

Understanding the Practice Assessment Tool (PAT)

Practice Assessment Introduction

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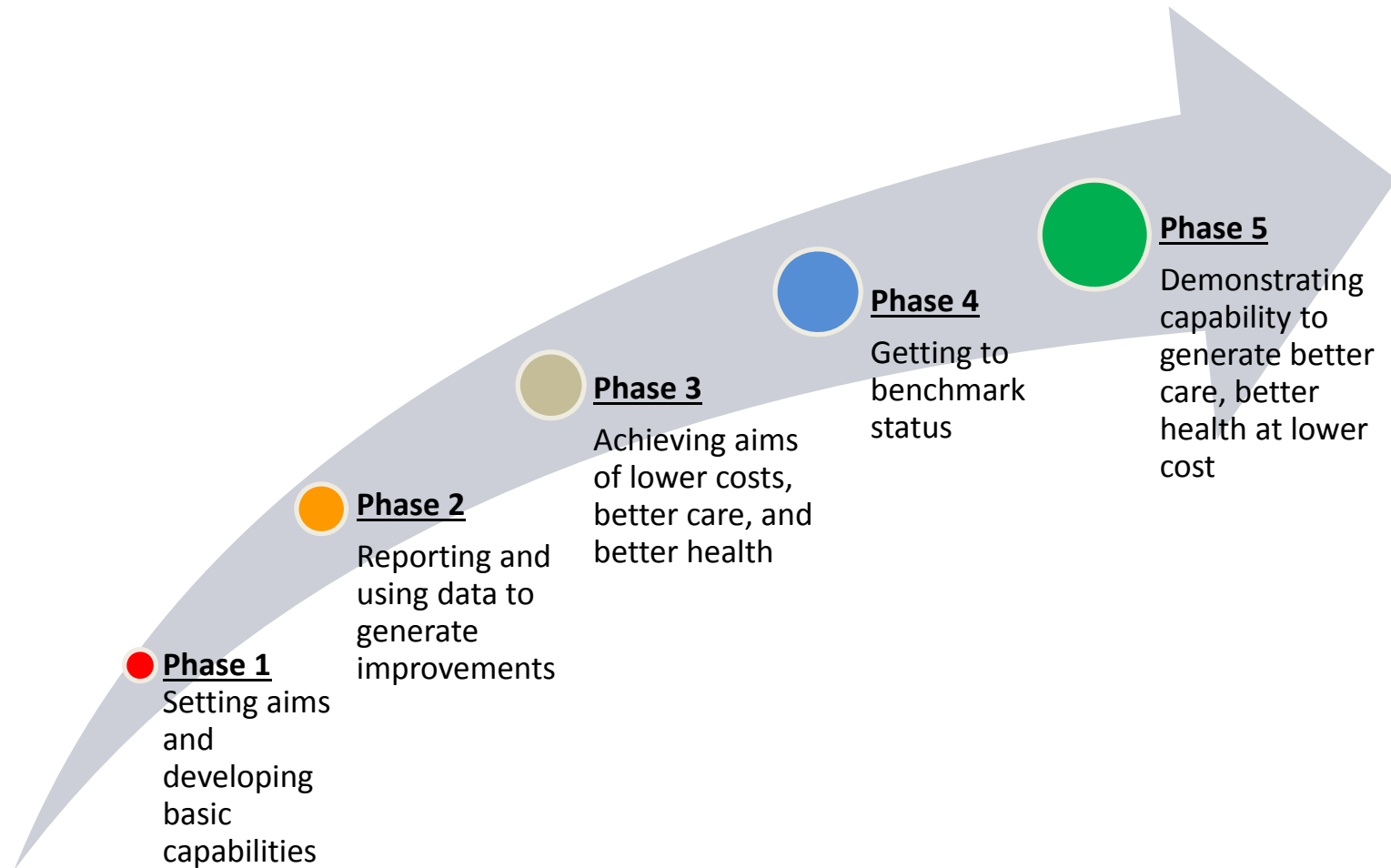
Quality Insights and WVMi

