



Quarterly Practice Report on Core Expectations Name of Practice:

Please Indicate your current progress score, indicate any activities completed this quarter, and complete through the final section.

Email to mainepcmhpilot@mainequalitycounts.org

Due: last day of month following end of each quarter (July, October, January and April)

Date:

1. Demonstrated Leadership				
0 - No Progress	1 - Early progress	2 - Moderate progress	3 - Regular part of care <i>Core Expectation / ** MUST PASS 12/2013</i>	Your Score (0-3)
We have not identified primary care provider (physician or NP) leader for the PCMH Pilot for our practice site.	We have identified a PCMH provider leader (physician or NP) for our practice site, but the role is still informal (i.e., role has not been widely communicated; no dedicated space in lead provider's schedule for PCMH team meetings).	We have identified at least one primary care physician or NP as a leader within the practice. Leadership has made a commitment to improve care and implement the PCMH model known to some in the organization.	** We have identified at least one primary care physician or nurse practitioner as a leader within the practice who visibly champions a commitment to improve care and implement the PCMH model.	
We have not identified primary care leader for the PCMH Pilot for our practice site.	We have identified a PCMH primary care leader, but they are not yet actively engaged with all providers and staff in supporting a team-based approach to care, or reviewing practice performance data.	Some of the primary care leaders (provider and administrative) take an active role in working with other providers and staff in the practice to build a team-based approach to care. Some individual providers, and occasionally teams, examine processes and structures to improve care, and review data on the performance of the practice.	**All of the primary care leader(s) take(s) an active role in working with other providers and staff in the practice to build a team-based approach to care, continually examine processes and structures to improve care, and review data on the performance of the practice.	
We have not identified primary care leader(s) for the PCMH Pilot for our practice site.	PCMH primary care leader(s) have been identified but are not yet taking an active role in our leadership team, and/or are not yet scheduled to participate in PCMH Learning Sessions	The primary care leader periodically participates as a member of the Leadership Team and participates in 50-75% of the PCMH Learning Collaboratives.	**The primary care leader(s) participate as a member of the practice Leadership Team and participate in all aspects of the PCMH Learning Collaborative	
Activities this quarter:				
2. Team-Based Approach to Care				
0 - No Progress	1 - Early progress	2 - Moderate progress	3 - Regular part of care <i>Core Expectation / **MUST PASS 2013</i>	Your Score (0 - 3)
We are planning to identify opportunities to optimize roles to move to a more team-based approach to care.	We have identified a model and are currently testing one or more changes to expand the roles of the non-physician providers to improve clinical workflows (see examples under Regular Part of Care)	We have begun to implement a team-based approach to care delivery that expands the roles of the non-physician providers to improve clinical workflows (e.g., staff education), but have not yet fully implemented team approach. (see examples under Regular Part of Care)	**We have implemented a team-based approach to care delivery that includes expanded roles of non-physician providers and staff (e.g. nurse practitioners, physician assistants, nurses, medical assistants) to improve clinical workflows. (Examples: scripts, front desk / MA's / RN's providing higher level of support; etc).	
We are planning to identify new models for providing care that will improve access and efficiency of the practice team.	We have identified and are testing one or more new models for providing care that will improve access and efficiency of the practice team (see examples under Regular Part of Care)	We are implementing one or more new models for improving access and efficiency of the team but have not yet fully implemented throughout the practice. Leadership's vision is known to all within the organization and a few providers are involved in testing some of the work in this area. (see examples under Regular Part of Care)	**We have fully implemented new ways to improve access and efficiency of the practice team such as: - planned visits, - integrating care management into clinical practice - delegating some testing or exams to non-physicians (e.g., ordering routine screenings, DM foot exams) - expanding patient education; - providing greater data support to physicians to enhance the quality and cost-effectiveness of their clinical work.	

We have not yet identified teams, roles and responsibilities	We have identified specific roles to support team-based care, but there are still some overlaps in roles (e.g., RN is rooming patients)	Some members of the practice team are brought into providing care as a team and specific roles and responsibilities have been assessed and developed for the team members.	**All members of our practice identify themselves as part of the team, and can identify their specific role and responsibilities within the team.	
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Activities this quarter:

