



2013 Core Expectations: Minimum Requirements

Practices must meet all 18 "Must Pass" elements, and must have made at least some progress on remaining 2 elements

* = Must Pass elements

Definitions		
1. Demonstrated Leadership		
<i>Moderate progress</i>	<i>Fully Implemented</i>	<i>2013 Expectation</i>
a. The practice has identified at least one primary care physician or nurse practitioner as a leader within the practice. Leadership has made a commitment to improve care and implement the PCMH model known to some in the organization.	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.	Fully Implemented* (Must Pass)
b. Some of the primary care leaders take an active role in working with other providers and staff in the practice to build a team-based approach to care. Individual providers, and occasional teams of providers, examine processes and structures to improve care, and review data on the performance of the practices.	All of the primary care leaders take an active role in working with other providers and staff in the practice to build a team-based approach to care, continually examine processes and structures to improve care, and review data on the performance of the practice.	Fully Implemented* (Must Pass)
c. The primary care leader periodically participates as a member of the Leadership Team and participates in 50-75% of the PCMH Learning Collaboratives.	The primary care leader participates as a member of the practice Leadership Team and participates in all aspects of the PCMH Learning Collaborative	Fully Implemented* (Must Pass)
2. Team Based Approach to Care		
<i>Moderate progress</i>	<i>Fully Implemented</i>	<i>2013 Expectation</i>
a. Practice has conducted education on the team-based approach to care and has staff buy-in to the concept of a team-based approach to care delivery and of expanding the roles of the non-physician providers to improve clinical workflows, but has not yet fully implemented team approach.	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 clinical workflows.	Fully Implemented* (Must Pass)
b. Practice has fundamental structures in place to meet this expectation and has done training but has not yet fully implemented. Leadership's vision is known to all within the organization and a few providers are involved in testing some of the work in this area.	The practice has committed to redesigning primary care practice in a way that utilizes non-physician staff to improve access and efficiency of the practice team in specific ways, such as through greater use of planned visits, integrating care management into clinical practice, delegating some types of patient testing or exams (e.g., ordering of routine screening tests, diabetic foot exams) to non-physicians; expanding patient education; and providing greater data support to physicians to enhance the quality and cost-effectiveness of their clinical work.	Fully Implemented* (Must Pass)
c. Some members of the practice team are bought into providing care as a team and specific roles and responsibilities have been assessed and developed for the team members.	Members of the practice team identify themselves as part of the practice team, and can identify their specific role and responsibilities within the team.	Fully Implemented* (Must Pass)

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3. Enhanced Access		
<i>Moderate progress</i>	<i>Fully Implemented</i>	2013 Expectation
a. Leadership's vision for preserving access to their patient populations is known by most in the organization.	The practice commits to preserving access to their population of patients.	Fully Implemented* <i>(Must Pass)</i>
b. Practice has incorporated open access scheduling for same day appointments and is exploring telephonic support or secure messaging as a means for patients to communicate.	The practice has a system in place that ensures patients have same-day access to their healthcare provider using some form of care that meets their needs – e.g. open-access scheduling for same-day appointments, telephonic support, and/or secure messaging.	Fully Implemented* <i>(Must Pass)</i>
Time to 3rd next available appointment (TTT) is consistently tracked and measured at zero.	Time to 3rd next available appointment (TTT) is consistently tracked and measured at zero.	Fully Implemented
3. Population risk stratification and management		
<i>Moderate progress</i>	<i>Fully Implemented</i>	2013 Expectation
The practice has a process in place for proactively identifying and stratifying patients across their population who are at risk for adverse outcomes and are starting to identify direct resources or care processes to help reduce those risks.	The practice has adopted a process for proactively identifying and stratifying patients across their population who are at risk for adverse outcomes, and direct resources or care processes to help reduce those risks.	Fully Implemented* <i>(Must Pass)</i>
5. Practice Integrated Care Management		
<i>Moderate progress</i>	<i>Fully Implemented</i>	2013 Expectation
a. Roles and responsibilities for care managers have been identified and care management staff identified to be part of the practice team.	Care management staff have clear roles and responsibilities, are integrated into the practice team, and receive explicit training to provide care management services.	Fully Implemented* <i>(Must Pass)</i>
b. The practice has identified a process for care management services that would meet the needs of their patients and practice and is beginning to identify specific individuals to work closely with the practice team to provide care management for patients at high risk for experiencing adverse outcomes.	The practice has a clear process for providing care management services, and has identified specific individuals to work closely with the practice team to provide care management for patients at high risk for experiencing adverse outcomes, including patients with chronic illness who are complex or fail to meet multiple treatment goals; patients identified at risk for avoidable hospitalization or emergency department use; and patients at risk for developing avoidable conditions or complications of illness	Fully Implemented* <i>(Must Pass)</i>
c. Practice leadership has worked with care management staff to develop methods for tracking outcomes for patients receiving care management services but are still refining and testing the methods.	Care management staff have defined methods for tracking outcomes for patients receiving care management services.	Fully Implemented
6. Behavioral Physical Health Integration		
<i>Moderate progress</i>	<i>Fully Implemented</i>	2013 Expectation
a. With the assistance of PCMH Pilot staff and consultants, practice participates in a baseline assessment of their current behavioral-physical health integration capacity.	With the assistance of PCMH Pilot staff and consultants, practice participates in a baseline assessment of their current behavioral-physical health integration capacity and leadership has informed all on the practice team of the results.	Fully Implemented* <i>(Must Pass)</i>

