TCPi Transforming Clinical Practices Initiative

Primary Care Phase 2, 3 & 4

			Faculty Expertise:			
Secondary Driver/Change Concept	**Milestone #**	**Milestone Description**	**Carol**	**Gail**	**George**	**Kathy**
AIM	1	**1 pt** Practice is monitoring the metrics related to TCPI aims but is not yet showing improvement in all metrics. **2 pts** Practice has shown improvement in metrics related to TCPi aims but has not reached its targets or improvement is not yet sustained **3 pts** Practice has met at least 75% of its targets and sustained improvements in practice-identified metrics for at least one year.	+		+	+
Organized, Evidence-based Care **1.6.5** Reduce unnecessary tests	2	**3 pts** Practice has demonstrated improvement in reducing unnecessary tests.	+		+	+
AIM	3	**3 pts** Practice has implemented and documented a tested process and has demonstrated a reduction in unnecessary hospitalizations from its baseline.	+			
Population Management **1.1.3** Collaborate with patients and families	4	**1 pt** Practice is training its staff in shared decision making approaches and developing ways to consistently document patient involvement in goal setting, decision making, and self-management. **3 pts** Practice can demonstrate that patients and families are collaborating in goal setting, decision making and self-management (e.g. shared care plans, documentation of self-management goals, compacts etc.)	+	+	+	+
Patient and Family Engagement **1.1.2** Listen to patient and family voice	5	**2 pts** Practice has a formal system for obtaining patient and family feedback but does not consistently incorporate the information received into the QI and overall management systems of the practice.		+	+	+

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		3 pts Practice has a formal system for obtaining patient and family feedback and can document operation or strategic decisions made in response to this feedback				
Team-based Relationships **1.2.2** Clarify team roles	6	**3 pts** The practice has documented each team member's role and accountability lanes and each team member works to the maximum of his skill set and credentials in order to optimize efficiency and outcomes.		+	+	
Team-based Relationships **1.2.3** Optimize continuity	7	**3 pts** Practice has implemented processes to promote continuity and has the metrics to demonstrate that the processes are effective.			+	
Population Management **1.3.1** Assign to panels	8	**3 pts** Practice has assigned all patients to a provider panel and confirmed the assignments with providers and patients. Practice reviews and updates panel assignments on a regular basis.				+
Population Management **1.3.3** Stratify risk	9	**1 pt** Practice has a process for identifying high risk patients but the identification process for other risk levels is inconsistent or not yet standardized. **3 pts** Practice has successfully implemented and documented a tested process that identifies patient risk level and includes follow up by the patient's care team with care appropriate to the risk level identified.			Behavioral Health Patients +	+
Population Management **1.3.3** Stratify risk	10	**2 pts** Practice has assigned accountability for care management and is piloting a process for standardizing care management for patients determined to be at highest risk of hospitalizations and/or complications. **3 pts** The care team consistently provides care management for patients at highest risk of hospitalizations and/or complications and has a standardized approach to documenting the care management plans			+	+

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Practice as a community partner **1.4.4** Use community resources	11	**2 pts** Practice is referring patients to appropriate community resources but does not have a consistent approach for following up on referrals made. **3 pts** Practice has completed its resources inventory and consistently links patients with appropriate community resources and follow up on referrals made.			+	+
Coordinated care delivery **1.5.2** Establish medical neighborhood roles	12	**2 pts** Practice has identified and reached out to members of its medical neighborhood who are regularly involved in the care of the practice's patients and is now standardizing communication plans and formal agreements with these partners. **3 pts** Practice has identified and reached out to members of its medical neighborhood who are regularly involved in the care of the practice's patients and has a standardized process for sharing information with these partners as well as an agreement in place that defines each partner's role.	++		+	
Coordinated care delivery **1.5.1** Manage care transitions	13	**2 pts** Practice is implementing a plan to follow up with patients within a designated time interval after an emergency room visit or hospital discharge but is not yet consistently accomplishing this goal. **3 pts** Practice has implemented and refined its plan and is consistently following up with patients within a designated time interval after an emergency room visit or hospital discharge.	+/-		+	+
Coordinated care delivery **1.5.3** Coordinate care	14	**2 pts** Practice has developed the job descriptions and roles and responsibilities for care coordination but these have not been fully implemented. **3 pts** The practice vision for care coordination is fully documented and fully implemented.			+	