3. Enhanced Access				Your Score (0 - 3)
0 - No Progress	1 - Early progress	2 - Moderate progress	3 - Regular part of care Core Expectation / **MUST PASS 2013	
We do not yet have panel population reports by provider.	We have begun generating panel reports and are working to ensure accuracy.	Leadership's vision for preserving access to their patient populations is seen by most in the organization. (e.g., we can generate accurate panel reports and are planning a system to regularly monitor these reports)	**We demonstrate our commitment to preserving access to our population of patients. (Examples: our providers receive and review accurate panel reports, and we monitor them to ensure sufficient access to care)	
We do not offer same day access scheduling	We provide same day access appointments for some, but not all, patients	We have daily openings in our schedule for same day appointments and we are exploring other systems to meet patients access to care that meets their needs (see examples under Regular Part of Care)	**We have systems in place to ensure our patients have same-day access to their provider, and use some form of care that meets their needs (Examples: telephonic support, and/or secure messaging, group visits, RN visits.)	
TTT is not tracked at this practice	We consistently track TTT across all providers for both short and longer office visit. Averages: short = 2+ days; longer = 7+ days	We have set a goal of zero for time to 3rd (TTT) next available appointment for short office visit (15/20 minutes); we consistently track TTT and have reached an average TTT of 3-6 days or less when measured across all providers over past 30 days.	We have set a goal of zero for time to 3rd (TTT) next available appointment for short office visit (15/20 minutes); we consistently track TTT and have reached an average TTT of <3 days when measured across all providers over past 30 days.	

Activities this quarter:

4. Population Risk Stratification and Management				Your Score (0 - 3)
0 - No Progress	1 - Early progress	2 - Moderate progress	3 - Regular part of care Core Expectation / **MUST PASS" 2013	
We do not have systems in place to identify high risk patients in the practice or stratify our patient population by level of risk.	We are identifying a process for proactively identifying and stratifying patients across our population who are at risk for adverse outcomes, and will then identify resources or care processes to help reduce those risks. (e.g., not fully implemented across all providers/teams)	We have a process in place for proactively identifying and stratifying patients across our population who are at risk for adverse outcomes, and are starting to identify resources or care processes to help reduce those risks (e.g., not fully implemented across all providers/teams).	** We have adopted a process for proactively identifying and stratifying patients across our population who are at risk for adverse outcomes, and direct resources or care processes to help reduce those risks.	

Activities this quarter:

5. Practice Integrated Care Management				Your Score (0 - 3)
0 - No Progress	1 - Early progress	2 - Moderate progress	3 - Regular part of care Core Expectation / **MUST PASS 2013	
Our practice has not yet identified specific processes for providing Care Management (CM) to at-risk patients	We have identified a process for care management services that would meet the needs of our patients but have not yet started to work with patients at high risk for experiencing adverse outcomes. (see definitions under Regular Part of Care)	We have identified a process for care management services that would meet the needs of our patients and are beginning to identify specific individuals to work closely with the practice team to provide care management for patients at high risk for experiencing adverse outcomes. (see definitions under Regular Part of Care)	**We have a clear process for providing care management services, and have identified specific individuals to work closely with us to provide care management for patients at high risk for experiencing adverse outcomes, including - patients with chronic illness who are complex or fail to meet multiple treatment goals; - patients identified at risk for avoidable hospitalization or emergency department use; and - patients at risk for developing avoidable conditions or complications of illness	
We have not identified CM roles and responsibilities, nor integrated CM into team(s)	We are in the process of identifying care management roles and responsibilities and/or integrating them into team(s)	Care management roles and responsibilities have been identified and care management staff identified to be part of the practice team.	**Care management staff (RN, social worker, etc) have clear roles and responsibilities, are integrated into the practice team, and receive explicit training to provide care management services.	
We do not yet have defined methods for tracking outcomes for patients receiving CM services.	We are still designing methods for tracking outcomes for patients receiving care management services.	Our leadership is working with care management staff to develop methods for tracking outcomes for patients receiving care management services, and are still refining and testing the methods.	Care management staff have defined methods for tracking outcomes for patients receiving care management services.	
No clinical/CCT meetings have been held.	Clinical/CCT meetings are held occasionally.	Clinical/CCT meetings are held regularly but less than monthly.	Clinical/CCT meetings are held at least monthly.	
Please tell us how many people your practice has referred to your CCT this quarter:				
Activities this quarter:				
6. Behavioral Health Integration				Your Score
0 - No Progress	1 - Early progress	2 - Moderate progress	3 - Regular part of care Core Expectation / *MUST PASS 2013	
We have not yet completed the BH Integration Assessment		We have the baseline assessment tool and are working to complete it	**We have participated in a baseline assessment of our current behavioral-physical health integration capacity	
We have not developed and (remove "d") Action Plan to integrate behavioral/physical health	We are still refining an Action Plan to integrate behavioral/physical health (see examples under Regular Part of Care)	We are still in the process of implementing our Action Plan to integrate behavioral/physical health (see examples under Regular Part of Care)	**Using results of baseline assessment, we have taken steps to make <u>one or more</u> improvement(s) to integrate behavioral/physical health. (e.g., carried out our action plan). For example: - Routine depression assessment (e.g., PHQ-9 or -2) for chronic illness patients; - Standard screening for substance abuse (e.g. AUDIT, DAST) - Behavioralist support for chronic condition management; - Co-locate behavioral health within the practice.	
Activities this quarter:				
7. Inclusion of Patient and Families				Your Score

