Centers for Medicare & Medicaid Services
Transforming Clinical Practices Initiative
Data Support and Feedback Reporting

TCPI Practice Assessment Tool 2.0 & Practice Assessment Report Template 2.0 (PART) Reporting & Submission User Guide

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Version 1

Table of Contents

I. Practice Assessment Tool 2.0

A. Introduction

The purpose of the Transforming Clinical Practice Initiative (TCPI) Practice Assessment Tool 2.0 (PAT 2.0) is to determine the Transformation Phase in which practices are functioning at baseline and follow-up intervals over the life of the initiative. This determination is based on the extent to which a practice exhibits attributes defined by a series of milestones aligned with the TCPI Change Package. Each milestone is scored on degree of implementation based on interviews with practice staff, review of applicable documents and reports and direct observation of practice activity as well as professional judgement. Practices participating in TCPI are expected to progress through five distinct Transformation Phases. These phases capture the progress that the practice as a whole is making towards being prepared to thrive as a business in a value-based payment environment. The phases of transformation for the operations of a practice are defined as follows:

Phase 1 – Practice leadership sets aims and develops a plan and capabilities for starting the transformation journey.
Phase 2 – The practice develops and initiates operational data and begins to use data.
Phase 3 – The practice further develops the infrastructure and begins to operationalize changes needed to drive results.
Phase 4 – The practice ensures full and consistent operation of systems and processes at a level of performance needed to achieve aims.
Phase 5 – The practice has sustainable operations built into budgets and financial plans.

Progression through these five Phases directly maps to the achievement of the larger goals of TCPI. The baseline PAT 2.0 assessments will be used to determine readiness for transformation and the position of the practice on the transformation continuum. Follow up assessments will be used to determine a practice's progress through the higher Phases and the level and nature of the technical assistance needed to support their transformation efforts. In addition to determining the Phase of practice transformation that the practices are in at each time of assessment, results will be used to both surface high performers and identify those areas requiring further assistance.

As a rule of thumb, a practice is considered to be in the Phase above the lowest Phase completed. For example, a practice that has completed requirements for Phase 2 and Phase 3 but has yet to complete the requirements for Phase 1, is considered to be "In Phase 1." Once the requirement for Phase 1 is met the practice would be considered to be in Phase 4 (having completed the requirements for Phases 1, 2 and 3).

A practice is defined by TIN and physical location. The location includes the Zip Code plus four digits (Zip+4). A practice assessment should represent a single practice. If a physical site has five distinct practices, five PAT 2.0's should be completed. In a large, multi-specialty practice group, each specialty within the TIN+zip+4 definition of a practice should have an individual assessment complete (e.g. an

orthopedic care center would have a separate assessment from a psychiatric care center, even if they are in the same TIN+ZIP+4). In the case of a large health system, one PAT 2.0 should be completed for each location and for each specialty practice.

B. Background and Structure

The PAT 2.0 was co-developed by a workgroup comprised of Practice Transformation Networks (PTNs), Quality Improvement Network-Quality Improvement Organizations (QIN-QIOs), Support and Alignment Networks (SANs), members of the National Development Management and Improvement Contractor (NDMIC) and other national experts. The PAT 2.0 utilizes the basic framework found in the TCPI Change Package. The change package can be found at the following link:

http://www.healthcarecommunities.org/Communities/MyCommunities/TCPI/TCPI/ChangePackage.aspx
(Communities > My Communities > TCPI > TCPI > Change Package)

The change package consists of three primary drivers and 15 secondary drivers. Each secondary driver has multiple change concepts and tactics associated with it.

The PAT 2.0 framework uses the 15 secondary drivers (associated with three primary drivers) as the basis for assessing a practice's transformation progress. A 16th driver was added to capture a practice's progress on three of the seven TCPI national performance aims. Each driver includes one or more milestones that reflect change concepts developed by the National Expert Panel and describe the ideal state(s) for that driver. Each milestone is "scored" on a scale of 0 – 3. In general, the scoring represents the following states:

0 = The milestone has not yet been addressed by the practice
1 = Work on the milestone is beginning or developing
2 = The milestone is being implemented or partially operating
3 = The milestone is functioning, performing and producing results

Exhibit 1 shows the Secondary Drivers and Milestones associated with the Primary Care PAT and Exhibit 2 shows the same information for the Specialist PAT.