- Non-profit company focused on measuring and improving healthcare quality
- Quality Innovation Network - Quality Improvement Organization (QIN-QIO) for West Virginia, Delaware, Pennsylvania, Louisiana and New Jersey
- Other healthcare-related contracts include Regional Extension Centers Services, VA External Peer Review Programs, Renal Networks, Medicare Measures Instrument Development and Support and the National Home Health Quality Improvement Campaign
- Current physician practice-based projects focus on cardiac health, diabetes, health information technology, quality measures, care coordination, practice transformation and immunizations
- Upcoming projects include preparing practices for MACRA and MIPS

The PAT and the QIN-QIO

- QIN-QIO TCPI responsibilities:
 - Conduct baseline and follow-up assessments of the participating practices within the contract service area
 - Partner with the PTNs to ensure participating clinician practices complete the assessments
 - Collect, analyze, submit and share data obtained through these assessments with PTNs, support contractors, clinicians and CMS to drive achievement of TCPI aims and goals
 - Engage practices and clinicians in advancement of the TCPI goals
 - Support the participation of practices that are rural, small or reaching medically underserved populations
 - Provide technical assistance as it relates to the practice assessment tool

Five Phases of Transformation



Drivers: Essential Factors to Achieve the Aims

TCPI AIMS/Goals

1. Practice Transformation:

Evidence of a culture of quality where the vision is clear and data is used to drive continuous improvement in quality, outcomes, cost of care and patient, family and staff experience.

2. Effective Solutions Moving to

Scale: Evidence of practice spreading effective improvement strategies to full scale for the entire population under its care.

Primary Drivers

**Patient and
Family-
Centered
Care Design**

Secondary Drivers

- 1.1 Patient & family engagement
- 1.2 Team-based relationships
- 1.3 Population management
- 1.4 Practice as a community partner
- 1.5 Coordinated care delivery
- 1.6 Organized, evidence-based care
- 1.7 Enhanced access



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Drivers: Essential Factors to Achieve the Aims, continued

TCPI AIMS/Goals

3. High Clinical Effectiveness:

Practice is effective in bringing all patient segments their health status goals.

4. Reduced Avoidable Hospital Use:

Rates of readmission and unnecessary admissions for practice's patients have been reduced.

5. Reduced Unnecessary Testing & Procedures:

Practice demonstrates a reduction in unnecessary testing and in the use of the ED by its patient population.

Primary Drivers

Continuous,
Data-Driven
Quality
Improvement

Secondary Drivers

- 2.1 Engaged and committed leadership
- 2.2 Quality improvement strategy supporting a culture of quality and safety
- 2.3 Transparent measurement and monitoring
- 2.4 Optimal use of HIT



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Drivers: Essential Factors to Achieve the Aims, continued

TCPI AIMS/Goals

6. *Reduced Costs*: Practice controls its internal costs as well as other elements of total cost of care.

7. *Documented Value*: Practice can articulate its value proposition and increases participation in available value-based payment agreements.

Primary Drivers

**Sustainable
Business
Operations**

Secondary Drivers

- 3.1 Strategic use of practice revenue
- 3.2 Staff vitality and joy in work
- 3.3 Capability to analyze and document value
- 3.4 Efficiency of operation



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Practice Assessment Tool: Starting Point and Milestones



- Used to identify where a practice is in the transformation journey
- Describes milestones that a practice needs to achieve for operational transformation to occur
- Based on attributes reflected in drivers and change concepts
- Milestones scored refer to related change concepts

Understanding the PAT



- Baseline assessment completed initially to see where the practice is
 - Serves as a snapshot in time to show practice strengths, opportunities to grow as well as resources that will be needed
- Follow-up assessments are conducted every six months to see how the practice is progressing through the five transformation phases



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The Demographics Tab

Practice Information									Practice Supports Rural Communities (setting type, telemedicine, other methods (Select Y or N from Dropdown list))
Date	Practice Name	TIN	NPI	Primary Care Practice Type (Select from Dropdown list)	Practice Location Zip Code+4	Number of Clinicians within Practice	Practice Setting (Select from Dropdown list)	Baseline or Follow-up (Select from Dropdown list)	

Patient Demographics											
Total Patients	Hispanic or Latino	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	Other	Primary Language is English (%)	Medicare (%)	Medicaid (%)	Dual Eligible (%)



