Transformation Accelerator Assessment for Community Health Centers

[Health Center Name]

Item #	Scoring level	Level D			Level C			Level B			Level A			Your Score	Comments Comment as needed to help explain your score (e.g., unusually high or low scores)
		1	2	3	4	5	6	7	8	9	10	11	12		
	I. Leadership & Culture (Adapted from BBPCA & BCCQ Assessment)														
1	Senior leaders	…are focused on short-term business priorities.			…visibly support and create an infrastructure for quality improvement, but do not commit resources.			…allocate resources and actively reward quality improvement initiatives.			…support continuous learning throughout the organization, review and act upon quality data, and have a long-term strategy and funding commitment to explore, implement and spread quality improvement initiatives.				
2	Strategic Planning	…is conducted for the organization but does not not address care delivery transformation (OR VBC). The Board of Directors has not yet discussed care delivery transformation (OR VBC).			…does not not address care delivery transformation (OR VBC). The Board of Directors has discussed the movement toward care delivery transformation (OR VBC).			…includes objectives for progress toward care delivery transformation (OR VBC). The Board of Directors has a clear strategy for care delivery transformation (OR VBC).			…includes initiatives for care delivery transformation (OR VBC) that are currently underway and there is measureable progress towards objectives.				
3	Clinic leaders	…intermittently focus on improving quality.			…have developed a vision for quality improvement, but no consistent process for getting there. Quality Improvement process includes setting clear aims and measures for improvement areas, regularly using PDSAs to test changes, documenting PDSAs and sharing results broadly.			…are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving.			…consistently champion and engage clinical teams in improving patient experience care, clinical outcomes, and appropriate use of resources.				
4	Senior leaders (engagement)	…mainly work in their own offices and rarely interact with clinic staff around issues of strategy, quality, and patient satisfaction.			…intermittently focus on improving quality and occasionally interact with clinic staff on substantive issues but their time is usually taken up by administrative meetings.			… interact with front line staff around issues of strategy, quality, and patient satisfaction; however, leaders *don't* have a strong sense of what's working well at the clinic or recent challenges.			…frequently interact with front line staff around issues of strategy, quality, and patient satisfaction. Leaders have a strong sense of both what's working well at the clinic as well as recent challenges or issues.				
5	Major organizational initiatives	… include top-management only (often relying heavily on external consultants); clinic staff are rarely involved in these initiatives.			… planning and execution processes include representatives from *most* key players or departments; but clinic staff are often *not* involved. This refers to having cross functional teams involved andn including clinical folks on your teams.			… planning and execution processes are participatory and include key players or departments; clinic staff interests are valued and staff are sometimes involved.			… planning and execution processes are participatory, include all departments and are team-oriented. Teams work together to align both clinical and administrative interests.				

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6	Clinic staff	… tend to operate in silos with care teams, sites, and/or departments rarely communicating with each other.			… occasionally communicate across care teams, sites, and departments, but do not have a structured way for the communication to occur.			… have regular, structured communication across care teams, sites, and departments but do not regularly communicate ideas upward to managers and senior leaders.			…have regular, structured communication across care teams, sites, departments, and senior leaders. Staff has a good rapport with each other, feels open to voicing concerns, and shares concerns and improvement ideas upward to managers and senior leaders.				

II. Quality Improvement Infrastructure (Adapted from BBPCA & BCCQ Assessment)

7	A culture of quality improvement	…has not yet formed. The organization has limited experience with managing and measuring improvement (e.g. use of PDSAs, monthly performance data) and there is limited involvement with learning collaboratives.	…is in early stages of development. The organization is managing improvement in some clinical and nonclinical areas, but there is not a consistent or formal approach across all areas. Some staff use performance improvement methodology.	...is evident in most areas and the organization has participated in practice transformation or improvement collaboratives. There is a formal model for managing improvement in both clinical and nonclinical areas. Some staff (but not all) regularly use proven performance improvement methodology.	...is deeply embedded in all areas of the organization and measurement-driven improvement is well integrated. There are institutionalized support systems for change management. All staff understand and participate in systematic testing (prototyping) of better practices. Everyone understands process measurement and uses data to make decisions on how to better serve patients.		
8	Quality improvement activities	…are not organized or supported consistently.	…are conducted on an ad hoc basis in reaction to specific problems.	…are based on a proven improvement strategy in reaction to specific problems.	…are based on a proven improvement strategy and used continuously in meeting organizational goals .		
9	Quality improvement activities are conducted by	…a centralized committee or department.	…topic specific QI committees.	…all practice teams supported by a QI infrastructure.	…practice teams supported by a QI infrastructure (e.g., dedicated QI staff) with meaningful involvement of patients and families.		
10	Goals and objectives for quality improvement activities/projects	…do not exist.	. …exist on paper, but are not widely known.	…are known by staff, but are only occasionally discussed in meetings, and no clear link to the organization wide goals and priorities.	…are the centerpiece of multidisciplinary meetings aimed at developing strategies to meet project specific objectives and to meet organization wide goals and priorities.		

