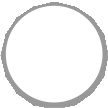
Primary Care Team Assessment

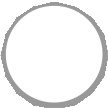
These self-assessment questions help a primary care team identify what is in place, and might be needed, to provide support to patients for better self-management. Ideally, the questions are answered individually, then the results collated and discussed as a team with a quality improvement facilitator or someone within the team who can do this well, to ensure the conversation is positive, purposeful and solutions focused.

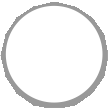
By answering individually first, the self-assessment provides an opportunity to identify questions which generate a wide variety of responses from team members and discuss why these variations exist.

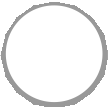
All, or some of the questions could be re-applied at regular intervals, focused on areas where changes are being made, and used to help monitor whether positive changes are being perceived by the team.

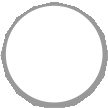
# GPs and nurse leaders...

 discuss improving quality but have no clear vision or process for getting there

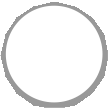
 have developed a vision for quality improvement but no clear process for getting there

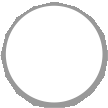
 are committed to a quality improvement process and sometimes engage teams in implementation and problem solving

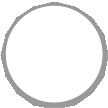
 consistently engage teams in improving patient experience of care and clinical outcomes, and provide time training and resources to complete the work

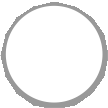
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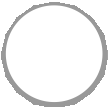
# People regularly involved in the health care team of patients with long-term conditions include...

 GPs and nurses

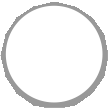
 GPs, nurses, specialists

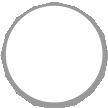
 GPs, nurses, specialists, pharmacists, health coaches or navigators,

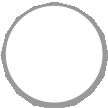
 as above plus social support services, whanau ora workers, peer support

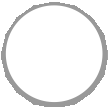
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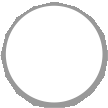
# Work processes for clinical teams...

 have not been documented and/or are different for each person or team

 have been documented, but are not used across the practice

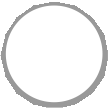
 have been documented and are used regularly

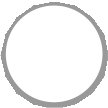
 have been documented, are used regularly and are evaluated and modified on a regular basis

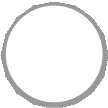


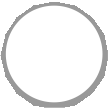
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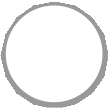
# The practice...

 does not have an organised approach to identify or meet the training needs for clinical and other staff

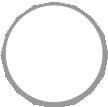
 routinely assesses training needs and encourages on-the-job training for staff needing it

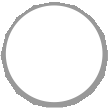
 routinely assesses training needs, and ensures that staff are appropriately trained for their roles and responsibilities

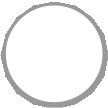
 routinely assesses training needs, ensures that staff are appropriately trained for their roles and responsibilities, and provides regular performance reviews to ensure that patient needs are consistently met.

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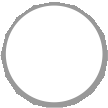
# Standing orders that can be acted on by registered nurses...

 do not exist for the practice

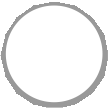
 have been developed for some conditions but are not regularly used

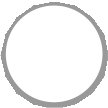
 have been developed for some conditions and are regularly used

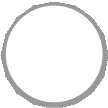
 have been developed for many conditions and are used extensively

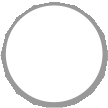
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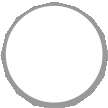
# In our practice, self-management support...

 mainly involves the distribution of information (pamphlets, booklets, websites)

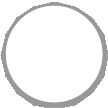
 is provided by referral to external self-management classes or groups

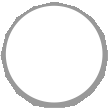
 is provided by goal setting and action planning with members of the practice team and referral to internal and external self- management classes or support

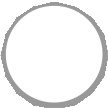
 is provided by members of the practice team trained in self-management support such as patient goal setting, action planning and problem-solving methodologies

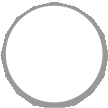
 is not relevant to my role

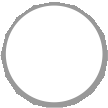
# Population tools such as dashboards and disease registers...