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Two Types of PATs

Primary Care PAT

- 27 milestones
- Practice types:
 - Internal
 - Family
 - Geriatric
 - Pediatric
 - Other

Specialty PAT

- 22 milestones
- Practice types:

– Allergy/Immunology	– Neonatology
– Anesthesia	– Neurology
– Cardiology	– Orthopedic
– Dermatology	– Pathology
– Emergency	– Podiatry
– Endocrinology	– Pulmonology
– Gastroenterology	– Psychiatry
– Gynecology	– Radiology
– Hematology	– Rheumatology
– Infectious Disease	– Other



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The PAT 2.0 for Primary Care

PRIMARY CARE 2.0

Practice Name:

0

	Change Concept Ref	Milestone	0	1	2	3	Score
Results related to Aims Only #2 has a direct change concept reference.							
1	None	Practice has met its targets and has sustained improvements in practice-identified metrics for at least one year.	Practice has identified the metrics it will track that are related to TCPI aims and has collected baseline information on these metrics.	Practice is monitoring the metrics related to TCPI aims but is not yet showing improvement in all metrics.	Practice has shown improvement in metrics related to TCPI aims but has not reached its targets or improvement is not yet sustained.	Practice has met at least 75% of its targets and sustained improvements in practice-identified metrics for at least one year.	
2	1.6.5	Practice has reduced unnecessary tests, as defined by the practice.	Practice has not reduced unnecessary tests or does not have baseline data on this measure.	Practice has identified the tests it will focus on for reduction and the corresponding metrics it will monitor and manage.	Practice has established a baseline, is regularly monitoring its identified metrics, but improvement has not yet been demonstrated.	Practice has demonstrated improvement in reducing unnecessary tests.	
3	None	Practice has reduced unnecessary hospitalizations.	Practice has not reduced unnecessary hospitalizations or does not have baseline data on this measure.	Practice has established a baseline but does not yet have a process to reduce unnecessary hospitalizations.	Practice has established a baseline and is piloting a process to reduce unnecessary hospitalizations.	Practice has implemented and documented a tested process and has demonstrated a reduction in unnecessary hospitalizations from its baseline.	

The PAT 2.0 for Primary Care, continued

	Change Concept Ref	Milestone	0	1	2	3	Score
Driver 1.1 Patient and Family Engagement							
4	1.1.3	Practice can demonstrate that it encourages patients and families to collaborate in goal setting, decision making, and self-management.	Practice does not regularly utilize shared decision making or other tools to encourage patient and family involvement in goal setting or decision making.	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.	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.	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.).	
5	1.1.2	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.	Practice does not have a formal system for obtaining patient feedback.	Practice has a limited system for obtaining patient and family feedback and does not have a system for acting on the information received.	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.	Practice has a formal system for obtaining patient and family feedback and can document operational or strategic decisions made in response to this feedback.	
Driver 1.2 Team-based Relationships							
6	1.2.2	Practice sets clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes, and accountability.	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.	The practice has identified the work required before, during, and after patient visits and identifies the skills and credentials needed to perform that work.	The practice has matched the work that must be done with the team member who will do the work.	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.	

PAT 2.0 for Specialty Care

	Change Concept Ref	Milestone	0	1	2	3	Score
9	1.5.2	Practice works with the primary care practices in its medical neighborhood to develop criteria for referrals for episodic care, co-management, and transfer of care/ return to primary care, processes for care transition, including communication with patients and family.	Practice has developed its own criteria for appropriate referrals but has not discussed these with the primary care providers in the medical neighborhood.	Practice has started to reach out to primary care providers in the medical neighborhood to discuss referral criteria and how transitions should take place.	Practice has collaborated with the primary care practices in its medical neighborhood and has jointly developed criteria for referrals for episodic care, co-management, and transfer of care but processes have not yet been implemented.	Practice has collaborated with the primary care practices in its medical neighborhood and has jointly developed and implemented criteria for referrals for episodic care, co-management, and transfer of care/ return to primary care, processes for care transition, including communication with patients and family.	
10		Practice identifies the primary care provider or care team of each patient seen and (where there is a primary care provider) communicates to the team about each visit/ encounter.	Practice does not ask about primary care provider.	Practice queries patients about their primary care provider and records this information in the medical record.	Practice identifies the primary care provider of each patient but the communication with the primary care team is not consistent.	Practice has a reliable system in place to identify the primary care provider of each patient and to communicate with the primary care team about each visit or encounter.	
11	1.6.3	Practice uses evidence -based protocols or care maps where appropriate to improve patient care and safety.	Practice is not using protocols or care maps.	Practice has identified groups of patients or conditions for which care maps or protocols are appropriate but these have not yet been developed.	Practice has developed or identified evidence -based protocols or care maps to use but these have not yet been implemented consistently within the practice.	Practice consistently uses evidence -based protocols or care maps where appropriate to improve patient care and safety.	

