QUALITY IMPROVEMENT ACTIVITIES FOR THE PCPCM

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Each item of the PCPCM is actionable. For example, if a clinician scores poorly on the item "Over time, this practice helps me to meet my goals", clinicians can use that feedback to make sure a discussion of patient goals is part of the clinical encounter. The PCPCM is freely available online, as is some advice regarding quality improvement activities and action reflection items to assist with quality improvement efforts. Examples related to each of the PCPCM items include:

1. **PCPCM Item: The practice makes it easy for me to get care**
   - ✓ Example Actions: Alter scheduling options, availability, or who does the scheduling; Provide options for asynchronous communication or telehealth visits
2. **PCPCM Item: This practice is able to provide most of my care**
   - ✓ Example Actions: Schedule longer visits for more complicated problems or patients so that you provide more of the care rather than referring out; Refer in-house to staff or clinicians with specialized expertise or interests
3. **PCPCM Item: In caring for me, my doctor considers all of the factors that affect my health**
   - ✓ Example Actions: Consider starting visits by asking patients what matters to them for this visit; Ask patients, "What one thing would you like someone taking care of you to know?" and add this to the medical record in a consistent and easy-to-see place
4. **PCPCM Item: My practice coordinates the care I get from multiple places**
   - ✓ Example Actions: The medical assistant asks and documents any care received elsewhere since my last visit; When completing medication reconciliation, ask about care received elsewhere
5. **PCPCM Item: My doctor or practice knows me as a person.**
   - ✓ Example Actions: Talk about at least one non-medical item during each visit; Ask patients what matters to them; Link recommended treatments to what gives meaning in the patient's life
6. **PCPCM Item: My doctor and I have been through a lot together.**
   - ✓ Example Actions: Do phone follow up after hospital discharges; Consider other ways you might connect with patients' important health and life events
7. **PCPCM Item: My doctor or practice stands up for me.**
   - ✓ Example Actions: Let patients know when you spend time doing prior authorizations; Discuss options regarding medications with patients to show them you are aware of patient costs and taking that into account
8. **PCPCM Item: The care I get takes into account knowledge of my family.**
   - ✓ Example Actions: Do a quick and dirty family tree and update it periodically – try to find a consistent place in the EHR to keep this information; Routinely ask about the family as a resource or the impact of the patient's illness on the family
9. **PCPCM Item: The care I get in this practice is informed by knowledge of my community.**
   - ✓ Example Actions: Participate in community events and include that in posters or on the practice website; Ask about the patient's neighborhood

10. PCPCM Item: Over time, this practice helps me to meet my goals.

- ✓ Example Actions: Frame care plans around patients' goals or what matters to them; Do HOPE notes: https://drwaynejonas.com/wp-content/uploads/2018/01/HOPENoteQuestions_WEB.pdf

11. PCPCM Item: Over time, my practice helps me to stay healthy.

- ✓ Example Actions: Look for teachable moments when the patient is open to a health behavior change; Use standing orders for immunizations

Each clinician or practice can create quality improvement activities best suited to their context.
The items within the PCPCM PRO instrument used to calculate the PCPCM PRO-PM performance measure are each individually supported by empirical resource as having a strong effect on desirable health outcomes. For instance, continuity of care is associated with improved intermediate outcomes and reductions in cost of care.[1,2] Comprehensiveness has been shown to be associated with lower hospitalization rates, greater use of preventive services, greater adherence to recommended treatment and reduction of burnout among clinicians.[3-8]

The ability to assess those aspects of primary care that uniquely contribute to primary care's proven ability to improve patient health outcomes and experience while reducing health burden and costs warrants a national measure. A 2014 review of measures used to assess primary care shows many aspects of care remain unassessed by current measures. The PCPCM allows for patient reported assessment of those aspects of primary care identified by patients and clinicians as most important.[9]

1. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;3:457-502.
2. Institute of Medicine (U.S.). Division of Health Care Services. Committee on the Future of Primary Care., Donaldson MS. Primary care : America´s health in a new era. Washington, D.C.: National Academy Press; 1996.
3. Stange KC, Etz RS, Gullett H, Sweeney SA, Miller WL, Jaén CR, Crabtree BF, Nutting PA, Glasgow RE. Metrics for assessing improvements in primary health care. Annu Rev Public Health. 2014;35:423-42.
4. McWhinney IR, Freeman T. Textbook of family medicine. Oxford ; New York: Oxford University Press; 2009.
5. Institute of Medicine (U.S.). Committee on Core Metrics for Better Health at Lower Cost, Blumenthal D, Malphrus E, et al. Vital signs: core metrics for health and health care progress. Washington D.C.: National Academies Press; 2015.
6. Stange KC. The paradox of the parts and the whole in understanding and improving general practice. Int J Qual Health Care. 2002 Aug;4:267-8.
7. Starfield B. Is patient-centered care the same as person-focused care? Perm J. 2011 Spring;2:63-9.
8. Soler JK, Okkes I, Wood M, et al. The coming of age of ICPC: celebrating the 21st birthday of the International Classification of Primary Care. Fam Pract. 2008 Aug;4:312-7.
9. Etz RS, Zyzanski SJ, Gonzalez MM, Reves SR, O´Neal JP, Stange KC. A New Comprehensive Measure of High-Value Aspects of Primary Care. Ann Fam Med. 2019 May;17(3):221-230.