Assessment of Preventive Services Delive

Version 3.5

Form Approved
OMB No. 0935-XXXX
Exp. Date XX/XX/20XX

Please complete the following information about you and your organization. This information will not be disclosed to anyone besides the research project team.

Practice Code #:	**Date:** _____/_____/_____ Month Day Year

Directions for Completing the Survey

This survey is designed to help systems and provider practices move toward the "state-of-the-art" in managi immunizations and other primary and secondary preventive services. The results can be used to help your team ident areas for improvement. Instructions are as follows:

1. **Answer each question** from the perspective of one physical site (e.g., a practice, clinic, hospital, health plan) t supports care for chronic illness.

2. For each row, **circle the point value** that best describes the level of care that currently exists in the site. The ro in this form present key aspects of preventive services delivery. Each aspect is divided into levels showing vario stages in improving the delivery of preventive services. The stages are represented by points that range from 0 11. The higher point values indicate that the actions described in that box are more fully implemented.

Again, we are interested in your implementation of office systems designed to maximize the effective delivery immunizations to children and adults and primary (prevention of disease) and secondary (screening for sub-clini disease) services. Examples of primary preventive services include (smoking cessation counseling, weight reducti assistance, exercise counseling, etc.). Secondary prevention includes (mammography, colorectal cancer screening, pa etc.).

Assessment of Preventive Services Delivery, Version 3.5

Part 1: Organization of the Healthcare Delivery System. Prevention programs can be more effective if the overall system (organization) in which care is provided is oriented and led in a manner that allows for a focus on prevention.

Components	Level D	Level C	Level B	Level A
Overall Organizational Leadership in Prevention	…does not exist or there is a little interest.	…is reflected in vision statements and business plans, but no resources are specifically earmarked to execute the work.	…is reflected by senior leadership and specific dedicated resources (dollars and personnel).	…is part of the system's long term planning strategy, receives necessary resources, and specific people are held accountable.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Organizational Goals for Prevention	…do not exist or are limited to a few preventive services only.	…exist but are not actively reviewed.	…are measurable and reviewed.	…are measurable, reviewed routinely, and are incorporated into plans for improvement.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Improvement Strategy for Prevention	…is ad hoc and not organized or supported consistently.	…utilizes ad hoc approaches for targeted services as they emerge.	…utilizes a proven improvement strategies for targeted services.	…includes a proven improvement strategies and uses them proactively in meeting organizational goals.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Incentives and Regulations for Prevention	…are not used to influence clinical performance goals.	…are used to influence utilization and costs of preventive services delivery.	…are used to support patient care goals.	…are used to motivate and empower providers to support patient care goals.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Senior Leaders	…discourage delivery of preventive services.	…do not make improvements in preventive services delivery a priority.	…encourage improvement efforts in prevention.	…visibly participate in improvement efforts in prevention
Score	0 1 2	3 4 5	6 7 8	9 10 11
Benefits	…discourage system changes.	…neither encourage nor discourage system changes.	…encourage system changes.	…are specifically designed to promote better preventive care.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Part 2: Community Linkages. Linkages between the provider practice and community resources play important roles in the delivery and effectiveness of preventive services.

Components	Level D	Level C	Level B	Level A
Linking Patients to Outside Resources	…is not done systematically.	…is limited to a list of identified community resources in an accessible format.	…is accomplished through a designated staff person or resource responsible for ensuring providers and patients make maximum use of community resources.	… is accomplished through active coordination between the health system, community service agencies and patients.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Partnerships with Community Organizations	…do not exist.	…are being considered but have not yet been implemented.	…are formed to develop supportive programs and policies.	…are actively sought to develop formal supportive programs and policies across the entire system.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Regional Health Plans	…do not coordinate prevention guidelines, measures or care resources at the practice level.	…would consider some degree of coordination of guidelines, measures or care resources at the practice level but have not yet implemented changes.	…currently coordinate guidelines, measures or care resources in one or two prevention areas.	…currently coordinate prevention guidelines, measures and resources at the practice level for most preventive services.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Part 3: Practice Level. Several components that manifest themselves at the level of the individual provider practice (e.g. individual clinic) have been shown to improve the delivery and/or effectiveness of preventive services. These characteristics fall into general areas of self-management support, delivery system design issues, decision support, and clinical information systems.

