrastructure.	…practice teams supported by a QI infrastructure with meaningful involvement of patients and families.
Score	1 2 3	4 5 6	7 8 9	10 11 12
6. Goals and objectives for quality improvement	…do not exist.	…exist on paper, but are not widely known.	…are known by staff, but are only occasionally discussed in meetings.	…are the centerpiece of multi-disciplinary meetings aimed at developing strategies to meet objectives.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 2: Data-driven improvement using computer-based technology

Components	Level D	Level C	Level B	Level A
7. Performance measures	…are not available for the clinical site.	…are available for the clinical site, but are limited in scope.	…are comprehensive – including clinical, operational, and patient experience measures – and available for the practice, but not for individual providers.	…are comprehensive – including clinical, operational, and patient experience measures – and fed back to individual providers.
Score	1 2 3	4 5 6	7 8 9	10 11 12
8. Reports on care processes or outcomes of care	…are not routinely available to practice teams.	…are routinely provided as feedback to practice teams but not reported externally.	…are routinely provided as feedback to practice teams, and reported externally (e.g. to patients, other teams or external agencies) but with team identities masked.	…are routinely provided as feedback to practice teams, and transparently reported externally to patients, other teams and external agencies.
Score	1 2 3	4 5 6	7 8 9	10 11 12
9. Registry or panel-level data	…are not available to assess or manage care for practice populations.	…are available to assess and manage care for practice populations, but only on an ad hoc basis.	…are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states.	…are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states.
Score	1 2 3	4 5 6	7 8 9	10 11 12
10. Registries on individual patients	…are not available to practice teams for pre-visit planning or patient outreach.	…are available to practice teams but are not routinely used for pre-visit planning or patient outreach.	…are available to practice teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states.	…are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states.
Score	1 2 3	4 5 6	7 8 9	10 11 12
11. An electronic health record that is meaningful-use certified	…is not present or being implemented.	…is in place and is being used to capture clinical data.	…is used routinely during patient encounters to provide clinical decision support and to share data with patients.	…is also used routinely to support population management and quality improvement efforts.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 3: Empanelment

Components	Level D	Level C	Level B	Level A
12. Patients	…are not assigned to specific practice panels.	…are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes.	…are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes.	…are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 4: Team-based care

Components	Level D	Level C	Level B	Level A
13. Non-physician practice team members	…play a limited role in providing clinical care.	…are primarily tasked with managing patient flow and triage	…provide some clinical services such as assessment or self-management support.	…perform key clinical service roles that match their abilities and credentials.
Score	1 2 3	4 5 6	7 8 9	10 11 12
14. Providers (Physicians, NP/PAs) and clinical support staff	…work in different pairings every day.	…are arranged in teams but are frequently reassigned.	…consistently work with a small group of providers or clinical support staff in a team.	…consistently work with the same provider/clinical support staff person almost every day.
Score	1 2 3	4 5 6	7 8 9	10 11 12
15. Workflows for clinical teams	…have not been documented and/or are different for each person or team.	…have been documented, but are not used to standardize workflows across the practice.	…have been documented and are utilized to standardize practice.	…have been documented, are utilized to standardize workflows, and are evaluated and modified on a regular basis.
Score	1 2 3	4 5 6	7 8 9	10 11 12
16. The practice	…does not have an organized approach to identify or meet the training needs for providers and other staff.	…routinely assesses training needs and assures that staff are appropriately trained for their roles and responsibilities.	…routinely assesses training needs, assures that staff are appropriately trained for their roles and responsibilities, and provides some cross training to permit staffing flexibility.	…routinely assesses training needs, assures that staff are appropriately trained for their roles and responsibilities, and provides cross training to assure that patient needs are consistently met.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Components	Level D	Level C	Level B	Level A
17. Standing orders that can be acted on by non-physicians under protocol	…do not exist for the practice.	…have been developed for some conditions but are not regularly used.	…have been developed for some conditions and are regularly used.	…have been developed for many conditions and are used extensively.
Score	1 2 3	4 5 6	7 8 9	10 11 12
18. The organization's hiring and training processes	…focus only on the narrowly defined functions and requirements of each position.	…reflect how potential hires will affect the culture and participate in quality improvement activities.	…place a priority on the ability of new and existing staff to improve care and create a patient-centered culture.	…support and sustain improvements in care through training and incentives focused on rewarding patient-centered care.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 5: Patient-team partnership