 are not available to practice teams for pre-visit planning or patient outreach

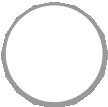
 are available to practice teams but are not routinely used for pre-visit planning or patient outreach

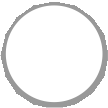
 are available to practice teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states

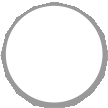
 are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states

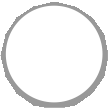
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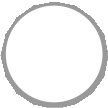
# A patient who comes in for an appointment and is overdue for preventative care (e.g. cancer screening)...

 will only get overdue preventative care if they request it or their GP notices

 might be identified as being overdue for preventive care through a patient management system, but these tools are inconsistently used

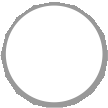
 will often be identified as being overdue for preventive care through practice systems (such as dashboards, huddles or other screening processes) that are consistently used

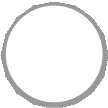
 will routinely be identified as being overdue for preventive care through effective practice systems (such as dashboards, huddles or other screening processes) that are consistently used, and staff act on these (e.g. administer immunisations) based on standing orders

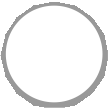
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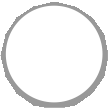
# Patients with long-term conditions...

 tend to see whoever is on duty so see different practice staff throughout the year

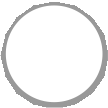
 are linked to GP/nurse in teams but frequently see other GPs or nurses

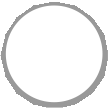
 have a named GP and nurse who they usually see

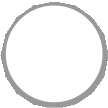
 have a designated care coordinator/health coach or nurse as their first point of contact as well as their GP

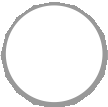
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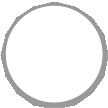
10.Follow-up by the practice team for higher risk patients seen in the emergency department or hospital...

 rarely happens unless the patient or hospital makes contact

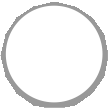
 sometimes happens if the GP notices something on the discharge letter

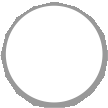
 often happens because the practice team makes proactive efforts to follow up patients admitted to hospital with significant health problems

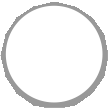
 routinely happens because the practice has systems in place to ensure care transitions for such patients are actively managed and follow-up occurs within a few days of discharge

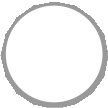
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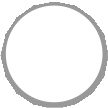
# In our practice medication management consists of...

 prescribers who order prescriptions and refills as necessary

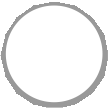
 a clinical staff member who reviews the medication list at regular intervals

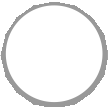
 a pharmacist, nurse, or coach/educator who sometimes conducts a medication self-management review to check patient’s understanding of their meds and how they are taking them

 in addition, regular medicine reviews and checking patient understanding, the practice prioritises medication self-management barriers and regularly works directly with patients (both individually or in groups) having challenges understanding or taking their medications

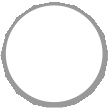
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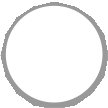
# Nurses in our practice...

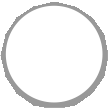
 are mostly focused on acute or preventive services such as recalls, immunisations, dressings and patient calls with no time for long-term condition management with patients

 are mostly focused on acute or preventive services (as above) with limited time for long-term condition management

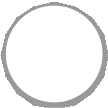
activities.

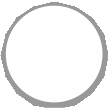
 provide a broader range of acute, preventive and planned care with at least some dedicated time for long-term condition management and care coordination for highest risk patients

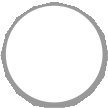
 provide a broad range of services with dedicated time or nurse clinics for planned care and self-management support. Activities typically include care coordination, care planning, monitoring response to treatment, and titrating treatment according to standing orders or clinical pathways in collaboration with the practice GPs

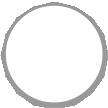
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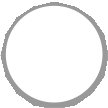
# Test results...

 are not routinely communicated to patients unless follow-up is required

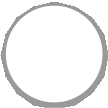
 are communicated to patients based on an ad hoc approach