Part 3a: Self-Management Support. Effective self-management support can help patients and families make the often difficult behavior changes required to prevent future health problems.

Components	Level D	Level C	Level B	Level A
Assessment and Documentation of Self-Management Needs and Activities	…are not done.	…are expected.	…are completed in a standardized manner.	…are regularly assessed and recorded in standardized form linked to a prevention plan available to practice and patients.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Self-Management Support	…is limited to the distribution of information (pamphlets, booklets).	…is available by referral to self-management classes or educators.	…is provided by trained clinical educators who are designated to do self-management support, affiliated with each practice, and see patients on referral.	…is provided by clinical educators affiliated with each practice, trained in patient empowerment and problem-solving methodologies, and see most patients needing preventive services.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Addressing Concerns of Patients and Families	…is not consistently done.	…is provided for specific patients and families through referral.	…is encouraged, and peer support, groups, and mentoring programs are available.	…is an integral part of care and includes systematic assessment and routine involvement in peer support, groups or mentoring programs.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Effective Behavior Change Interventions and Peer Support	…are not available.	…are limited to the distribution of pamphlets, booklets or other written information.	…are available only by referral to specialized centers staffed by trained personnel.	…are readily available and an integral part of routine care.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Part 3b: Decision Support. Effective prevention programs assure that providers have access to evidence-based information necessary to care for patients--decision support. This includes evidence-based practice guidelines or protocols, specialty consultation, provider education, and activating patients to make provider teams aware of effective approaches.

Components	Level D	Level C	Level B	Level A
Evidence-Based Guidelines	…are not available.	…are available but are not integrated into care delivery.	…are available and supported by provider education.	…are available, supported by provider education and integrated into care through reminders and other proven provider behavior change methods.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Provider Education for Prevention	…is provided sporadically.	…is provided systematically through traditional methods.	…is provided using optimal methods (e.g. academic detailing).	…includes training all practice teams in prevention methods such as population-based management, and self-management support.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Informing Patients about Guidelines	…is not done.	…happens on request or through system publications.	…is done through specific patient education materials for each guideline.	…includes specific materials developed for patients which describe their role in achieving guideline adherence.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Part 3c: Delivery System Design. Evidence suggests that effective delivery of preventive services involves more than simply adding additional interventions to a current system focused on acute care. It may necessitate changes in the organization of practice that impact provision of care.

Components	Level D	Level C	Level B	Level A
Practice Team Functioning	…is not addressed.	…is addressed by assuring the availability of individuals with appropriate training in key elements of prevention.	…is assured by regular team meetings to address guidelines, roles and accountability, and problems in prevention.	…is assured by teams who meet regularly and have clearly defined roles including patient self-management education, proactive follow-up, and resource coordination.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Appointment System	…can be used to schedule acute care visits, follow-up and preventive visits.	…assures scheduled follow-up with healthy patients.	…are flexible and can accommodate innovations such as customized visit length or group visits.	…includes organization of care that facilitates the patient seeing multiple providers in a single visit.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Follow-up	…is scheduled by patients or providers in an ad hoc fashion.	…is scheduled by the practice in accordance with guidelines.	…is assured by the practice team by monitoring patient utilization.	…is customized to patient needs, varies in intensity and methodology (phone, in person, email) and assures guideline follow-up.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Planned Visits for Preventive Services	…are not used.	…are occasionally used for complicated patients.	…are an option for interested patients.	…are used for all patients and include regular assessment, preventive interventions and attention to self-management support.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Continuity of Care	…is not a priority.	…depends on written communication between primary care providers and specialists.	…between primary care providers and specialists and other relevant providers is a priority but not implemented systematically.	…is a high priority and all preventive interventions include active coordination between primary care, specialists and other relevant groups when indicated.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Part 3d: Clinical Information Systems. Timely, useful information about individual patients and populations of patients is a critical feature of effective prevention programs, especially those that employ population-based approaches.[7, 8]