Exhibit 1 – Primary Care Layout

Milestone #	Milestone score: 0= Not Yet; 1=Getting Started; 2=Implementing, Partially Operating; 3=Functioning, Performing	0	1	2	3
AIMS					
1	Practice has met its targets and has sustained improvements in practice-identified metrics for at least one year.				
2	Practice has reduced unnecessary tests, as defined by the practice.				
3	Practice has reduced unnecessary hospitalizations.				
PFE					
4	Practice can demonstrate that it encourages patients and families to collaborate in goal setting, decision making, and self-management.				
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.				
TEAM BASED RELATIONSHIP					
6	Practice sets clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes, and accountability.				
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.				
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.				
9	Practice has a reliable process in place for identifying risk level of each patient and providing care appropriate to the level of risk.				
10	The practice provides care management for patients at highest risk of hospitalizations and/or complications and has a standard approach to documentation.				
COMMUNITY PARTNER					
11	Practice links patients with appropriate community resources to facilitate referrals.				
COORDINATED CARE					
12	Practice has defined its medical neighborhood and has formal agreements in place with these partners to define roles and expectations.				
13	Practice follows up via phone, visit, or electronic means with patients within a designated time interval (24 hours/ 48 hours/ 72 hours/ 7 days) after an emergency room visit or hospital discharge.				
14	Practice clearly defines care coordination roles and responsibilities and these have been fully implemented within the practice.				
ORGANIZED EVIDENCED-BASED CARE					
15	Practice ensures that care addresses the whole person, including mental and physical health.				
16	Practice uses population reports or registries to identify care gaps and acts to reduce them.				
ENHANCED ACCESS					
17	Practice has mechanisms in place for patient to speak with their care team 24/7.				
ENGAGED AND COMMITTED LEADERSHIP					
18	Practice has developed a vision and plan for transformation that includes specific clinical outcomes and utilization aims that are aligned with national TCPI aims and that are shared broadly within the practice.				
QUALITY IMPROVEMENT STRATEGY SUPPORTING CULTURE OF QUALITY					
19	Practice uses an organized approach (e.g. use of PDSAs, Model for Improvement, Lean, Six Sigma) to identify and act on improvement opportunities.				
20	Practice builds QI capability in the practice and empowers staff to innovate and improve.				
TRANSPARENT MEASUREMENT AND MONITORING					
21	Practice regularly produces and shares reports on performance at both the organization and provider/care team level, including progress over time and how performance compares to goals. Practice has a system in place to assure follow up action where appropriate.				
OPTIMIZE HEALTH INFORMATION TECHNOLOGY					
22	Practice uses technology to offer scheduling and communication options that improve patient access by including alternative visit types and electronic communication approaches.				
STRATEGIC USE OF REVENUE					
23	Practice uses sound business practices, including budget management and return on investment calculations.				
WORKFORCE VITALITY AND JOY IN WORK					
24	Practice has effective strategies in place to cultivate joy in work and can document results.				
CAPABILITY TO ANALYZE AND DOCUMENT VALUE					
25	Practice shares financial data in a transparent manner within the practice and has developed the business capabilities to use business practices and tools to analyze and document the value the organization brings to various types of alternative payment models.				
26	Practice considers itself ready for migrating into an alternative based payment arrangement.				
OPERATIONAL EFFICIENCY					
27	Practice uses a formal approach to understanding its work processes and increasing the value of all processing steps.				