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11	The clinic has worked on	…fewer than 3 quality and process improvement initiatives over the last three years. The clinic has seen very little or no improvements in efficiency or outcomes as a result of these projects. Staff that work on these improvement projects meet as needed.			… a few (<5) quality and process improvement initiatives over the last three years, but most projects have focused on improving operational efficiencies (cycle time, no show rates, workflows, etc.). Staff that work on these improvement projects meet monthly. A committee that oversees these all quality improvement projects meets quarterly.			…many (>5) quality and process improvement initiatives over the last three years, and can point to some improvements in clinical outcomes (e.g., screening/immunization rates, HbA1c, blood pressure, etc.). The project team(s) is/are currently working on 2+ improvement projects and meets every other week. A committee that oversees these efforts meets monthly to quarterly.			… many (>5) quality and process improvement initiatives over the last three years, has demonstrated improvements across multiple clinical outcomes, and has standardized many of these improvements across the organization. Staff working on current quality improvement efforts meet weekly, and a committee that oversees these efforts meets at least monthly.				

III. Data-based decision making (Source: BBPCA, Building Block #2)

12	Performance measures	…are not available for the clinical site.			…are available for the clinical site, but are limited in addressing multiple domains of care delivery.			…are comprehensive –including clinical, operational, and patient experience measures – and available for the practice, but not for individual providers.			…are comprehensive – including clinical, operational, and patient experience measures – and fed back to individual providers.				
13	Registry or panel level data	…are not available to assess or manage care for practice populations.			…are available to assess and manage care for practice populations, but only on an ad hoc basis.			…are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states.			…are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states.				
14	Registries on individual patients	…are not available to practice teams for pre-visit planning or patient outreach.			…are available to practice teams but are not routinely used for pre-visit planning or patient outreach.			…are available to practice teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states.			…are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states.				
15	An electronic health record that is meaningful-use certified	…is not present or being implemented.			…is in place and is being used to capture clinical data.			…is used routinely during patient encounters to provide clinical decision support and to share data with patients.			…is also used routinely to support population management and quality improvement efforts.				
16	Data and information	…are used mostly for retrospective reporting using historical data. Line staff has very little exposure to data for day-to-day decision making.			…are available and used by department heads, but not uniformly required when making operational decisions or changing strategy.			…are used by managers, directors and department heads on a regular basis. Data are pushed down & across the organization and required to support business cases and key decisions.			…are used to drive decisions at all levels in the organization. Line staff knows how their day-to-day actions affect performance metrics and achievement of goals.				

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17	Data quality	…is not a priority. Most efforts are focused on clean-up and individual intervention.			… reviews occur within selected teams, departments or sites but the efforts are usually one time efforts and not sustained on an ongoing basis.			…tracking reports are produced on a regular basis for departments. Data quality efforts occur regularly across the organization; common errors are assessed and training occurs to address them.			…measures (e.g., % accuracy) prioritize and inform ongoing data quality efforts and trace errors to individuals for training. Data collection and aggregation is highly automated with built-in data quality checks and exception reports.				
18	IT support and data services	… for analytics consists mainly of maintenance and support of database platforms that capture health record data (e.g., EHR, PM). Dedicated analytics systems or tools are limited in functionality and utility.			…for analytics includes support for reporting and data mining from existing systems and basic analytics support. Analysis tools are limited to spreadsheets and databases with limited functions for systematic reporting and advanced data analyses. Limited structures exist to prioritize data requests.			… has established analytics systems to support the needs of high priority areas, selected departments or sites and for some levels of staff (e.g., leadership only). Some structures and processes are in place to prioritize data requests and provide self-service access to reports and dashboards.			… include dedicated IT staff that are deployed to maintain and support optimization of analytics systems. Analytics systems interface with and leverage existing IT platforms, fully support organization data needs to build a data-driven culture with self-service analytics. Data governance processes are fully formed to guide the provision of data analytic services.				
	IV. Team-based care (Source: BBPCA, Building Block #4)														
19	Non-physician practice team members	…play a limited role in providing clinical care.			…are primarily tasked with managing patient flow and triage.			…provide some clinical services such as assessment or self-management support.			…perform key clinical service roles that match their abilities and credentials.				
20	Providers (Physicians, NP/PAs) and clinical support staff	…work in different pairings every day.			…are arranged in teams but are frequently reassigned.			…consistently work with a small group of providers or clinical support staff in a team.			…consistently work with the same provider/ clinical support staff person almost every day.				
21	Workflows for clinical teams	…have not been documented and/or are different for each person or team.			…have been documented, but are not used to standardize workflows across the practice.			…have been documented and are utilized to standardize practice.			…have been documented, are utilized to standardize workflows, and are evaluated and modified on a regular basis.				
22	The practice	…does not have an organized approach to identify or meet the training needs for providers and other staff.			…routinely assesses training needs and assures that staff are appropriately trained for their roles and responsibilities.			…routinely assesses training needs, assures that staff are appropriately trained for their roles and responsibilities, and provides some cross training to permit staffing flexibility.			…routinely assesses training needs, assures that staff are appropriately trained for their roles and responsibilities, and provides cross training to assure that patient needs are consistently met.				