Components	Level D	Level C	Level B	Level A
Registry list of patients with preventive services indicated and received	…is not available.	…includes name, diagnosis, contact information and date of last contact either on paper or in a computer database.	…allows queries to sort sub-populations by services needed.	…is tied to guidelines which provide prompts and reminders about needed services.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Reminders to Providers	…are not available.	… include general notification of the need for preventive services, but does not specify needed services at time of encounter.	…includes indications of needed services for populations of patients through periodic reporting.	…includes specific information for the team about guideline adherence at the time of individual patient encounters.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Feedback	…is not available or is non-specific to the team.	…is provided at infrequent intervals and is delivered impersonally.	…occurs at frequent enough intervals to monitor performance and is specific to the team's population.	…is timely, specific to the team, routine and personally delivered by a respected opinion leader to improve team performance.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Information about Relevant Subgroups of Patients Needing Services	…is not available.	…can only be obtained with special efforts or additional programming.	…can be obtained upon request but is not routinely available.	…is provided routinely to providers to help them deliver planned care.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Patient Preventive Service Plans	…are not expected.	…are achieved through a standardized approach.	…are established collaboratively and include self management as well as prevention goals.	…are established collaboratively and include self management as well as clinical management. Follow-up occurs and guides care at every point of service.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Integration of Prevention Model Components. Effective systems of care integrate and combine all elements of the Preventive Services Model; e.g., linking patients' goals to information systems/registries.

Components	Little support	Basic support	Good support	Full support
Informing Patients about Guidelines **Score**	...is not done. 0 1 2	...happens on request or through system publications. 3 4 5	...is done through specific patient education materials for each guideline. 6 7 8	...includes specific materials developed for patients which describe their role in achieving guideline adherence. 9 10 11
Information Systems/Registries **Score**	...do not include patient self-management goals. 0 1 2	...include results of patient assessments (e.g., at risk status; readiness to engage in self-management activities), but no goals. 3 4 5	...include results of patient assessments, as well as self-management goals that are developed using input from the practice team/provider and patient. 6 7 8	...include results of patient assessments, as well as self-management goals that are developed using input from the practice team and patient; and prompt reminders to the patient and/or provider about follow-up and periodic re-evaluation of goals. 9 10 11
Community Programs **Score**	...do not provide feedback to the health care system/clinic about patients' progress in their programs. 0 1 2	...provide sporadic feedback at joint meetings between the community and health care system about patients' progress in their programs. 3 4 5	...provide regular feedback to the health care system/clinic using formal mechanisms (e.g., Internet progress report) about patients' progress. 6 7 8	...provide regular feedback to the health care system about patients' progress that requires input from patients that is then used to modify programs to better meet the needs of patients. 9 10 11
Organizational Planning for	...does not involve a population-based approach.	...uses data from information systems to plan	...uses data from information systems to	...uses systematic data and input from practice teams

Components	Little support	Basic support	Good support	Full support
Prevention		care.	proactively plan population-based care, including the development of self-management programs and partnerships with community resources.	to proactively plan population-based care, including the development of self-management programs and community partnerships, that include a built-in evaluation plan to determine success over time.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Routine follow-up for appointments, patient assessment and goal planning	is not ensured. 0 1 2	Is sporadically done, usually for appointments only. 3 4 5	is ensured by assigning responsibilities to specific staff (e.g., nurse case manager). 6 7 8	is ensured by assigning responsibilities to specific staff (e.g., nurse case manager) who uses the registry and other prompts to coordinate with patients and the entire practice team. 9 10 11
Guidelines for preventive services	...are not shared with patients.	...are given to patients who express a specific interest in self-management.. 3 4	...are provided for all patients to help them develop effective self-management or behavior modification programs, and identify when they should see a provider.	...are reviewed by the practice team with the patient to devise a self-management or behavior modification program consistent with the guidelines that takes into account patient's goals and readiness to change.

Components	Little support 0 1 2	Basic support 5	Good support 6 7 8	Full support 9 10 11

For Research Team Use Only

Scoring Summary

Total Org. of Health Care System Score	_____
Total Community Linkages Score	_____
Total Self-Management Score	_____
Total Decision Support Score	_____
Total Delivery System Design Score	_____
Total Clinical Information System Score	_____
Total Integration Score	_____
Overall Total Program Score (Sum of all scores)	_____
Average Program Score (Total Program /7)	_____