

6. Feedback through performance measures regarding the care of my populations of patients with particular chronic diseases...

...is not available, or is available but I don't really use the information in the care of my patients.

...is provided and has some influence on how I practice.

...is routinely provided, and I use the feedback to monitor my performance and make changes in how I provide care to my patients with chronic disease.

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Self-management support refers to a process in which a clinician actively engages patients in their own care, including having the patients set goals for various issues surrounding their care (such as targeted weight loss, activity levels, or disease outcomes such as Hgb A1c levels). This is particularly useful for patients with chronic diseases, but also is appropriate for all patients, especially those needing to change health behaviors.

7. I assess the self-management needs and activities of my patients with chronic disease...

...rarely.

... occasionally.

... routinely.

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8. I provide self-management support for my patients...

...rarely, or by distributing educational materials (such as pamphlets, or booklets) that do not include any specific self-management strategies.

...by distributing materials to help patients develop individualized self-management plans, but without formal follow-up on those plans with the patients.

...by distributing materials and providing counseling to help patients develop individualized self-management plans, and having members of my care team follow up with the patients to reinforce their progress.

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9. The information systems, registries, and/or patient records that I use in my care of patients with chronic disease...

...do not include information related to patient self-management goals.

... include results of patient assessments (such as health behaviors and readiness to engage in self-management activities), but no specific patient self-management goals.

...include results of patient assessments, self-management goals developed jointly with the patient, and reminders for the clinician to periodically follow-up and re-evaluate the goals.

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10. The care of my patients with chronic disease ...

...primarily relies on me, with few other resources involved.

...centers on me, but with some help from other resources within my practice

...is a well-coordinated team effort involving a number of different people and resources.

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11. Setting specific patient-centered goals for health behavior change or for issues surrounding chronic diseases....

...is generally not done with my patients, as I set the goals for their care and management.

...occurs sporadically with selected patients, who are highly motivated and assertive.

...is done collaboratively with most patients, with specific goals that are systematically reassessed and progress documented on the patient's chart.

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12. I use evidence-based guidelines for various chronic diseases....

... rarely or never

...to guide my patient care in general, but not in any formal way in my practice.

...as the template for my care of my patients with chronic disease, forming the basis for flow charts and systems used to monitor their care.

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13. I share information with my patients regarding evidence based guidelines for their chronic disease....

...rarely or never.

...as part of patient education materials provided to patients to help them understand their care.

...to assist patients and families in setting self-management goals and tracking their own care.

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14. Consultation with specialists to help in taking care of my patients with chronic disease...

...is accomplished by referral to specialists who seldom communicate with me about treatment plans and patient progress.

...is accomplished by referral to some specialists who communicate with me well and regularly and others who don't.

...is coordinated with my care through through active and effective communication with specialists in most areas of care.

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15. Follow-up of my patients with chronic disease...

...is largely left up to the patient to return as necessary.

...is scheduled by the front desk in accordance with guidelines that we have set up

...is assured by my care team, which contacts the patient between visits to check on adherence to the treatment plan, progress, side effects, etc.

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16. I use flow sheets for my continuity patients to track their health maintenance and preventive care issues ...

....never

...sometimes, with selected patients or limited health maintenance issues.

...routinely, with most or all patients and for most health maintenance issues.

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17. Contact with my patients with chronic disease between office visits ...

...is done by me on an as-needed basis with selected patients.

...is done by me or by other care team members on a planned basis with selected patients.

...is done on a planned basis by me or other trained care team members with most or all patients with chronic disease, using a system with tracking and reminders.

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18. I arrange for education for my patients with chronic disease (such as diet and other diabetic education for patients with diabetes)...

...rarely, doing most of the education myself.

...for many of my patients with chronic disease by referral to people in my practice or the community who can provide most of the education needed.

...for most or all of my patients with chronic diseases through integrated . education service that coordinates with my care through active communication.

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19. In order to improve the level of care available for my patients with chronic disease...

...I have focused on my own practice and not on community resources for patients with chronic disease.

...I have sought out information regarding community resources, but have not attempted to link with those resources.

...I have actively worked with community resources to impact the level of services available for patients with chronic disease and to coordinate the care of my patients.

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20. I use a symptom checklist with my depressed patients to monitor patient progress and change in the number or severity of depression symptoms ...

....never

...sometimes, focusing on patients who do not seem to be improving.

...routinely, to monitor treatment response and to watch for relapse on stopping therapy.

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21. Emotional health (such as symptoms of depression or anxiety, sources of stress, family conflicts)...

