



# Maine PCMH Pilot - Practice Self-Assessment

Name of Practice: \_\_\_\_\_

Please Indicate your current progress score, indicate any activities completed this quarter, and complete through the final section. Email to both your QI Specialist AND (lbrochu@mainequalitycounts.org) by 4/30/13.

Date: \_\_\_\_\_

<b>Degree of Progress</b>					
<b>1. Demonstrated Leadership</b>	<b>0 - No Progress</b>	<b>1 - Early progress</b>	<b>2 - Moderate progress</b>	<b>3 - Regular part of care Core Expectation /"MUST PASS" 2013</b>	<b>Your Score (0 - 3)</b>
a. The practice had 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 provider leader 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)	Our PCMH provider leader is identified and has a clear role for leading PCMH change (i.e., others can identify them; established space in their schedule for PCMH work, team meetings, etc.)	Our PCMH provider leader is identified, has a clear role in leading PCMH change internally and externally (i.e. regularly participates in and communicates with leadership, advocates for and reports on PCMH activities.)	
b. Primary care leader(s) take an active role in working with other providers and staff in the practice to build a team-based approach to care, examine processes / structures to improve care, and review performance data w/ team(s).	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 in supporting a team-based approach to care, or reviewing practice performance data.	Our PCMH primary care leader is either engaged with all providers supporting team-based approach to care, OR has a formal role and dedicated time to regularly review processes, structures or data with team.	Our PCMH primary care leader takes an active role supporting a team-based approach to care in our practice, and regularly reviews processes, structure and data with team.	
c. The primary care leader(s) also participate as a member of the practice Leadership Team and participate in all aspects of the PCMH Learning Collaborative	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	PCMH primary care leader(s) are identified / participating on leadership team, but not yet participating in PCMH Learning Collaborative (Learning Sessions, webinars, etc).	PCMH primary care leader(s) are actively participating on leadership team, and is fully participating in PCMH Learning Collaborative, (e.g., scheduled to attend Learning Sessions and webinars)	
<b>Activities this quarter:</b>					
<b>2. Team Based Approach to Care</b>	<b>0 - No Progress</b>	<b>1 - Early progress</b>	<b>2 - Moderate progress</b>	<b>3 - Regular part of care Core Expectation /"MUST PASS" 2013</b>	<b>Your Score (0 - 3)</b>
a. The practice uses a team-based approach to care delivery that includes expanding the roles of non-physician providers (e.g. nurse practitioners, physician assistants, nurses, medical assistants) to improve workflows.	We are planning to identify opportunities to optimize roles to move to a more team-based approach to care.	We have identified a model for optimizing team roles, and are currently testing one or more change (i.e., scripts, "huddles," front desk / MA's / RN's providing higher level of support; etc).	We are implementing specific changes that expand roles of the team to optimize the roles of all staff to improve clinical workflows in the practice.	We have implemented these changes and have embedded these optimized roles into job descriptions, written protocols and supervision.	
b. Utilize non-physician staff to improve i.e., planned visits; care management; routine tests / exams by non-physicians (i.e., screening, diabetic foot check); patient education; and providing data to physicians to enhance quality and cost outcomes.	We are planning to identify new models for providing care that will improve access and efficiency of the practice team.	We have identified one or more new models for providing care that will improve access and efficiency of the practice team (i.e., planned visits, using non-physician staff with standing orders and guideline-based care; group visits, etc.)	We have implemented models or specific changes to improve access and efficiency of the practice team. (i.e., planned visits, using non-physician staff with standing orders and guideline-based care; group visits, etc.)	We have redesigned the practice and are using at least two or more new models of care to improve access & efficiency of the practice team in specific ways. (i.e., planned visits, using non-physician staff with standing orders and guideline-based care; group visits, etc.)	

