Primary Care PAT

Practice Name

Assessment Date

NPI

TIN

Practice Location Zipcode + 4

Number of Clinicians within the Practice

Practice Type (circle one)

Internal Family Geriatric Pediatric Other

Practice Setting (circle one)

Rural Urban

Practice Supports Rural Communities (circle one): Yes No

Patient Demographics

Enter the total number of patients for each demographic.

Hispanic or Latino

American Indian or Alaskan Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

Other

Coverage Type

Enter the percentage of patients who speak English as a primary language.

Medicare (%)

Medicaid (%)

Dual Eligible (%)

Person and Family Engagement Performance Metrics Questions

PFE is a strategic and essential aspect of practice transformation. This survey measures six key areas of PFE within the practice.

Active e-Tool

Does the practice use an e-tool (patient portal or other E-Connectivity technology) that is accessible to both patients and clinicians and that shares information such as test results, medication list, vitals and other information and patient record data?

- [ ] Yes, this practice has broadly implemented the practices described
- [ ] No
- [ ] No, but plan to implement in 6 months
- [ ] No, this practice is unable to access the Internet

Shared Decision-Making

Does the practice support shared decision-making by training and ensuring that clinical teams integrate patient-identified goals, preferences, concerns and desired outcomes into the treatment plan (e.g. those based on the individual's culture, language, spiritual, social determinants, etc.)?

- [ ] Yes, this practice has broadly implemented the practices described
- [ ] No
- [ ] No, but plan to implement in 6 months
- [ ] N/A, practitioners never manage patient care over time or never provides care recommendations directly to the patient

Patient Activation

Patient activation refers to a "patient's knowledge, skills, ability, and willingness to manage his or her own health and care."[1] Tools to measure patient activation can include the Patient Activation Measure (PAM)*, but it can also include other tools that measure a patients' willingness and capacity to take on the role of managing their own health and health care. TCPI is striving to achieve patient activation through a broader perspective of care management that is aligned with the change package. Does the practice utilize a tool to assess and measure patient activation?

- [ ] Yes, this practice has broadly implemented the practices described
- [ ] No
- [ ] No, but plan to implement in 6 months
- [ ] N/A, practitioners never manage patient care over time or never provides care recommendations directly to the patient

Health Literacy Survey

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Is a health literacy patient survey being used by the practice (e.g., CAHPS Health Literacy Item Set)?

- [ ] Yes, this practice has broadly implemented the practices described
- [ ] No
- [ ] No, but plan to implement in 6 months
- [ ] N/A, practitioners never manage patient care over time or never provides care recommendations directly to the patient

Medication Management

Medication management involves patient-centered care to optimize safe, effective and appropriate drug therapy. Care is provided through collaboration with patients and their health care teams. Does the clinical team work with the patient and family to support their patient/caregiver management of medications?

- [ ] Yes, this practice has broadly implemented the practices described
- [ ] No
- [ ] No, but plan to implement in 6 months
- [ ] N/A, practitioners never manage patient care over time or never provides care recommendations directly to the patient, or never prescribes medication

Support for Patient and Family Voices

To accelerate practice transformation, inviting patients and families to serve as valued advisors and improvement partners is essential. The TCPI Change Package identifies development of a PFAC as a best practice that infuses their voices in the policies, procedures, and governance of the practice. Another approach is to use patients and families on committees, quality improvement teams, and other groups. Some organizations use both approaches. Either approach constitutes a YES response to this question. Are there policies, procedures and actions taken to support patient and family participation in governance or operational decision-making in the practice (Person and Family Advisory Councils, Practice Improvement Teams, Board Representatives, etc.)?

☐	Yes, this practice has broadly implemented the practices described
☐	No
☐	No, but plan to implement in 6 months

Milestone 1

Description: Practice has met its targets and has sustained improvements in practice-identified metrics for at least one year.