Exhibit 2 – Specialist Layout

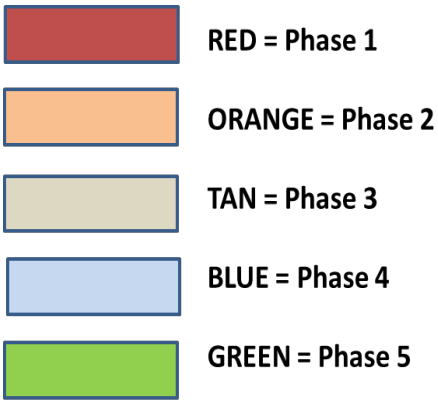
Milestone #	Milestone score: 0= Not Yet; 1=Getting Started; 2=Implementing, Partially Operating; 3=Functioning, Performing	0	1	2	3
AIMS					
1	Practice has met its targets and has sustained improvements in practice-identified metrics for at least one year.				
2	Practice has reduced unnecessary tests, as defined by the practice.				
3	Practice has reduced unnecessary hospitalizations.				
PFE					
4	Practice can demonstrate that it encourages patients and families to collaborate in goal setting, decision making, and self-management.				
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.				
TEAM BASED RELATIONSHIP					
6	Practice sets clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes, and accountability.				
POPULATION MANAGEMENT					
7	Practice has a reliable process in place for identifying risk level of each patient and providing care appropriate to the level of risk.				
COMMUNITY PARTNER					
8	Practice links patients with appropriate community resources to facilitate referrals.				
COORDINATED CARE					
9	Practice works with 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 communications 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.				
ORGANIZED EVIDENCED-BASED CARE					
11	Practice uses evidence -based protocols or care maps where appropriate to improve patient care and safety.				
ENHANCED ACCESS					
12	Practice has mechanisms in place for patient to access their care team 24/7.				
ENGAGED AND COMMITTED LEADERSHIP					
13	Practice has developed a vision and plan for transformation that includes specific clinical outcomes and utilization aims that are aligned with national TCPI aims and that are shared broadly within the practice.				
QUALITY IMPROVEMENT STRATEGY SUPPORTING CULTURE OF QUALITY					
14	Practice uses an organized approach (e.g. use of PDSAs, Model for Improvement, Lean, Six Sigma) to identify and act on improvement opportunities.				
15	Practice builds QI capability in the practice and empowers staff to innovate and improve.				
TRANSPARENT MEASUREMENT AND MONITORING					
16	Practice regularly produces and shares reports on performance at both the organization and provider/care team level, including progress over time and how performance compares to goals. Practice has a system in place to assure follow up action where appropriate.				
OPTIMIZE HEALTH INFORMATION TECHNOLOGY					
17	Practice uses technology to offer scheduling and communication options that improve patient access by including alternative visit types and electronic communication approaches.				
STRATEGIC USE OF REVENUE					
18	Practice uses sound business practices, including budget management and return on investment calculations.				
WORKFORCE VITALITY AND JOY IN WORK					
19	Practice has effective strategies in place to cultivate joy in work and can document results.				
CAPABILITY TO ANALYZE AND DOCUMENT VALUE					
20	Practice shares financial data in a transparent manner within the practice and has developed the business capabilities to use business practices and tools to analyze and document the value the organization brings to various types of alternative payment models.				
21	Practice considers itself ready for migrating into an alternative based payment arrangement.				
OPERATIONAL EFFICIENCY					
22	Practice uses a formal approach to understanding its work processes and increasing the value of all processing steps.				

The scale for the milestone descriptions is based on the TRANSLATE rubric developed by the Upstate New York Practice Based Research Network in their expansion of the TRANSLATE framework.[11] The

[1] TRANSLATE is a framework developed in the 1990's by Dr. Kevin Peterson of The University of Minnesota in his work to improve diabetes management care in multiple primary care practices. He performed a literature review and identified nine distinct elements with evidence to support the improvement of care when implemented in PCPs. In a randomized control trial of over 8,000 people with diabetes, implementing the nine elements of TRANSLATE led to clinically significant improvement of care in multiple measures within one year

primary care practice assessment tool differs in certain content areas from the specialist practice assessment tool. There are 27 milestones for the Primary Care PAT 2.0 and 22 for the Specialist PAT 2.0. In both PATs, each milestone has been assigned at least one Transformation Phase, signified by a color in the scoring cell that represents the level of achievement in that milestone. The colors assigned to the phases are as shown in Exhibit 3. There may be more than one Phase associated with each milestone as certain levels of achievement correspond to certain phases of transformation.

Exhibit 3 – Transformation Phase Color Scheme



A simple example of this can be seen with the very first set of milestones. These milestones relate to the achievement of three of the aims of TCPI. In the first milestone of the PAT 2.0, there are four descriptions associated with the scores 0 to 3. Under the "1" score, the box is colored Orange for Phase 2. This means that if the practice is scored a 1 for this milestone, it has completed a requirement for Phase 2. Likewise, if the practice is scored a "2" it will have completed this requirement for Phase 3. It is important to note here that a score of "2" would mean that the practice has completed this requirement for both Phases 2 and 3, and will be given credit for doing so. This will be explained further in the Scoring section that follows.

Each of the milestones was evaluated and assigned a phase. Exhibits 4 and 5 display how the milestone structure incorporates the phases of transformation for the Primary Care PAT 2.0 and Specialty Care PAT 2.0 respectively. Notice that there is only one "Red" box for Phase 1. A score of "3" on milestone 18 of the Primary Care PAT 2.0 or milestone 13 on the Specialty Care PAT 2.0 would indicate that the practice has completed the requirements for Phase 1. Any lower score would mean that that requirement has not yet been completed.