c. Members of the practice team identify themselves as part of the practice team, and can identify their specific role and responsibilities within the team.	We have not yet identified teams, roles and responsibilities	We are testing some workflows that expand roles (e.g., include front desk, referrals, etc).	We have implemented new team roles, and some members of the practice team can identify their role and responsibilities within the team.	All members of the team know their roles and responsibilities. We have written protocols, training and supervision that supports optimization of team roles.	
<b>Activities this quarter:</b>					
<b>3. Enhanced Access</b>	<b>0 - No Progress</b>	<b>1 - Early progress</b>	<b>2 - Moderate progress</b>	<b>3 - Regular part of care</b> <i>Core Expectation /"MUST PASS" 2013</i>	<b>Your Score</b> <b>(0 - 3)</b>
a. The practice commits to preserving access to their population of patients.	We do not yet have panel population reports by provider.	We have begun generating panel reports and are working to ensure accuracy.	We can generate accurate panel reports for each provider, and are planning a system to regularly monitor those reports.	We use accurate panel reports for our providers, and regularly monitor those reports to ensure sufficient access to care for our patients.	
b. The practice ensures patients have same-day access using some form of care that meets their needs – e.g. open-access scheduling, telephonic support, and/or secure messaging.	We do not offer open access scheduling	We provide open access appointments for some, but not all, patients; OR we do not routinely provide our patients with alternatives to office visits	We provide open-access appointment scheduling, and are actively planning to offer patients one or more alternatives to office visits	We routinely provide open-access appointment scheduling for all our patients and providers, and also offer our patients one or more alternatives to office visits.	
c. Time to 3rd next available appointment (TTT) is consistently tracked and measured at zero.	TTT is not tracked at this practice	We track TTT, and it is currently more than 5 days	We track TTT, and it is currently 1 - 5 days	We track TTT, and, it is currently less than 1 day on average	
<b>Activities this quarter:</b>					
<b>4. Population risk stratification and management</b>	<b>0 - No Progress</b>	<b>1 - Early progress</b>	<b>2 - Moderate progress</b>	<b>3 - Regular part of care</b> <i>Core Expectation /"MUST PASS" 2013</i>	<b>Your Score</b> <b>(0 - 3)</b>
Proactively identify and stratify patients at risk for adverse outcomes,* and direct resources or care to help reduce those risks. (* "Adverse outcomes" = clinical outcomes, avoidable utilization such as admissions, ED visits, and/or non-evidence based use of diagnostic testing or procedures.)	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 testing systems or algorithms to stratify our patient populations according to level of risk.	We are implementing systems or algorithms for stratifying our patient population, and have some systems in place to direct specific resources to help support those patients (e.g. care management, Community Care Team).	We have systems or algorithms for stratifying our patient population according to level of risk, and routinely direct resources to support them (e.g. care management, Community Care Team).	
<b>Activities this quarter:</b>					
<b>5. Practice Integrated Care Management</b>	<b>0 - No Progress</b>	<b>1 - Early progress</b>	<b>2 - Moderate progress</b>	<b>3 - Regular part of care</b> <i>Core Expectation /"MUST PASS" 2013</i>	<b>Your Score</b> <b>(0 - 3)</b>
a. Identify specific processes and individuals to work with the practice team to provide care management (CM) to patients at high risk for experiencing adverse outcomes (based on disease state/outcomes, hospitalization or utilization)	Our practice has not yet identified specific staff and/or processes for providing CM to at-risk patients	Our practice is currently testing processes and/or staff roles for managing high risk patients	Our CM processes and staff support some (but not all) patients at risk based on disease state/outcomes, hospitalization and/or utilization	Our CM processes and staff support all at risk patients based on disease state/outcomes, hospitalizations, and/or utilization	
b. Care management (CM) staff have clear roles/responsibilities, are integrated into the practice team, and receive explicit training to provide CM services.	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)	We are formalizing care management roles (including training) and are integrating CM staff into team(s)	We have fully implemented care management roles and have fully integrating them into training and team(s)	