0	Practice has identified the metrics it will track that are related to TCPI aims and has collected baseline information on these metrics.
1	Practice is monitoring the metrics related to TCPI aims but is not yet showing improvement in all metrics.
2	Practice has shown improvement in metrics related to TCPI aims but has not reached its targets or improvement is not yet sustained.
3	Practice has met at least 75% of its targets and sustained improvements in practice-identified metrics for at least one year.

Milestone 2

Description: Practice has reduced unnecessary tests, as defined by the practice.

0	Practice has not reduced unnecessary tests or does not have baseline data on this measure.
1	Practice has identified the tests it will focus on for reduction and the corresponding metrics it will monitor and manage.
2	Practice has established a baseline, is regularly monitoring its identified metrics, but improvement has not yet been demonstrated.
3	Practice has demonstrated improvement in reducing unnecessary tests.

Milestone 3

Description: Practice has reduced unnecessary hospitalizations.

0	Practice has not reduced unnecessary hospitalizations or does not have baseline data on this measure.
1	Practice has established a baseline but does not yet have a process to reduce unnecessary hospitalizations.
2	Practice has established a baseline and is piloting a process to reduce unnecessary hospitalizations.
3	Practice has implemented and documented a tested process and has demonstrated a reduction in unnecessary hospitalizations from its baseline.

Milestone 4

Description: Practice can demonstrate that it encourages patients and families to collaborate in goal setting, decision making, and self-management.

0	Practice does not regularly utilize shared decision making or other tools to encourage patient and family involvement in goal setting or decision making.
1	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.
2	Practice has developed approaches to encourage and document patient and family involvement in goal setting, decision making and self-management, but the process is not yet routine.
3	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.).

Milestone 5

Description: Practice has a formal approach to obtaining patient and family feedback and incorporating this into the QI system, as well as the strategic and operational decisions made by the practice.

0	Practice does not have a formal system for obtaining patient feedback.
1	Practice has a limited system for obtaining patient and family feedback and does not have a system for acting on the information received.
2	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.
3	Practice has a formal system for obtaining patient and family feedback and can document operational or strategic decisions made in response to this feedback.

Milestone 6

Description: Practice sets clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes, and accountability.

0	The practice has not established clear roles for each member of the care team or set clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes, and accountability.
1	The practice has identified the work required before, during, and after patient visits and identifies the skills and credentials needed to perform that work.
2	The practice has matched the work that must be done with the team member who will do the work.
3	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.

Milestone 7

Description: Practice has a process in place to measure and promote continuity between a patient and his/her care team so that patients and care teams recognize each other as partners in care.

0	Practice does not have a process in place to measure continuity.
1	Practice is starting to measure continuity but does not have systems in place to promote it.
2	Practice has introduced processes and systems for promoting continuity (e.g. scheduler scripts, patient cards with team member names and photos) but patients sometimes see providers other than their panel provider.
3	Practice has implemented processes to promote continuity and has the metrics to demonstrate that the processes are effective.

Milestone 8

Description: Practice uses a consistent approach to assign patients to a provider panel and confirms assignments with providers and patients. Practice reviews and updates panel assignments on a regular basis.

0	Practice does not consistently assign patients to a provider panel or has no way to track the assignments in the PM or EHR systems.
1	Practice has an approach to assign patients to a provider panel but not all patients have been assigned and their assignment confirmed.
2	Practice has assigned patients to a provider panel according to its defined method and confirms the assignments as patients are scheduled and seen. Practice is not reviewing and updating panel assignments on a regular basis.
3	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.

Milestone 9

Description: Practice has a reliable process in place for identifying risk level of each patient and providing care appropriate to the level of risk. This risk includes developing a health condition not already present, exacerbation of a condition or complications, need for a higher intensity of care, including hospitalization.

0	Practice does not have a defined process for identifying patient risk level.
1	Practice has a process for identifying high risk patients but the identification process for other risk levels is inconsistent or not yet standardized.
2	Practice has introduced a standard process for identifying patient risk level and is developing corresponding descriptions of the type of care required at each level.
3	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.

Milestone 10

Description: The practice provides care management for patients at highest risk of hospitalizations and/or complications and has a standard approach to documentation.