Exhibit 4 – Primary Care PAT 2.0 Phases

Milestone #	Milestone score: 0= Not Yet; 1=Getting Started; 2=Implementing, Partially Operating; 3=Functioning, Performing	0	1	2	3
AIMS					
1	Practice has met its targets and has sustained improvements in practice-identified metrics for at least one year.				
2	Practice has reduced unnecessary tests, as defined by the practice.				
3	Practice has reduced unnecessary hospitalizations.				
PFE					
4	Practice can demonstrate that it encourages patients and families to collaborate in goal setting, decision making, and self-management.				
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.				
TEAM BASED RELATIONSHIP					
6	Practice sets clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes, and accountability.				
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.				
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.				
9	Practice has a reliable process in place for identifying risk level of each patient and providing care appropriate to the level of risk.				
10	The practice provides care management for patients at highest risk of hospitalizations and/or complications and has a standard approach to documentation.				
COMMUNITY PARTNER					
11	Practice links patients with appropriate community resources to facilitate referrals.				
COORDINATED CARE					
12	Practice has defined its medical neighborhood and has formal agreements in place with these partners to define roles and expectations.				
13	Practice follows up via phone, visit, or electronic means with patients within a designated time interval (24 hours/ 48 hours/ 72 hours/ 7 days) after an emergency room visit or hospital discharge.				
14	Practice clearly defines care coordination roles and responsibilities and these have been fully implemented within the practice.				
ORGANIZED EVIDENCED-BASED CARE					
15	Practice ensures that care addresses the whole person, including mental and physical health.				
16	Practice uses population reports or registries to identify care gaps and acts to reduce them.				
ENHANCED ACCESS					
17	Practice has mechanisms in place for patient to speak with their care team 24/7.				
ENGAGED AND COMMITTED LEADERSHIP					
18	Practice has developed a vision and plan for transformation that includes specific clinical outcomes and utilization aims that are aligned with national TCPI aims and that are shared broadly within the practice.				
QUALITY IMPROVEMENT STRATEGY SUPPORTING CULTURE OF QUALITY					
19	Practice uses an organized approach (e.g. use of PDSAs, Model for Improvement, Lean, Six Sigma) to identify and act on improvement opportunities.				
20	Practice builds QI capability in the practice and empowers staff to innovate and improve.				
TRANSPARENT MEASUREMENT AND MONITORING					
21	Practice regularly produces and shares reports on performance at both the organization and provider/care team level, including progress over time and how performance compares to goals. Practice has a system in place to assure follow up action where appropriate.				
OPTIMIZE HEALTH INFORMATION TECHNOLOGY					
22	Practice uses technology to offer scheduling and communication options that improve patient access by including alternative visit types and electronic communication approaches.				
STRATEGIC USE OF REVENUE					
23	Practice uses sound business practices, including budget management and return on investment calculations.				
WORKFORCE VITALITY AND JOY IN WORK					
24	Practice has effective strategies in place to cultivate joy in work and can document results.				
CAPABILITY TO ANALYZE AND DOCUMENT VALUE					
25	Practice shares financial data in a transparent manner within the practice and has developed the business capabilities to use business practices and tools to analyze and document the value the organization brings to various types of alternative payment models.				
26	Practice considers itself ready for migrating into an alternative based payment arrangement.				
OPERATIONAL EFFICIENCY					
27	Practice uses a formal approach to understanding its work processes and increasing the value of all processing steps.				