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6. Behavioral Physical Health Integration (Continued)		
<i>Moderate progress</i>	<i>Fully Implemented</i>	2013 Expectation
b. Practice team has used the results of the baseline assessment to develop a plan for taking steps toward specific improvements to integrate behavioral and physical health care.	Using results from this baseline assessment, practice has taken steps to make one or more specific improvements to integrate behavioral and physical health care— e.g., implement a system to routinely conduct a standard assessment for depression (e.g. PHQ-9) in patients with chronic illness; implement system to conduct screening for substance abuse using standard tools (e.g. AUDIT, DAST); and/or incorporate behavioralist into the practice to assist with chronic condition management; and/or co-locate behavioral health services within in the practice.	Fully Implemented (Must Pass)
7. Inclusion of Patients & Families		
<i>Moderate progress</i>	<i>Fully Implemented</i>	2013 Expectation
a. With the assistance of PCMH Pilot staff and consultants, practice has identified at least two patients or family members to be part of the practice Leadership Team	Patients and family members are a regular part of leadership meetings or some advisory process to identify needs and implement creative solutions. There are tangible supports to enable patients and families to participate in this process (e.g., after hours events, transportation, stipends, etc.)	Fully Implemented* (Must Pass)
b. Practice is using one or more mechanisms for routinely soliciting input from patients and families on how well the practice is meeting their needs, and has identified methods for sharing results of patient surveys or other patient input with all members of the practice	Practice systematically learns about patients and draws upon patient and family input at least annually (e.g., via mail survey, phone survey, point of care questionnaires, focus groups, etc.) to design and implement office changes that address needs and gaps in care.	Fully Implemented* (Must Pass)
8. Connection to Community--Health Maine Partnership		
<i>Moderate progress</i>	<i>Fully Implemented</i>	2013 Expectation
Practice identifies and routinely makes referrals to local community resources and social support services that provide self-management support to individuals and their families to help them overcome barriers to care and meet health goals.	Practice identifies and routinely makes referrals to local community resources and social support services that provide self-management support to individuals and their families to help them overcome barriers to care and meet health goals.	Fully Implemented* (Must Pass)
9. Commitment to Reducing Waste, unnecessary healthcare spending, reducing waste, and improving cost-effective		
<i>Moderate progress</i>	<i>Fully Implemented</i>	2013 Expectation
Practice has fundamental structures in place for this core expectation including regular meetings with leadership from local hospitals and specialists. Practice has identified a list of specialists who consistently demonstrate high quality and cost efficient use of resources. Practice has studied baseline resource and utilization data and has set goals and targets for improvement. Leadership's vision for reducing waste is known to all in the organization.	The practice makes a clear and firm commitment to reduce wasteful spending of healthcare resources and improving the cost-effective use of healthcare services by targeting at least 1-3 specific waste reduction initiatives – i.e. practice commits specific resources or processes in the practice towards... (e.g.) o Reducing avoidable hospitalizations o Reducing avoidable emergency department visits o Reducing non-evidence-based use of expensive imaging – e.g. MRI for low back pain or headache	Fully Implemented* (Must Pass)

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10. Integration of Health Information Technology		
<i>Moderate progress</i>	<i>Fully Implemented</i>	2013 Expectation
Practice is working towards use of integrated HIT (e.g. registry, electronic medical record, personal health records, health information exchange, provider-patient secure messaging) to support improved communication with and for patients, and to assure patients get care when and where they need and want it in a culturally and linguistically appropriate manner.	Practice uses an electronic data system that includes identifiers and utilization data about patients. This data is used for monitoring, tracking and indicating levels of care complexity. Additional, the system is used to support the documentation of need, monitoring of clinical care, following of evidence-based practice, care plan development and related coordination and the determination of outcomes (e.g., clinical, functional, satisfaction, and cost outcomes).	Fully Implemented* <i>(Must Pass)</i> <i>(NEW for 2013!)</i>