0	Practice has not identified an approach for identifying and providing care management for patients at highest risk of hospitalizations and/or complications.
1	Practice identifies high risk patients but is not consistently able to provide care management to those at highest risk.
2	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	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.

Milestone 11

Description: Practice facilitates referrals to appropriate community resources, including community organizations and agencies as well as direct care providers.

0	Practice does not regularly refer patients to available community resources.
1	Practice is compiling an inventory of resources and establishing communication with them to link patients with appropriate community resources.
2	Practice is referring patients to appropriate community resources but does not have a consistent approach for following up on referrals made.
3	Practice has completed its resources inventory and consistently links patients with appropriate community resources and follows up on referrals made.

Milestone 12

Description: Practice has defined its medical neighborhood and has formal agreements in place with these partners to define roles and expectations.

0	Practice has not identified its medical neighborhood.
1	Practice has identified its medical neighborhood to include specialists, hospitals, nursing homes and other organizations with which the practice or its patients interact on a regular basis (i.e. monthly), but has not clearly defined expectations for each other's roles nor what and how information is to be shared.
2	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	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.

Milestone 13

Description: Practice follows up via phone, visit, or electronic means with patients within a designated time interval (24 hours/ 48 hours/ 72 hours/ 7 days) after an emergency room visit or hospital discharge.

0	Practice does not regularly receive information from hospitals about discharges and is not regularly following up with patients after an emergency room visit or hospital discharge.
1	Practice is working on establishing a system for regularly receiving information from hospitals about discharges and ED visits so that follow up can consistently occur.
2	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	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.

Milestone 14

Description: Practice clearly defines care coordination roles and responsibilities and these have been fully implemented within the practice.

0	Practice has not developed its approach to providing care coordination for its patient population.
1	Practice has a plan for care coordination, but it has yet to be formally documented in writing or translated to specific roles and responsibilities within the practice.
2	Practice has developed the job descriptions and roles and responsibilities for care coordination but these have not been fully implemented.
3	The practice vision for care coordination is fully documented and fully implemented.

Milestone 15

Description: Practice ensures that care addresses the whole person, including mental and physical health.

0	Practice does not have a consistent system for assessing and addressing behavioral health needs.
1	Practice identifies patients requiring behavioral health treatment or follow up and refers patients to providers outside the practice. Access is not always assured and no formal relationship is in place.
2	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	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.

Milestone 16

Description: Practice uses population reports or registries to identify care gaps and acts to reduce them.

0	Practice does not collect data on care gaps for its population of patients.
1	Practice produces or receives care gap reports but these reports are limited to specific payer or diagnostic groups and do not cover the entire population of patients.
2	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	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.

Milestone 17

Description: Practice has a system in place for patients to speak with their care team 24/7.

0	After hours, practice has an answering system with a recorded message. Message may tell patients to go to an ER or leave a message for a call back in the morning.
1	Practice uses a live answering service that takes messages from patients. Clinicians and care team members may call in for messages but timeframes are not standard. The service does not use any triage algorithms.
2	Practice uses a contract clinician or a nurse triage service that provides algorithm-driven advice to patients who call after hours but the service or clinician does not have any access to the patient's records.
3	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.

Milestone 18

Description: Practice has developed a vision and plan for transformation that includes specific clinical outcomes and utilization aims that are aligned with national TCPI aims and that are shared broadly within the practice.

0	Practice has not yet begun developing its transformation vision and detailed plan.
1	Practice is beginning to develop a vision and plan that addresses goals of transformation but aims are not yet set.
2	Practice has developed a plan that addresses goals of transformation with specific aims but has not yet detailed how the aims will be addressed.
3	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.

Milestone 19

Description: Practice uses an organized approach (e.g. use of PDSAs, Model for Improvement, Lean, FMEA, Six Sigma) to identify and act on improvement opportunities.