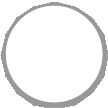
 are systematically communicated to patients in a way that is convenient to the practice

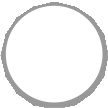
 are systematically communicated to patients in a variety of ways based on their preferred method (text, portal, phone etc)

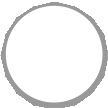
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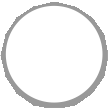
# Linking patients to supportive community services such as NGOs or smoking cessation providers...

 is not done systematically

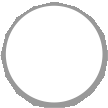
 is limited to providing patients with a list of identified community resources in an accessible format

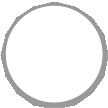
 is managed by a designated staff person or resource responsible for connecting patients with community resources

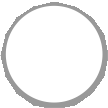
 is managed through active coordination between the health system, community service agencies and patients

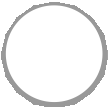
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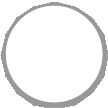
# A pharmacist...

 is not involved in our practice

 is available to our practice but is not usually involved in clinical care

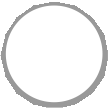
 is available to answer medication-related questions from GPs and other staff both directly and electronically

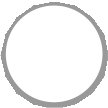
 works closely with the core practice team to review prescribing practices and proactively assists patients having challenges understanding or taking their medications, side effects and medication management challenges

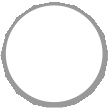


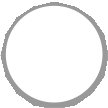
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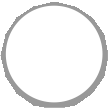
# Health worker or health care assistant roles in our practice...

 are limited to reception or administration and are not involved in clinical care

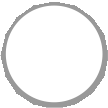
 include non-clinical patient-facing roles such as reception, with the addition of service navigation, transport or referral management

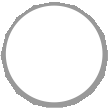
 include individuals who do one or more of the following: provide self-management coaching, coordinate care, help patients navigate the health care system, or access community services

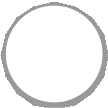
 are clearly developed, match the ethnicity of our population, provide self-management coaching, coordinate care, help patients navigate the health care system, or access community services and are key members of patient care teams

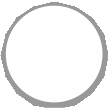
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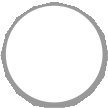
# Assessing patient and family cultural values and preferences (such as traditional foods)...

 is not done

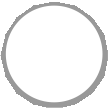
 is done, but not used in planning and organising care

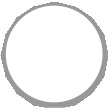
 is incorporated in planning and organising care on an ad-hoc basis

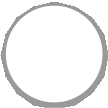
 is systematically incorporated in planning and organising care

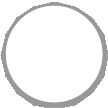
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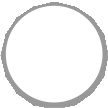
# Involving patients in decision-making and care...

 is not a priority

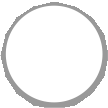
 is managed by providing patient education materials or referrals to classes

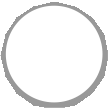
 is supported and documented by practice teams

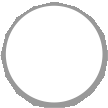
 is systematically supported by practice teams trained in decision making techniques and use of tools such as decision aids

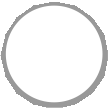
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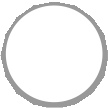
# The effectiveness of staff in building patient understanding...

 is not assessed

 is self-assessed by some staff and managed by assuring that information is at a level and in a language that patients understand

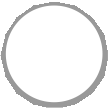
 is self-assessed by all staff and managed by hiring multi-lingual staff, and assuring that both written materials and spoken communications are at a level and language that patients understand

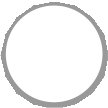
 is supported at an organisational level by translation services, hiring multi-lingual staff, and training staff in health literacy and communication techniques as well as appropriate checking that patients know what to do to manage conditions at home

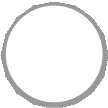


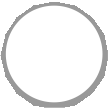
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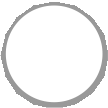
# The principles of patient-centred care...

 are not visible in the organisation’s vision and mission statement

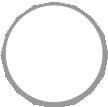
 are a key organisational priority and included in training and orientation

