|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Site**(name and location): | | | | | | | | | | | | | | |
| Name and Address | | | | | | | | | | | | | | |
| **Month/Year**: |  | **Start Date**: | | |  | **NCQA**(level, year and expiration): | | |  | **Dev. Contract Stage**: | | | | |
|  |  | 2017\_July | | |  |  | | |  | Measurement Period 1 | | | | |
| **Meeting date(s)**: | | | | | | | | | | |  | **Total Practice Hours**: | | |
|  | | | | | | | | | | |  |  | | |
| **Reviewed by**: | | |  | **Date Reviewed**: | | |  | **Submitted by**: | | | | |  | **Date submitted**: |
|  | | |  |  | | |  |  | | | | |  |  |

**Quality Based Reporting Up To Date**: Y

**Clinical Quality Measures** (PY 1: Meets 3 / 5; PY 2: Meets 3 / 5; Additional $0.25 for meeting 5 out of 5):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Goal**: | 3/5 |  | **Achieved**: | /5 |  |

**New Quality Measures**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | BMI | DM A1C Good Control (<8) | Hypertension BP Control (<140/90) | Screening for Clinical Depression and Follow Up Plan | Tobacco Cessation |
| Q2 2017 |  |  |  |  |  |

**CAHPS** (PY 1: Goal is to meet the threshold for access and meet office staff or communication, or show 2.5%

improvement in access and meet threshold for office staff and communication; PY2: Meet the threshold for

access and meet 3 composite measures or show 2.5% improvement in access and meet threshold for 4 composite measures):

**New CAHPS Measures**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Access | Communication | Office Staff |
| 2017 Goal |  |  |  |
| 2017 |  |  |  |

**NCM Activity**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | NCM Activity with High Risk Patients | | | | |
|  | Blue Cross | NHPRI | Tufts | United | Practice Site |
| Q2 2017 |  |  |  |  |  |

**Utilization** (Meet 5% improvement compared to comparison group): **Indicate practice action plan if practice specific results are worse than the comparison group: need to check the CTC website.**

|  |  |  |
| --- | --- | --- |
|  | All Cause Inpatient admissions | All cause ED |
| Trend compared to comparison group | 15.3 | 14.25 |
| Practice action plan if above comparison group |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Goals | Change areas (CTC deliverables are highlighted) | Current Status (Y/N for bolded areas) | Next Steps (Who, What, When) |
| 1. | **Improve patient centered interactions** | * **Attest to compliance with outpatient transitions best practices - Y** * Promote self-management * Provide interpreter services * Assess customer service * **Meets office staff CAHPS – N** * **Meets provider CAHPS – N** * Assess physical environment * Monitor front desk interactions |  |  |
| 2. | **Coordinate patient care** | * **All compacts with specialists submitted – Y** * Assist patients with referrals * Track referrals * Address transitions of care * **Create high risk registry – Y** * **ED lower than comparison –N** * **IP lower than comparison – N** |  |  |
| 3. | **Enhance team based care and functioning** | * Hire, train and retain NCM * Submit NCM reports to CTC and health plans * **Meets NCM engagement – Y/N** * Create huddle processes * Establish regular communication between staff members * Clearly define staff roles | . |  |
| 4. | **Improve patient access** | * **Maintain an after-hours policy – Y** * Assess phone access * Maintain evening and weekend hours * Assess appointment wait times * **Meets access CAHPS – N** * Track no-show rates |  |  |
| 5. | **Engage leadership** | * Submit budget for approval to CTC and share information with practice staff * Develop transformation plan and QI program * Regularly engage in quality improvement activities * Solicit and respond to patient/family feedback * Provide orientation for new hires and professional development for all staff |  |  |
| 6. | **Implement evidence based practices** | * Review best practices * Develop point of care reminders |  |  |
| 7. | **Improve clinical quality outcomes** | * Prepare and submit clinical quality measures. * **Quality measures exceed threshold – Y** * Assess and adapt process and outcome measures * Conduct rapid PDSA cycles as appropriate * Embed QI strategies in practice operations (include in job descriptions and monthly meeting agendas, form QI team) |  |  |
| 8. | **Address empanelment** | * Ensure each patient is assigned to PCP * Have patients see PCP for sick and well visits * Evaluate and adjust panels as needed |  |  |
|  | **OHIC PCMH Requirements Submitted** |  |  |  |
|  | **NCQA related goals** |  |  |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |

**Best Practices:**

**MacColl Survey**: Y **Culture Survey**: Y **Gap analysis provided to practice**: Y

**Goals Met:**

|  |  |  |
| --- | --- | --- |
| **Coordinate patient care** |  |  |
| **Enhance team based care and functioning** |  |  |
| **Improve patient centered interactions** |  |  |
| **Improve clinical quality outcomes** |  |  |
| **Empanelment** |  |  |
| **Access** |  |  |

**CurrentCare**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Enrollment thru | Enrollment thru | At least 1 Provider has reached MU thru Medicare or Medicaid EHR Incentive Program | Live on CurrentCare Viewer | Live on CurrentCare Hospital Alerts | Direct Account Established | Ability to Produce Stable CTC Practice Reports |
|  |  |  |  |  |  |  |