Scoring Worksheet

Transforming Clinical Practice Initiative
PAT 2 - Scoring Worksheet - PRIMARY CARE
Date: 8/30/2016

Name: 1 Physician Practice
TIN: 123456789
Type: Family

Milestone #	Milestone score: 0= Not Yet; 1=Getting Started; 2=Implementing, Partially Operating; 3=Functioning, Performing	0	1	2	3	Score	Driver Status
AIMS							
1	Practice has met its targets and has sustained improvements in practice-identified metrics for at least one year.					0	
2	Practice has reduced unnecessary tests, as defined by the practice.					1	
3	Practice has reduced unnecessary hospitalizations.					1	
PFE							
4	Practice can demonstrate that it encourages patients and families to collaborate in goal setting, decision making, and self-management.					1	
5	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.					3	
TEAM BASED RELATIONSHIP							
6	Practice sets clear expectations for each team member’s functions and responsibilities to optimize efficiency, outcomes, and accountability.					0	
7	Practice has a process in place to measure and promote continuity so that patients and care teams recognize each other as partners in care.					1	
POPULATION MANAGEMENT							
8	Practice uses a data-driven 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.					1	
9	Practice has a reliable process in place for identifying risk level of each patient and providing care appropriate to the level of risk.					2	
10	The practice provides care management for patients at highest risk of hospitalizations and/or complications and has a standard approach to documentation.					0	

Scoring Worksheet, continued

SUMMARY		#	Ct	Pct
Counts of Concepts Complete (Counting the Colors)				
Phase 1 =		1	0	0%
Phase 2 =		12	5	42%
Phase 3 =		13	1	8%
Phase 4 =		16	1	6%
Phase 5 =		2	0	0%
TOTAL		44	7	16%

Adding Up the Score (Counting the Points 0 - 3)		#	Sum	Poss	Pct
Phase 1 =		1	0	3	0%
Phase 2 =		12	7	22	32%
Phase 3 =		13	2	32	6%
Phase 4 =		16	3	48	6%
Phase 5 =		2	0	6	0%
TOTAL		44	12	111	11%

Total Number of Secondary Drivers/AIMs Complete	0
Total Number of Secondary Drivers/AIMs	16
% of Secondary Drivers/AIMs Complete	0%

Colors Correlate to Phases



Red = Phase 1



Orange = Phase 2



Tan = Phase 3



Blue = Phase 4



Green = Phase 5



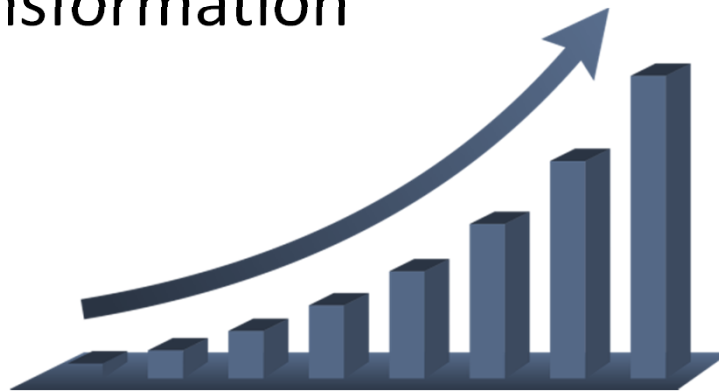
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What Happens Next?

- Encrypted PAT sent to the PTN
- Quality Insights submits the PAT to QualityNet
- The results will be used by the PTN and the practice to drive process improvement to complete the five stages of transformation



Thank You

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