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Organized, evidence-based care **1.6.1** Consider the whole person	15	**2 pts** Practice is able to consistently provide access to behavioral health providers but information may not always be shared in a timely or consistent fashion and coordination with the primary care team is likewise inconsistent. **3 pts** Practice is able to consistently provide access to behavioral health providers either within the practice or using a formal relationship so that care is fully integrated or coordinated and respective provider roles are understood.			+	+
Organized, evidence-based care **1.6.4** Decrease care gaps	16	**2 pts** Practice produces or receives care gap reports for prevention and chronic conditions/ other diagnoses prevalent in the practice's patient population, but does not yet have a system in place to follow up on each report in order to reduce the gaps. **3 pts** Practice analyzes care gap reports for prevention and chronic conditions/other diagnoses prevalent in the practice's patient population and has a system in place to regularly act on the data, including outreach to individual patients needing intervention.				+
Enhanced Access **1.7.1** Provide 24/7 access	17	**3 pts** Practice has a clinician available from the practice or on contract who can speak to patients after hours while being able to access the patient's record.				
Engaged and committed leadership **2.1.2** Develop a roadmap: Ensure that there is the compelling vision, strategy, capacity, and capability for change.	18 (Phase 1 only)	**3 pts** Practice has developed and shared a vision and detailed plan that addresses goals of transformation with specific clinical outcomes and utilization aims along with the detail on how each of the aims will be addressed.			+	+
Quality improvement	19	**2 pts** The practice is beginning to incorporate regular improvement		+		+

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strategy supporting a culture of quality and safety **2.2.1** Use an organized QI approach		methodology to execute change ideas in the practice setting but the methodology has not yet been implemented in all areas of the practice. **3 pts** The practice fully incorporates regular improvement methodology to execute change ideas in the practice setting.				
Quality improvement strategy supporting a culture of quality and safety **2.2.2** Build QI capability **2.2.3** Empower staff	20	**2 pts** Practice is actively building QI capability within the practice through approaches such as including QI skills in orientation for all new staff and ensures that all staff participate in QI training. **3 pts** Practice has developed QI capability within the practice and empowers staff/providers to participate in QI activities, including QI within defined job duties, recognizing and rewarding innovation and improvement.		+		+
Transparent measurement and monitoring **2.3.1** Use data transparently	21	**3 pts** Practice regularly produces reports on how providers and/or care teams are performing and meeting quality goals, transparently shares them within the organization, and has an effective system for follow up.				+
Optimal Use of Health Information Technology (HIT) **2.4.1** Innovate for access	22	**3 pts** Practice offers multiple forms of alternative visit types (e.g. email, Skype, or tele-visits) or communication media (e.g. portal, texting) and has integrated these alternatives into regular practice.			+	
Strategic Use of Practice Revenue **3.1.1** Use sound business practices	23	**3 pts** Practice consistently uses sound business practices, managing budgets at both the practice and department level (if applicable); return on investment calculations are factored into decisions on new programs and these are factored into budget projections.			+	
Workforce vitality and joy in work **3.2.3** Cultivate joy	24	**1 pt** Practice has developed strategies to improve the experience of staff and create joy in work but implementation of these initiatives is limited.	+	+		

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		3 pts Practice has implemented strategies to support joy in work and can demonstrate the results through metrics such as staff survey results high retention rates, or low turnover.				
Capability to Analyze and Document Value **3.3.3** Develop financial acumen	25 (Phase 5 only)	**3 pts** Practice shares financial data in a transparent manner within the practice and has developed the business capabilities to use business practices and tools to analyze and document the value the organization brings to various types of alternative payment models.			+	
Capability to Analyze and Document Value **3.3.4** Document value	26	**2 pts** Practice is developing its internal capability to succeed in an alternative payment system and a date has been set for this migration has been set within the TCPI timeframe.				
Efficiency of Operation **3.4.1** Streamline work	27	**2 pts** Practice has worked to streamline a number of its work flows by reviewing the steps and eliminating waste and rework, but the concept of value is not consistently considered during these efforts. **3 pts** Practice uses an organized approach (e.g. lean process mapping) to review its processes, eliminating or reducing waste in the process and understanding the value of each process step to the patient and other customers.				+

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Note from Carol: *I can help at basic level with many but did not check those, others likely better at, especially for primary care or that CHITA role*