Components	Level D	Level C	Level B	Level A
19. Assessing patient and family values and preferences	…is not done.	…is done, but not used in planning and organizing care.	…is done and providers incorporate it in planning and organizing care on an ad hoc basis.	…is systematically done and incorporated in planning and organizing care.
Score	1 2 3	4 5 6	7 8 9	10 11 12
20. Involving patients in decision-making and care	…is not a priority.	…is accomplished by provision of patient education materials or referrals to classes.	…is supported and documented by practice teams.	…is systematically supported by practice teams trained in decision making techniques.
Score	1 2 3	4 5 6	7 8 9	10 11 12
21. Patient comprehension of verbal and written materials	…is not assessed.	…is assessed and accomplished by assuring that materials are at a level and language that patients understand.	…is assessed and accomplished by hiring multi-lingual staff, and assuring that both materials and communications are at a level and language that patients understand.	…is supported at an organizational level by translation services, hiring multi-lingual staff, and training staff in health literacy and communication techniques (such as closing the loop) assuring that patients know what to do to manage conditions at home.
Score	1 2 3	4 5 6	7 8 9	10 11 12
22. The principles of patient-centered care	…are included in the organization's vision and mission statement.	…are a key organizational priority and included in training and orientation.	…are explicit in job descriptions and performance metrics for all staff.	…are consistently used to guide organizational changes and measure system performance as well as care interactions at the practice level.
Score	1 2 3	4 5 6	7 8 9	10 11 12
23. Comprehensive, guideline-based information on prevention or chronic illness treatment	…is not readily available in practice.	…is available but does not influence care.	…is available to the team and is integrated into care protocols and/or reminders.	…guides the creation of tailored, individual-level data that is available at the time of the visit.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Components	Level D	Level C	Level B	Level A
24. Care plans	…are not routinely developed or recorded.	…are developed and recorded but reflect providers' priorities only.	…are developed collaboratively with patients and families and include self-management and clinical goals, but they are not routinely recorded or used to guide subsequent care.	…are developed collaboratively, include self-management and clinical management goals, routinely recorded and guide care at every subsequent point of service.
Score	1 2 3	4 5 6	7 8 9	10 11 12
25. After visits summaries	… are not provided or are just printed and handed to patients.	…are reviewed by a team member who repeats aloud key aspects of the care plan and may highlight them on a printed summary.	…are reviewed by a team member who asks the patient to describe in his/her own words the care plan (teachback).	…are reviewed by a team member who asks the patient to describe in his/her own words the care plan (teachback) and guides the patient in making a personal action plan and identifying and addressing barriers to adherence to the plan.
Score	1 2 3	4 5 6	7 8 9	10 11 12
26. Measurement of patient-centered interactions	…is not done or is accomplished using a survey administered sporadically at the organizational level.	…is accomplished through patient representation on boards and regularly soliciting patient input through surveys.	…is accomplished by getting frequent input from patients and families using a variety of methods such as point of care surveys, focus groups, and ongoing patient advisory boards.	…is accomplished by getting frequent and actionable input from patients and their families on all care delivery activities, and incorporating their feedback in quality improvement activities.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 6: Population management