0	The practice does not incorporate standard improvement methodology to execute change ideas in the practice setting.
1	The practice has decided on a standard QI methodology and is planning the implementation process.
2	The practice is beginning to incorporate regular improvement methodology to execute change ideas in the practice setting but the methodology has not yet been implemented in all areas of the practice.

3	The practice fully incorporates regular improvement methodology to execute change ideas in the practice setting.

Milestone 20

Description: Practice builds QI capability in the practice and empowers staff to innovate and improve.

0	Practice recognizes the need for QI capacity and has developed or identified training programs for staff in QI skills and tools.
1	A limited number of practice staff/providers have QI skills and are involved in the practice's QI initiatives.
2	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	Practice has developed QI capability within the practice and empowers staff/ providers to participate in QI activities by allocating time for QI activities, including QI within defined job duties, recognizing and rewarding innovation and improvement.

Milestone 21

Description: Practice regularly produces and shares reports on performance at both the organization and provider/care team level, including progress over time and how performance compares to goals. Practice has a system in place to assure follow up action where appropriate.

0	Practice does not produce reports on how providers and/or care teams are meeting quality goals.
1	Practice produces some reports on organizational or provider/ care team performance and how they are meeting quality goals but the reports are not shared in a fully transparent manner.
2	Practice is regularly producing reports on how providers and/or care teams are performing and meeting quality goals but distribution of the reports is limited or there is inconsistent follow up on the reports.
3	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.

Milestone 22

Description: Practice uses technology to offer scheduling and communication options that improve patient access by including alternative visit types and electronic communication approaches.

0	Practice relies on face to face encounters and phone interactions with patients.
1	Practice is considering the use of technology to offer alternatives to face to face visits but has not yet formalized this practice nor communicated the options to patients.
2	Practice has the capability of providing alternative visit types or communication media but these are in limited use.
3	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.

Milestone 23

Description: Practice uses sound business practices, including budget management and return on investment calculations.

0	Practice operates on a cash basis, balancing revenue and expense regularly, but is not prospectively developing budgets and routinely using budget variance calculations and ROI calculations for new investments.
1	Practice has an annual operating budget at the practice level but does not regularly perform variance analysis or make required adjustments.
2	Practice reviews its budget against actual performance regularly. Variances are explained and adjustments made as needed. However, decisions on new or expanded programs/ services are not systematically reviewed to determine expected ROI and how this impacts the budget.
3	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.

Milestone 24

Description: Practice has effective strategies in place to cultivate joy in work and can document results.

0	Practice has no proactive strategies aimed at creating joy in work.
1	Practice has developed strategies to improve the experience of staff and create joy in work but implementation of these initiatives is limited.

2	Practice has strategies in place to promote joy in work (e.g. reward and recognition programs, staff development, social activities) but has no mechanism for determining whether the programs initiated are successful.
3	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 rates.

Milestone 25

Description: 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.

0	Practice, or the larger system to which it may belong, has not developed business acumen in the various types of alternative payment models. Financial skills development is limited to finance staff.
1	Practice has identified resources for educating staff at all levels in principles of business management, commensurate with their roles in contracting and analysis of alternative payment arrangements that a practice might consider.
2	Practice is providing education and practice data on business metrics to staff at all levels across the organization. Specialized training is being provided to those at the practice level that may be involved in analysis of alternative payment arrangements and in contracting for services.
3	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.

Milestone 26

Description: Practice considers itself ready for migrating into an alternative based payment arrangement.

0	Practice not yet considering alternative payment approaches.
1	Practice is participating in performance-based incentive programs but is not yet ready for alternative payment approaches.
2	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.
3	Practice is confident of its readiness for migrating into alternative payment approaches.

Milestone 27

Description: Practice uses a formal approach to understanding its work processes, eliminating waste in the processes, and increasing the value of all processing steps.

0	Practice has not started working on systematically streamlining its processes.
1	Practice has identified processes that it intends to study and streamline but the improvement work has not yet begun.
2	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	Practice uses an organized approach (e.g. lean, process mapping) to reviewing its processes, eliminating or reducing waste in the process, and understanding the value of each process step to the patient and other customers.