Care management staff have defined methods for tracking outcomes for patients receiving care management services.	We do not yet have defined methods for tracking outcomes for patients receiving CM services.	We are testing methods for tracking outcomes for patients receiving care management services.	We are implementing/spreading methods for tracking outcomes for patients receiving care management services.	We have fully implemented methods for tracking outcomes for patients receiving care management services.	
Please note the extent to which your practice holds clinical meetings with CCTs, which include practice-level staff and providers to coordinate care for specific patients.	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.	
<b>Please tell us how many people your practice has referred to your CCT this quarter:</b>					
<b>Activities this quarter:</b>					
<b>6. Behavioral Health Integration</b>	<b>0 - No Progress</b>	<b>1 - Early progress</b>	<b>2 - Moderate progress</b>	<b>3 - Regular part of care</b> <i>Core Expectation / "MUST PASS" 2013</i>	<b>Your Score</b> <b>(0 - 3)</b>
a. With the assistance of PCMH Pilot, participate in a baseline assessment of behavioral-physical health integration.	We have not yet completed the BH Integration Assessment	We have completed the BH Integration Assessment	We have completed the BH Integration Assessment and are reviewing the results with leadership	We have used the BH Integration Assessment to inform an action plan to integrate behavioral and physical health care	
b. Improvement(s) to integrate behavioral/physical health: - Routine depression assessment (PHQ-9) 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.	We do not currently use standard assessments for depression and substance abuse	We have analyzed our population trends in chronic condition management, depression and substance abuse, and are testing some changes to meet patient needs (such as partnering with behavioralist or behavioral/mental health provider)	We have analyzed our population trends in chronic condition management, depression and substance abuse, and are implementing changes to meet patient needs and tracking results	We have successfully embedded a BH integration model that meets the needs of our patients	
<b>Activities this quarter:</b>					
<b>7. Inclusion of Patients and Families</b>	<b>0 - No Progress</b>	<b>1 - Early progress</b>	<b>2 - Moderate progress</b>	<b>3 - Regular part of care</b> <i>Core Expectation "MUST PASS" 2013</i>	<b>Your Score</b> <b>(0 - 3)</b>
a. Identify at least two patients or family members to be part of the practice Leadership Team	We have not yet identified patient(s) / family member(s)	We are identifying patient(s)/family member(s) to be included in practice leadership	We are starting to work with patient(s)/family member(s) as part of practice leadership	We have fully incorporated patient(s)/family member(s) to be included in practice leadership	
b. Routinely solicit input from patients and families on how well the practice is meeting their needs	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 use at least one mechanism for soliciting patient/family input and using it to inform improvement efforts	We have a system for regularly soliciting patient/family input and using it to inform improvement efforts	
c. Please tell us how you are engaging patients in the management of their care through (for example) education materials that easy to understand, self-management tools and action plans, and/or motivational interviewing training for all staff	We have not begun to implement (or improve) tools and materials that promote patient self-management	We are testing some tools and materials that promote patient self-management	We are implementing the standardized use of some tools and materials that promote patient self-management	We consistently use standardized patient education, motivational interviewing, and action planning tools to promote self-management.	
<b>Activities this quarter:</b>					

8. Connection to Community	0 - No Progress	1 - Early progress	2 - Moderate progress	3 - Regular part of care Core Expectation /"MUST PASS" 2013	Your Score (0 - 3)
Practice identifies and routinely makes referrals to local community resources and services that provide self-management support to individuals / families to help them overcome barriers to care and meet health goals.	We do not have a working list of local resources and social services to help patients / families meet goals	We are compiling local community resources and social supports, and are testing/measuring how these referrals impact care outcomes/goals	We are standardizing a system for referring to local community resources and social supports that have the best impact on care outcomes/goals	We have a fully functioning system for referring to local community resources and social supports that have the best impact on care outcomes/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)
Reduce wasteful spending, improve cost-effectiveness: o Improve coordination of care and care transitions o Reduce avoidable ED visits o Reduce non-evidence-based procedures – e.g. MRI, CT	We need more data to analyze the effectiveness of our services (i.e., utilization reports from hospitals or plans)	We are analyzing data to determine outcome- & cost- effectiveness and testing improvements.	We have successfully tested new guidelines to improve outcomes/reduce cost, and seen positive results - starting to spread to other teams/across the practice.	We continually review trends in utilization, outcomes and cost to inform improvements at the team and practice level	
Activities this quarter:					
10. Integration of Health Information Technology	0 - No Progress	1 - Early progress	2 - Moderate progress	3 - Regular part of care Core Expectation /"MUST PASS" 2013	Your Score (0 - 3)
Use integrated HIT 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)	We do not have either an electronic medical record OR a registry to support improved communication for patient care	We have (or are implementing) basic Health IT systems to support communications with/for patients (e.g., exploring EMR, registry)	We are currently implementing some advanced Health IT systems to enhance patient care (such as patient portal, secure email, or Health Info Exchange)	Staff and patients utilize advanced Health IT systems to and ensure patients get what they need when/how they need it (such as secure messaging and/or patient access to notes)	
Activities this quarter:					
<b>Action Plan for Addressing Gaps in Core Expectations</b>					
Consider any gaps you may have in meeting the above Core Expectations, what action steps are you taking to improve <u>in at least three</u> 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?