Components	Level D	Level C	Level B	Level A
27. A patient who comes in for an appointment and is overdue for preventive care (e.g., cancer screenings)	…will only get that care if they request it or their provider notices it.	…might be identified as being overdue for needed care through a health maintenance screen or system of alerts, but this is inconsistently used.	…will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, but clinical assistants may not act on these overdue care items without patient-specific orders from the provider.	…will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, and clinical assistants may act on these overdue care items (e.g., administer immunizations or distribute colorectal cancer screening kits) based on standing orders.
Score	1 2 3	4 5 6	7 8 9	10 11 12
28. A patient who comes in for an appointment and is overdue for chronic care (e.g., diabetes lab work)	…will only get that care if they request it or their provider notices it.	…might be identified as being overdue for needed care through a health maintenance screen or system of alerts, but this is inconsistently used.	…will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, but clinical assistants may not act on these overdue care items without patient-specific orders from the provider.	…will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, and clinical assistants may act on these overdue care items (e.g., complete lab work) based on standing orders.
Score	1 2 3	4 5 6	7 8 9	10 11 12
29. When patients are overdue for preventive (e.g., cancer screenings) but do <u>not</u> come in for an appointment	…there is no effort on the part of the practice to contact them to ask them to come in for care.	…they might be contacted as part of special events or using volunteers but outreach is not part of regular practice.	…they would be contacted and asked to come in for care, but clinical assistants may not act on these overdue care items without patient-specific orders from the provider.	…they would be contacted and asked to come in for care, and clinical assistants may act on these overdue care items (e.g., distribute colorectal cancer screening kits) based on standing orders.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Components	Level D	Level C	Level B	Level A
30. When patients are overdue for chronic care (e.g., diabetes lab work) but do not come in for an appointment	…there is no effort on the part of the practice to contact them to ask them to come in for care.	…they might be contacted as part of special events or using volunteers but outreach is not part of regular practice.	…they would be contacted and asked to come in for care, but clinical assistants may not act on these overdue care items without patient-specific orders from the provider.	…they would be contacted and asked to come in for care, and clinical assistants may act on these overdue care items (e.g., complete lab work) based on standing orders.
Score	1 2 3	4 5 6	7 8 9	10 11 12
31. Self-management support	…is limited to the distribution of information (pamphlets, booklets).	…is accomplished by referral to self-management classes or educators.	…is provided by goal setting and action planning with members of the practice team.	…is provided by members of the practice team trained in patient empowerment and problem-solving methodologies.
Score	1 2 3	4 5 6	7 8 9	10 11 12
32. Clinical care management services for high risk patients	…are not available.	…are provided by external care managers with limited connection to practice.	…are provided by external care managers who regularly communicate with the care team.	…are systematically provided by the care manager functioning as a member of the practice team, regardless of location.
Score	1 2 3	4 5 6	7 8 9	10 11 12
33. Visits	…largely focus on acute problems of patient.	…are organized around acute problems but with attention to ongoing illness and prevention needs if time permits.	…are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. The practice also uses subpopulation reports to proactively call groups of patients in for planned care visits.	…are organized to address both acute and planned care needs. Tailored guideline-based information is used in team huddles to ensure all outstanding patient needs are met at each encounter.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 7: Continuity of care

Components	Level D	Level C	Level B	Level A
34. Patients are encouraged to see their paneled provider and practice team	…only at the patient's request.	…by the practice team, but is not a priority in appointment scheduling.	…by the practice team and is a priority in appointment scheduling, but patients commonly see other providers because of limited availability or other issues.	…by the practice team, is a priority in appointment scheduling, and patients usually see their own provider or practice team.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 8: Prompt access to care