0 - No Progress	1 - Early progress	2 - Moderate progress	3 - Regular part of care Core Expectation / *MUST PASS 2013	Your Score (0 - 3)
We have not yet identified patient(s)/family member(s) to advise us in our improvement efforts	We are identifying patient(s)/family member(s) to be included in practice leadership, improvement or advisory team	We have identified at least two patients or family members to be part of the practice Leadership, improvement, or advisory team and have developed a specific plan to include them in identifying improvement needs and implementing creative solutions	**At least two patients and family members are a regular part of leadership meetings or some advisory process to identify needs and implement creative solutions. There are tangible supports to enable them to participate in this process (e.g., after hours events, transportation, stipends, etc.)	
We currently do not use any mechanism for soliciting patient/family input	We are testing at least one mechanism for soliciting patient/family input	We are using one or more mechanisms for routinely soliciting input from patients and families on how well the practice is meeting their needs, and have identified methods for sharing results of patient surveys or other patient input with all members of the practice	We systematically learn about our patients and use their input at least annually (e.g., via mail survey, phone survey, point of care questionnaires, focus groups, etc.) to design and implement changes that address needs and gaps in care.	
We have not begun to implement (or improve) tools, training or materials that promote patient, education, self-management, etc	We are testing some tools, training and/or materials that promote patient education, self-management, etc	We are implementing the standardized use of some tools, training and/or materials that promote patient education, self-management, etc.	We consistently use standardized patient education, motivational interviewing, and/or action planning tools to promote self-management.	

Activities this quarter:

8. Connection to Community Resources and Social Support Services

0 - No Progress	1 - Early progress	2 - Moderate progress	3 - Regular part of care Core Expectation / **MUST PASS 2013	Your Score (0 - 3)
We do not have a working list of local resources and social services to help patients / (?delete spaces) families meet goals	We are compiling local community resources and social supports	We have identified resources in our community and are making some referrals but we are still refining the process.	**We can identify and routinely make referrals to local community resources and social support services that provide self-management support to individuals and their families and/or to help them overcome barriers to care so they can meet health goals.	

Activities this quarter:

9. Commit to Reduce Waste, Unnecessary Spending, and Improving Cost-Effective Use of Healthcare Services

0 - No Progress	1 - Early progress	2 - Moderate progress	3 - Regular part of care Core Expectation / *MUST PASS 2013	Your Score (0 - 3)
We need more data to analyze the effectiveness of our services (i.e., utilization reports from hospitals or plans)	We are compiling/collecting data to determine outcome- & cost- effectiveness and are identifying areas to improve. (Note, sources of data may include hospital reports, or payer utilization reports (such as RTI, Health Homes), or MHMC Practice Reports.)	We have analyzed data to determine gaps in outcome- & cost- effectiveness and are testing improvements in the areas defined (see definitions under Regular Part of Care)	** We demonstrate commitment to reduce wasteful spending of healthcare resources and to improve the cost-effective use of healthcare services, through specific efforts in the following areas: - Reducing avoidable hospitalizations through improved coordination of care - Improving care transitions and reducing avoidable rehospitalizations - Reducing avoidable emergency department visits - Reducing non-evidence-based use of advanced imaging, e.g. MRI, CT (for example, participation in Choosing Wisely)	

Activities this quarter:

10. Integration of Health Information Technology				Your Score (0 - 3)
0 - No Progress	1 - Early progress	2 - Moderate progress	3 - Regular part of care Core Expectation / **MUST PASS 2013	
We do not have either an electronic medical record OR a registry to support improved communication for patient care	We are exploring integrated Health IT systems to support improved communication with and for patients, to assure they get care when and where they need and want it in a culturally and linguistically appropriate manner. (For examples, see Regular Part of Care)	We are currently implementing integrated Health IT systems to support improved communication with and for patients, to assure they get care when and where they need and want it in a culturally and linguistically appropriate manner. (For examples, see Regular Part of Care)	**We use integrated Health IT to support improved communication with and for patients, and to assure patients get care when and where they need it in a culturally and linguistically appropriate manner. (e.g. registry, electronic medical record, personal health records, health information exchange, provider-patient secure messaging)	

Activities this quarter:

Action Plan for Addressing Gaps in Core Expectations

Consider any gaps you may have in meeting the above Core Expectations, what action steps are you taking to improve in at least three areas.

Clinical Quality Data Review and Plan

Please review the Clinical Quality Measures. What action steps are you taking this quarter to improve at least three Clinical Quality Measures?

Successes & Challenges

Do you have any successes you wish to share with other practices?	What challenges do you struggle with - what would you like to learn from other practices?
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How is your practice currently utilizing the funding received as being part of the Maine PCMH pilot?