**Appendix A - Baseline Practice Assessment**

Form Approved  
OMB No. xxxx-xxxx  
Exp. Date xx/xx/xxxx

**Application for Participation in Guide to Improve Patient Safety in Primary Care Settings by Engaging Patients and Families**

Thank you for agreeing to implement the Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families (the Guide). The Guide is being developed by a team led by the MedStar Health Research Institute and the project is funded by the Agency for Healthcare Research and Quality (AHRQ).

The following assessment should be completed by one member of the practice staff. The information provided will remain confidential. The assessment will take approximately 60 minutes to complete.

Please complete this form by answering all of the questions on the survey.

**General Information About Your Practice**

|  |  |  |
| --- | --- | --- |
| **Practice Name** |  | |
| **Location (City, State)** |  | |
| **Select one:** | **Urban**  **Inner City**  **Rural**  **Suburban**  **Other (Specify)** |  |
| **Contact Person** |  | |
| **Medical Director** |  | |
| **Number of** | **Physicians** | \_\_\_\_\_\_\_\_\_\_ |
|  | **Nurse Practitioners** | \_\_\_\_\_\_\_\_\_\_ |
|  | **Nurses** | \_\_\_\_\_\_\_\_\_\_ |
|  | **Medical Assistants** | \_\_\_\_\_\_\_\_\_\_ |
|  | **Pharmacists** | \_\_\_\_\_\_\_\_\_\_ |
|  | **Social Workers** | \_\_\_\_\_\_\_\_\_\_ |
|  | **Case Managers**  **Other Practice Staff** | \_\_\_\_\_\_\_\_\_\_ |
|  | **Other (specify)** | \_\_\_\_\_\_\_\_\_\_ |
|  |  |  |

Public reporting burden for this collection of information is estimated to average 90 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-0179) AHRQ, 5600 Fishers Lane, Mail Stop Number 07W41A, Rockville MD 20857

|  |  |  |
| --- | --- | --- |
| **Total Number of Patients Served by Practice** |  | |
| **Payer Mix (Indicate % of Patients)** | Self-Pay  Medicare  Medicaid  Private Insurance  Uninsured  Other | \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_% |
| **Race (indicate % of patients)** | **White**  **Black or African American**  **American Indian or Alaska Native**  **Asian**  **Native Hawaiian or Other Pacific Islander** | \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_% |
| **Ethnicity (indicate % of patients)** | **Hispanic or Latino**  **Not Hispanic or Latino** | \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_% |

**Information about Patient Safety and Quality Improvement Activities of the Practice**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **Does your practice routinely conduct a patient safety culture survey?** | ☐   * Please specify which survey you use: \_\_\_\_\_\_\_\_\_\_\_\_\_ * Date of the last survey \_\_\_\_\_\_\_\_ | ☐ |
| **Is your practice part of a larger healthcare system?** | ☐  Please indicate which health system you are affiliated with:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ☐ |
| **Is your practice currently part of the Patient Centered Medical Home initiative?** | ☐ | ☐ |
| **Is your practice currently part of the Center for Medicare & Medicaid Innovation (CMMI) Transforming Clinical Practice Initiative?** | ☐ | ☐ |
| **Is your practice currently working on any other practice improvement strategies?** | ☐ | ☐ |
| **Does your practice have or use the services of a practice facilitator?** | ☐ | ☐ |

**Experience with Using the Guide Interventions**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **Does your practice currently use Teach-back?** | ☐  Please specify how long you have been using teach-back. \_\_\_\_\_\_\_\_\_ | ☐ |
| **Does your practice currently use any of the approaches below?** |  |  |
| Questions are the Answer | ☐ | ☐ |
| Ask Me 3 | ☐ | ☐ |
| Patient Decision Aids | ☐ | ☐ |
| Shared Decision Making | ☐ | ☐ |
| Patient’s Toolkit for Diagnosis | ☐ | ☐ |
| Teach-back | ☐ | ☐ |
| Medication Lists for Patients/Families | ☐ | ☐ |
| **Does your practice currently use materials and/or approaches to support medication management?** | ☐ | ☐ |
| **Does your practice currently use a process of warm hand-off?** | ☐    Please specify how long you have been using warm handoff. \_\_\_\_\_\_\_\_\_\_\_ | ☐ |

The assessment will be completed by one practice member (e.g. by the practice champion) and completed on paper and the results entered into a REDCap® form by the contractor. It is anticipated that the collection of the information to respond to the assessment will take approximately 60-minutes. This assessment will be completed at baseline only.