ANNALS OF FAMILY MEDICINE

Online Supplementary Material

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http://www.annfammed.org/content/11/3/272.

Supplemental Appendix 2. Site Visit Guide

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Domains of Observation[1,2]

1. **Control** (Autonomy) Team member influence over work environment
    - **a. Working conditions**
        - **i.** To what degree does provider and other team members have influence/control over working conditions: hours, patient volumes, schedule template, patient mix, panel size, support staff, role responsibility among staff?
    - b. **Leadership**
        - i. Who is the leadership team?
        - ii. What are the channels of communication for leadership to front line and vice versa?
2. **Order** (Mastery) Operational efficiency, staff quality; competency
    - **a. Have any systems been put in place to direct nonclinical and low-level clinical work away from the provider?**
        - **i.** In-box: Do laboratory results, attestations, requests for phone management and prescription renewal go directly to MD or are they filtered by the nurse? Are messages handled electronically directly to the physician or verbally through the nurse/MA?
        - **ii.** Information: Who inputs and looks up data (laboratory results, script changes) in the information system?
        - **iii.** EHR: Who signs in, navigates to action screens, does order entry, processes new scripts?
        - **iv.** Clerical: How is the visit documented? (typing/dictation; all MD or collaborative) Who does *ICD-9* assessment documentation? Who fills out disability papers, FMLA forms, prior authorization paperwork?
    - **b. Time**
        - **i.** How many patient contact hours per week for FTE?
        - **ii.** How many noncontact hours per week per FTE (results review/paperwork)?
        - **iii.** Do providers take work home at night?
    - **c. Team**
        - i. Composition: Who is on the team? What are their roles? Is there consistency day to day? Is case management in-practice or remote? Is there a behavioralist on site?
        - **ii.** Tasks: How are the tasks of primary care distributed among the physicians and staff, with special attention to the distribution of clerical tasks? Who does medication reconciliation, e-prescribing, order entry? Are there standing orders to allow staff to initiate care element (cancer screening, immunization, preappointment laboratory testing)?

iii. Distributive knowledge: Do team members each possess special capacities: ie, do nurses own the initial teaching for outpatient management of DVT or do nurses know details of pharmaceutical company indigent drug plan.
iv. Distributive leadership? Do team members each own special responsibilities, ie, are nurses in charge of prevention; are certain staff in charge of handouts, or are others in charge of room standardization and stocking?
v. Communication: How do team members communicate? Are there team meetings?
vi. Messaging: How are messages handled (electronic or in-person)?
vii. Space: How is the physical space configured to support the work? Were things located in the right place to minimize steps: printers in the room vs down a hallway, light notification system vs walk around untill you find someone?
viii. Spirit: Would you like to get your care here? Would you like to practice here? Did the provider seem harried or calm? Was there a spirit of cohesion and cooperation or frustration and suspicion?
ix. Scope of competency: What procedures are done in practice? Inpatient and outpatient care? How soon is referral made for CKD, CHF, DM?
x. Flow: Did processes flow smoothly or was there constant turbulence? Sand in the gears vs well oiled machine?

3. **Meaning** Satisfaction with clinical and human aspects of care
   a. **How is culture maintained?**
      i. Are there team meetings?
      ii. What degree of relational coordination is observed (comfort communicating across role type)?
      iii. Do providers meet to share cases or in other ways learn from each other?
      iv. How is communication between different specialties handled? (telephone, hall consults, or indirect through record?)
   b. **Roles**
      i. What creates trust and reliance, rather than redundancy and silos, among the team?
      ii. What percentage of the time was the provider working at the top of her license?
      iii. What are the skills, attitudes, and competencies that the physicians in these practices exhibit that help them maximally contribute to vibrant primary care?
      iv. What skills do they feel they are missing that would make a better practice for themselves and their patients?
      v. Does clinical assistant remain in the room with physician?
   c. **Satisfaction**
      i. What is provider turnover?
      ii. How does the practice measure and/or support continuity?
   d. **Quality**
      i. What is the quality improvement infrastructure?
      ii. What is the quality management infrastructure?
   e. **Vision**
      i. What do providers dream of as the next step in improvement?

CHF = congestive heart failure; CKD = chronic kidney disease; DA = diabetes mellitus; DVT = deep vein thrombosis; EHR = electronic health record; FMLA = Family Medical Leave Act; FTE = full-time equivalent; *ICD-9* = *International Classification of Diseases, Ninth Revision;* MA = medical assistant; MD = medical doctor.

References

1. Dunn PM, Ametz BB, Christensen J, Homer L. Meeting the imperative to improve physician well-being: assessment of an innovative program. *J Gen Intern Med.* 2010;22(11):1544–1552.
2. Pink D. The puzzle of motivation. TED talks, August 25, 2009. http://www.youtube.com/watch?v=rrkrvAUbU9Y. Accessed April 23, 2013.