COMIRB Protocol #19-1348
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Comprehensive Primary Care Practice Monitor
FAST Version – 12-19

Please consider how fully each item has been implemented or functions in your practice. Fill in the circle that best reflects the completeness of implementation in your practice. If you rate something as a 4, it means it is now routine across the entire practice. A rating of 1, 2, or 3 means that the statement is only done sometimes, or only in part, or not by everyone in the practice.

1. ENGAGED LEADERSHIP	**Not at all ▼**				**Completely ▼**
a. Practice leaders support innovation and are willing to take risks and tolerate occasional failures in order to improve	⓪	①	②	③	④
b. A culture of shared leadership has been created, with everyone sharing responsibility for change and improvement in the practice	⓪	①	②	③	④
c. The practice has a shared vision for practice transformation that everyone understands and supports.	⓪	①	②	③	④
d. Practice leaders proactively remove organizational barriers to change and improvement	⓪	①	②	③	④

2. DATA DRIVEN IMPROVEMENT	**Not at all ▼**				**Completely ▼**
a. Our practice has a sustainable, effective quality improvement team that meets regularly and deals effectively with challenges	⓪	①	②	③	④
b. QI team meetings are well-organized, with agendas, meeting summaries, prepared leaders and members.	⓪	①	②	③	④
c. The QI team uses QI tools effectively – AIM statements, process mapping, PDSA.	⓪	①	②	③	④
d. QI team members reliably follow-up on assignments and tasks, with good team accountability.	⓪	①	②	③	④
e. Staff members are actively and regularly involved in QI team meetings	⓪	①	②	③	④
f. Clean and accurate quality measurement data are available for targeted conditions.	⓪	①	②	③	④
g. We are able to extract data from our medical record systems for registries (lists of patients with particular conditions and with key information about those patients)	⓪	①	②	③	④
h. Workflows for maintaining accurate registry data have been reliably implemented.	⓪	①	②	③	④
i. Quality measures and other data are used as a central area of focus for the practice's improvement activities.	⓪	①	②	③	④

3. EMPANELMENT	Not at all ▼				Completely ▼
a. Our practice has an ongoing, reliable system for empanelment and panel management within our data systems and practice processes.	⓪	①	②	③	④
b. Each patient is assigned a personal clinician, with a small team to serve as back-up when the personal clinician is unavailable	⓪	①	②	③	④
c. Patient panels are used as a foundation for population health management	⓪	①	②	③	④
4. TEAM-BASED CARE	**Not at all ▼**				**Completely ▼**
a. Care teams have been designated and have regular team meetings	⓪	①	②	③	④
b. Standardized protocols and standing orders have been created to maximize the efficiency of the practice workflow	⓪	①	②	③	④
c. Team members have defined roles that makes optimal use of their training and skill sets	⓪	①	②	③	④
d. Team huddles are used to discuss patient load for the day and to plan for patient visits	⓪	①	②	③	④
5. PATIENT-TEAM PARTNERSHIP	**Not at all ▼**				**Completely ▼**
a. A system has been implemented for including patient and family input in ongoing improvement activities (such as patient advisory groups or patients and family members on QI teams)	⓪	①	②	③	④
b. A patient experience survey is administered regularly (monthly or quarterly) and the data used to monitor and improve practice performance	⓪	①	②	③	④
c. Patients and families are actively linked with community resources to assist with their self-management goals.	⓪	①	②	③	④
d. Patients and families are provided with tools and resources to help them engage in the management of their health between office visits	⓪	①	②	③	④
e. Personalized shared care plans are developed collaboratively with patients and families	⓪	①	②	③	④
f. Personalized shared care plans are regularly reviewed to monitor patient progress in accomplishing their goals and adjusted when appropriate	⓪	①	②	③	④
g. Our practice has implemented and regularly uses shared decision making tools or aids for at least two health conditions, decisions, or tests	⓪	①	②	③	④
6. POPULATION MANAGEMENT	**Not at all ▼**				**Completely ▼**
a. Our practice uses a standardized method or algorithm for identifying its high risk patients	⓪	①	②	③	④
b. Patients with care or outcomes falling outside of guidelines are identified for more intensive care	⓪	①	②	③	④

c.	Our practice has a patient recall system to identify and bring in patients for needed care	⓪ ① ② ③ ④
d.	Our practice provides care management services for patients and families identified as being high risk or needing additional assistance and/or contact between visits	⓪ ① ② ③ ④
e.	Our practice links patients to community resources to address social determinants of health (such as housing, food security, transportation, legal assistance, help paying bills, personal safety)	⓪ ① ② ③ ④
f.	Our practice engages with public health or community organizations to make improvements in mutual population health goals	⓪ ① ② ③ ④

Practice name: _____

Date Monitor completed: _____