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23	Standing orders that can be acted on by non-physicians under protocol	…do not exist for the practice.			…have been developed for some conditions but are not regularly used.			…have been developed for some conditions and are regularly used.			…have been developed for many conditions and are used extensively.				
24	The organization's hiring and training processes	…focus only on the narrowly defined functions and requirements of each position.			…reflect how potential hires will affect the culture and participate in quality improvement activities.			…place a priority on the ability of new and existing staff to improve care and create a patient-centered culture.			…support and sustain improvements in care through training and incentives focused on rewarding patient-centered care.				
	V. Access to Care (Source: CPCA CP3 & CMS PAT 2.0)														
25	Enhanced access for office visits	…are not available. The organization offers extended weekday/weekend office hours.			…are not available. The organization has extended hours at all sites. The organization offers patients office visits with non-clinical (MD/NP/PA) providers, such as nutritionists or health coaches.			…has been partially implemented at selected sites with some same-day visit or other open access options for patients.			…has been fully implemented across all sites with same-day visit or other open access options for patients.				
26	A system for patients to speak with their care team 24/7	…is not in place. After hours, clinic 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.			…is partially in place. Clinic 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.			…is mostly in place. Clinic 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.			…is fully in place. Clinic 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.				
	VI. Panel/Population Management (Source: BBPCA, Building Blocks #3 & 6)														
27	Patients	…are not assigned to specific practice panels.			…are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes.			…are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes.			…are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.				
28	A patient who comes in for an appointment and is overdue for preventive care (e.g., cancer screenings)	…will only get that care if they request it or their provider notices it.			…might be identified as being overdue for needed care through a health maintenance screen or system of alerts, but this is inconsistently used.			…will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, but clinical assistants may not act on these overdue care items without patient specific orders from the provider.			…will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, and clinical assistants may act on these overdue care items (e.g., administer immunizations or distribute colorectal cancer screening kits) based on standing orders.				

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29	A patient who comes in for an appointment and is overdue for chronic care (e.g., diabetes lab work)	…will only get that care if they request it or their provider notices it.			…might be identified as being overdue for needed care through a health maintenance screen or system of alerts, but this is inconsistently used.			…will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, but clinical assistants may not act on these overdue care items without patient specific orders from the provider.			…will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, and clinical assistants may act on these overdue care items (e.g., complete lab work) based on standing orders.				
30	When patients are overdue for preventive (e.g., cancer screenings) but do not come in for an appointment	…there is no effort on the part of the practice to contact them to ask them to come in for care.			…they might be contacted as part of special events or using volunteers but outreach is not part of regular practice.			…they would be contacted and asked to come in for care, but clinical assistants may not act on these overdue care items without patient-specific orders from the provider.			…they would be contacted and asked to come in for care, and clinical assistants may act on these overdue care items (e.g., distribute colorectal cancer screening kits) based on standing orders.				
31	When patients are overdue for chronic care (e.g., diabetes lab work) but do not come in for an appointment	…there is no effort on the part of the practice to contact them to ask them to come in for care.			…they might be contacted as part of special events or using volunteers but outreach is not part of regular practice.			…they would be contacted and asked to come in for care, but clinical assistants may not act on these overdue care items without patient-specific orders from the provider.			…they would be contacted and asked to come in for care, and clinical assistants may act on these overdue care items (e.g., complete lab work) based on standing orders.				
32	Self-management support	…is limited to the distribution of information (pamphlets, booklets).			…is accomplished by referral to self-management classes or educators.			…is provided by goal setting and action planning with members of the practice team.			…is provided by members of the practice team trained in patient empowerment and problem solving methodologies.				
33	34. Clinical care management services for high risk patients	…are not available.			…are provided by external care managers with limited connection to practice.			…are provided by external care managers who regularly communicate with the care team.			…are systematically provided by the care manager functioning as part of the team.				
34	Population health and whole person care	…is practiced informally. Clinic does not have a consistent system for assessing and addressing behavioral health needs.			…is practiced through external linkages. Clinic 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.			…is practiced with internal linkages. Clinic consistently provides 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.			…is fully embedded and integrated. Clinic consistently provides 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.				