...is not routinely assessed in my patients unless they bring up problems.

...is assessed in my patients by me when I see indicators that they are having problems.

...is routinely assessed in my patients using standardized screening and monitoring protocols.

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22. Information about relevant subgroups of my patients with chronic disease needing services (such as those needing labs or referrals, not returning for follow-up, etc) ...

...is not available, or is available but I don't use the information.

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...can be obtained upon request, and I occasionally use the information.

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...is provided to me routinely and is used by me and my team to help deliver planned care to my patients with chronic disease.

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23. In my delivery of preventive services to my patients, I...

...rely on my patients coming in for health maintenance visits.

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...have a system for tracking where my patients stand on preventive services so I can remind them of what they need whenever they present for care.

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...have a system for tracking where my patients stand on preventive services that is used to send patients reminders regarding needed services.

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24. When I receive feedback on my performance in the form of performance measurement data, I....

...pay little attention to it.

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...use the data for myself to point out areas that I need to work on, but with no formal process for improvement.

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...share the data with the rest of my practice as part of a process to identify and improve performance.

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25. My level of participation in my practice's quality improvement process can be characterized as...

...I work on things informally to improve my care, but don't have a formal process.

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...My practice has an improvement process that operates sporadically, and I participate in it at times.

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...I am an active part of our practice's improvement process, which is very active and meets regularly.

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26. When my patients need counseling regarding health behavior changes (such as for diet, exercise, or stopping smoking), I...

...provide limited counseling myself, with few or no other services available to assist them.

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...provide limited counseling myself, plus recommend at least some limited services that are available in the community.

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...provide extensive counseling myself based on goals set by the patients and/or refer them to specific services in my practice or community that are coordinated with my care.

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27. When discussing treatment options with patients, I...

...tell the patients my selection of the best choice for them, mentioning other options as I think necessary.

...outline other treatment options as well as my own selection to see if they have strong feelings about the choice.

...carefully discuss the options and patient preferences, jointly coming to a consensus regarding the best selection for the particular patient and situation.

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28. My use of guidelines at the point of care to guide my decisions regarding the care of patients...

...relies on my memory regarding the guidelines and what needs to be accomplished for each patient.

...is supported by guideline-based reminders of needed services for patients in a few key areas.

...is supported by automated reminder systems based on guidelines for most chronic conditions and preventive care areas and tailored to patients' needs and self-management goals.

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29. The care plans for my patients...

...are basically outlined in my progress notes from patient visits.

...are summarized in a specific care plan in the chart that is available to my staff.

...are summarized in a care plan in the chart that includes patient goals and preferences for treatment and is used to guide the efforts of everyone involved with the patients' care.

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30. Effective mental health counseling for my patients with mental health issues...

...is difficult to arrange, but I can make a referral for patients who seriously need it.

...is available by referral to mental health specialists who sometimes communicate with me regarding treatment plans and patient progress.

...is readily available and is coordinated with my care through active and effective communication with the mental health specialist.

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31. The planning of care for my patients ...

...flows from my assessment of the patient's needs.

...is done by me, but with some discussion of the patient's specific needs and desires.

...is done through interactive discussions and goal setting with the patient and family by me and my care team.

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32. In thinking about the composition of the team in my care of my patients...

...I view the team as consisting of health professionals only.

...I view the patient and family as part of the team managing the patient's chronic illness.

...I actively engage the patient and family in setting goals and managing the patient care plan.

33. In sharing clinical information with patients...

...a paper copy of medication lists or lab/x-ray reports is provided to the patient upon request.

...there is a system in place through which I make sure that patients are provided with their clinical information, including lab/ray reports and medication lists.

...there is a web- based system for patients to access their clinical information and share their personal health information with me or my staff.

34. In order to enhance support for my patients with chronic disease...

I do not make use of peer support groups.

...I sometimes suggest that patients and families find a peer support group.

...I routinely assist patients in connecting with peer support groups in the community.

35. Considering our quality improvement processes in my practice...

...I do not believe it is necessary to involve patients and families in our QI process.

...I believe that patients and families can help in enhancing my practice's QI process and and occasionally ask for their input.

...I actively engage patients in my practice's quality improvement process.

Name of your practice: _____

Your position in the practice (check the best response):

Clinical faculty:

Physician _____

PA/NP _____

Behavioral _____

Other _____

Non-clinical faculty _____

First year resident _____

Second year resident _____

Third year resident _____

Other _____

How long have you worked in this practice? _____ years and _____ months.