Components	Level D	Level C	Level B	Level A
35. The approach to providing same-day access relies on	…squeezing in urgent patients into a clinician's schedule.	…designating a "clinician of the day" who has slots open for urgent care.	…reserving a few slots in each clinician's daily schedule for urgent appointments.	…systematically implementing a schedule that reserves sufficient appointment slots each day to match documented historical demand.
Score	1 2 3	4 5 6	7 8 9	10 11 12
36. Appointment systems	…are limited to a single office visit type.	…provide some flexibility in scheduling different visit lengths.	…provide flexibility and include capacity for same day visits.	…are flexible and can accommodate customized visit lengths, same day visits, scheduled follow-up and multiple provider visits.
Score	1 2 3	4 5 6	7 8 9	10 11 12
37. Contacting the practice team during regular business hours	…is difficult.	…relies on the practice's ability to respond to telephone messages.	…is accomplished by staff responding by telephone within the same day.	…is accomplished by providing a patient a choice between email and phone interaction, utilizing systems which are monitored for timeliness.
Score	1 2 3	4 5 6	7 8 9	10 11 12
38. After hours access	... is not available or limited to an answering machine.	…is available from a coverage arrangement without a standardized communication protocol back to the practice for urgent problems.	…is provided by coverage arrangement that shares necessary patient data and provides a summary to the practice.	…is available via the patient's choice of email, phone or in-person directly from the practice team or a provider closely in contact with the team and patient information.
Score	1 2 3	4 5 6	7 8 9	10 11 12
39. A patient's insurance coverage issues	…are the responsibility of the patient to resolve.	..are addressed by the practice's billing department.	…are discussed with the patient prior to or during the visit.	…are viewed as a shared responsibility for the patient and an assigned member of the practice to resolve together.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Block 9: Coordination of care

Components	Level D	Level C	Level B	Level A
40. Medical and surgical specialty services	…are difficult to obtain reliably.	…are available from community specialists but are neither timely nor convenient.	…. are available from community specialists and are generally timely and convenient.	…are readily available from specialists who are members of the care team or who work in an organization with which the practice has a referral protocol or agreement.
Score	1 2 3	4 5 6	7 8 9	10 11 12
41. Behavioral health services	…are difficult to obtain reliably.	…are available from mental health specialists but are neither timely nor convenient.	…are available from community specialists and are generally timely and convenient.	…are readily available from behavior health specialists who are onsite members of the care team or who work in a community organization with which the practice has a referral protocol or agreement.
Score	1 2 3	4 5 6	7 8 9	10 11 12
42. Patients in need of specialty care, hospital care, or supportive community-based resources	…cannot reliably obtain needed referrals to partners with whom the practice has a relationship.	…obtain needed referrals to partners with whom the practice has a relationship.	…obtain needed referrals to partners with whom the practice has a relationship and relevant information is communicated in advance.	…obtain needed referrals to partners with whom the practice has a relationship, relevant information is communicated in advance, and timely follow-up after the visit occurs.
Score	1 2 3	4 5 6	7 8 9	10 11 12
43. Follow-up by the primary care practice with patients seen in the Emergency Room or hospital	... generally does not occur because the information is not available to the primary care team.	…occurs only if the ER or hospital alerts the primary care practice.	…occurs because the primary care practice makes proactive efforts to identify patients.	…is done routinely because the primary care practice has arrangements in place with the ER and hospital to both track these patients and ensure that follow-up is completed within a few days.
Score	1 2 3	4 5 6	7 8 9	10 11 12
44. Linking patients to supportive community-based resources	…is not done systematically.	…is limited to providing patients a list of identified community resources in an accessible format.	…is accomplished through a designated staff person or resource responsible for connecting patients with community resources.	…is accomplished through active coordination between the health system, community service agencies and patients and accomplished by a designated staff person.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Components	Level D			Level C			Level B			Level A		
45. Test results and care plans	…are not communicated to patients.			…are communicated to patients based on an ad hoc approach.			…are systematically communicated to patients in a way that is convenient to the practice.			…are systematically communicated to patients in a variety ways that are convenient to patients.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

Block 10: Template of the future

Components	Level D			Level C			Level B			Level A		
46. The scheduling template for the clinic	…only includes individual, face-to-face visits with providers.			…includes a few visit formats, such as visits with chronic care nurses and/or group visits.			…includes a variety of visits formats convenient to the patient, such as group visits, home visits, email or phone visits, visits with non-provider members of the care team.			…includes a variety of visits formats, the number of clinician visits is reduced to allow time for group visits and e-visits, and a significant amount of care is provided through RN or MA visits or other alternatives to the provider visit.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

Overview of the 10 Building Blocks of Primary Care: An experiential workshop

Evaluation

1) I understand the 10 building blocks of high performing primary care better than I did before this workshop.

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

2) This exercise was well presented with an effective approach to teaching the material

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

3) The information from this activity is relevant to my practice

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

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