

## Value of participation in the MMC PHO Clinical Improvement Plan (CLIP)

- Promote effective, efficient and equitable patient care
- Improve outcomes by supporting adherence to evidence-based treatment
- Prevent or delay serious and costly complications
- Develop a recognition system for physicians demonstrating improved clinical outcomes
- Encourage participation in external quality initiatives that provide financial and/or public reporting benefits

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## CLINICAL IMPROVEMENT PLAN

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Promoting effective patient care and improving outcomes through quality initiatives



# CLINICAL IMPROVEMENT PLAN

## Electronic Systems Support

### Access to and support for electronic systems

- Provision of a tool for effective management of patient populations via the Clinical Improvement Registry (CIR)
- Access to Electronic Health Records (EHR) and electronic interfaces to assist practices in meeting the requirements of meaningful use as defined by the American Recovery and Reinvestment Act (ARRA)
- Reporting for quality programs through CIR helps ease the burden of reporting to quality programs
- Competitive edge for public recognition

## Quality Care Recognition Program

- Alignment of MMC PHO initiatives with state and national quality programs
- Assistance in excelling in public reporting and incentive programs
- Ability to report to pay-for-performance and public reporting initiatives for additional income:
  - Aetna Depression Program
  - Anthem Quality Insights (AQI)
  - Bridges to Excellence
  - Center for Medicaid and Medicare Services (CMS) Physician Quality Reporting Initiative (PQRI)
  - Maine Health Management Coalition (MHMC) Pathways to Excellence (PTE)

- National Committee for Quality Assurance
- Participation in tiered networks

## Practice Support

### Assistance in maximizing your team's ability to provide safe, effective, efficient, and patient-centered care.

#### Issues we can help address:

- Creating effective teams
- Plan-Do-Study-Act rapid cycles of improvement & setting improvement goals
- Implementing huddles
- Assistance in achieving targets in external quality programs

## Access to Clinical Tools

- Access to the latest evidence-based guidelines
- Provider/staff education (clinical and office process)

## Chronic Illness RN Care Manager

- Additional support for patients to meet clinical targets as well as personal goals
  - Assess patient's ability to manage their health condition
  - Provide detailed education and empower with actionable information
  - Promote patient self management
  - Facilitate access to community resources
  - Promote and facilitate care coordination

## Care Transitions Coach

- Support for adult patients transitioning from hospital to home
  - Coach meets with the patient in the hospital, makes a home visit and provides three follow-up phone calls during the 4-week intervention. Focused coaching areas include:
    - Medication reconciliation and self-management
    - Use of a Personal Health Record
    - Importance of prompt primary care and specialist follow-up
    - Knowledge of "red flags" and what to do

## Care Coordination

- Improve the process of transitioning patients between primary care and specialty providers thereby reducing unnecessary consults, testing, procedures, errors and administrative burdens
- Foster improved communication among providers by creating common communication tools
- Enhance the application of evidence based guidelines by developing algorithms to guide referrals

**Participating now prepares you for the future.**