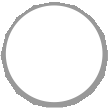
 are a priority, included in training and are explicit in job descriptions and performance metrics for all

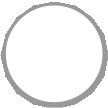
 are a priority, included in training, explicit in job descriptions and performance metrics and are consistently used to guide and measure system performance as well as care interactions at the practice

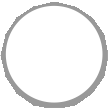
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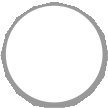
# Care plans...

 are not routinely developed, recorded or shared with patients

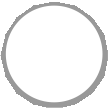
 are developed and recorded but mainly reflect staff priorities and are not routinely shared with patients

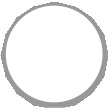
 are developed collaboratively with patients and families and include self-management and clinical goals and are communicated to patients, but the plans are not routinely recorded or used to guide subsequent care

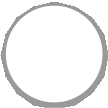
 are developed collaboratively, include self-management and clinical management goals, routinely communicated to patients, recorded and guide care at every point of service

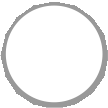
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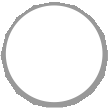
# Appointments within our practice...

 are largely organised around patients presenting with acute problems or repeat medications

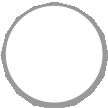
 are organised around acute problems with attention to ongoing illness and prevention needs if time permits

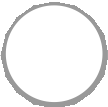
 are a mix of acute and planned visits. The practice also uses population reports to proactively call groups of patients in for planned care visits

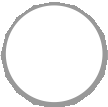
 are planned and organised to get the maximum benefit for the patient in the time available. This includes activities such as pre- visit checks, blood tests and preparation to enhance shared decision making, care planning and patient-centred goal setting

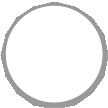
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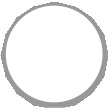
# Patients can access tailored advice and support...

 from their practice team during standard working hours through phone calls or consultations

 from their practice team through calls, portal messaging, phone consultations or face to face consultations

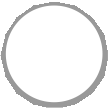
 through a range of access options including phone consultations, video consultations, portal messaging and extended practice hours

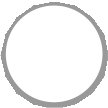
 through a range of access options, plus 24/7 support by an after-hours service accessing their shared care plan, acute plan or shared record at all other times

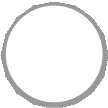


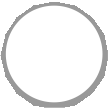
I don't know

# A patient portal...

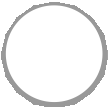
 is not available

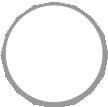
 is available for booking appointments

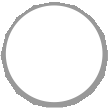
 is encouraged for booking appointments, viewing results, secure messaging and requesting repeat prescriptions

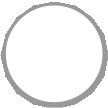
 is encouraged for bookings, viewing results, secure messaging, repeat prescriptions and also provides access for patients to view their own notes (Open Notes)

# Patients trying to contact their clinical team during regular business hours...

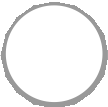
 find it difficult

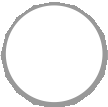
 depend on the practice’s ability to respond to telephone messages

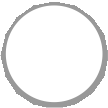
 are responded to by staff by telephone within the same day

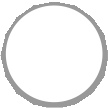
 are provided with a choice between patient portals and phone interaction, using systems which are monitored for timeliness

# Are you...

 in the administration team

 a general practitioner

 a nurse

from another service area

NOTES: This assessment was developed and piloted as an online survey as part of a Self-Management Support project in 2017 with Health Navigator NZ and Health Literacy NZ. It was based on a range of key documents such as: Improving Primary Care Team Assessment, 10 Essential Elements for effective chronic care, Nicholas Mays (2012). [Reorienting the New Zealand health care system to meet the challenge of long-term conditions in a fiscally constrained environment](http://www.treasury.govt.nz/government/longterm/fiscalposition/2013) and the 10 Building Blocks for Primary Care tool.

Further refinements are planned so if you wish to use it, please contact [editor@healthnavigator.org.nz](mailto:editor@healthnavigator.org.nz) so any enhancements are shared back to the sector.