Exhibit 5 – Specialty Care PAT 2.0 Phases

Milestone #	Milestone score: 0= Not Yet; 1=Getting Started; 2=Implementing, Partially Operating; 3=Functioning, Performing	0	1	2	3
AIMS					
1	Practice has met its targets and has sustained improvements in practice-identified metrics for at least one year.				
2	Practice has reduced unnecessary tests, as defined by the practice.				
3	Practice has reduced unnecessary hospitalizations.				
PFE					
4	Practice can demonstrate that it encourages patients and families to collaborate in goal setting, decision making, and self-management.				
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.				
TEAM BASED RELATIONSHIP					
6	Practice sets clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes, and accountability.				
POPULATION MANAGEMENT					
7	Practice has a reliable process in place for identifying risk level of each patient and providing care appropriate to the level of risk.				
COMMUNITY PARTNER					
8	Practice links patients with appropriate community resources to facilitate referrals.				
COORDINATED CARE					
9	Practice works with 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 communications 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.				
ORGANIZED EVIDENCED-BASED CARE					
11	Practice uses evidence -based protocols or care maps where appropriate to improve patient care and safety.				
ENHANCED ACCESS					
12	Practice has mechanisms in place for patient to access their care team 24/7.				
ENGAGED AND COMMITTED LEADERSHIP					
13	Practice has developed a vision and plan for transformation that includes specific clinical outcomes and utilization aims that are aligned with national TCPI aims and that are shared broadly within the practice.				
QUALITY IMPROVEMENT STRATEGY SUPPORTING CULTURE OF QUALITY					
14	Practice uses an organized approach (e.g. use of PDSAs, Model for Improvement, Lean, Six Sigma) to identify and act on improvement opportunities.				
15	Practice builds QI capability in the practice and empowers staff to innovate and improve.				
TRANSPARENT MEASUREMENT AND MONITORING					
16	Practice regularly produces and shares reports on performance at both the organization and provider/care team level, including progress over time and how performance compares to goals. Practice has a system in place to assure follow up action where appropriate.				
OPTIMIZE HEALTH INFORMATION TECHNOLOGY					
17	Practice uses technology to offer scheduling and communication options that improve patient access by including alternative visit types and electronic communication approaches.				
STRATEGIC USE OF REVENUE					
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WORKFORCE VITALITY AND JOY IN WORK					
19	Practice has effective strategies in place to cultivate joy in work and can document results.				
CAPABILITY TO ANALYZE AND DOCUMENT VALUE					
20	Practice shares financial data in a transparent manner within the practice and has developed the business capabilities to use business practices and tools to analyze and document the value the organization brings to various types of alternative payment models.				
21	Practice considers itself ready for migrating into an alternative based payment arrangement.				
OPERATIONAL EFFICIENCY					
22	Practice uses a formal approach to understanding its work processes and increasing the value of all processing steps.				

C. Scoring the PAT 2.0

As each milestone is assessed, the assessor using all available information and their best professional judgement assigns a score of 0 to 3 based on the description that best aligns with the current state of

the practice. The scoring methodology enables the assessor to evaluate the practice's progress in three ways:

Exhibit 6 – Three Ways of Summarizing Scores

1.	Count the number of boxes that are complete by color (Phase) and compare to the total possible number of boxes.
2.	Sum the number of "points" (the score) for each color (Phase) and compare to the total possible number of points.
3.	Count the number of secondary drivers/aims that are complete and compare to the total number of 16 that are possible.

The two Excel workbooks for the Primary Care and Specialty Care PATs automatically summarize the scoring based on the data entered on the PAT 2.0 (See the PAT 2.0 Instructions below). The summary creates three tables for review and use by the assessor. Exhibit 7 shows the three tables produced by the Excel PAT 2.0 workbooks.

Exhibit 7 – Three Summary Scoring Tables for the Primary Care PAT 2.0

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

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

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

In the first table, the number of milestones associated with each Phase is shown. For the Primary Care PAT 2.0, there are 44 colored boxes representing the five Phases of transformation (there are 36 boxes for the Specialist PAT). As noted earlier, there is one red box, representing Phase 1, there are 12 orange boxes representing Phase 2, 13 tan boxes representing Phase 3 and so on.

Notice how there is 27 milestones and 44 colored boxes. That is because a milestone can have more than one Phase associated with it. When scoring it is important to note that when a practice receives a score that it might count as 2 or 3 boxes. Exhibit 8 shows an example of this phenomenon.

Exhibit 8 – Primary Care PAT 2.0 Scoring Summary

Transforming Clinical Practice Initiative		Name:	TEST PRACTICE				
PAT 2 - Scoring Worksheet - PRIMARY CARE		TIN:	12345678				
Date:	3/31/2016	Type:	Baseline				
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.					2	
2	Practice has reduced unnecessary tests, as defined by the practice.					1	
3	Practice has reduced unnecessary hospitalizations.					2	
PFE							
4	Practice can demonstrate that it encourages patients and families to collaborate in goal setting, decision making, and self-management.					3	
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.					2	

For Milestone 1, a score of 2 indicates that the practice has met a Phase 3 requirement as the 2 corresponds to a tan box. However, it also means that it has met the requirements of Phase 2 (as can be deduced by the orange box to the left and under the 1 column). When counting the number of boxes complete for this milestone, the scoring would credit the practice with 2 boxes completed, one for the orange box and one for the tan box. As a rule of thumb, count every colored box to the left of the box selected.

The second table on Exhibit 7 works like the first table with the only difference being instead of counting the number of colored boxes, the number of points is summed for each phase. The table shows that there are 111 points available for the primary care practices (and there are 90 available points for the specialty practice).

The third and final table shows the number of secondary drivers that can be considered complete. This occurs when the practice has met the requirements for all of the milestones associated with a particular driver.

D. Scoring Example 1

Exhibit 9 shows an example of a practice that has completed the requirements for Phases 1 and 2 and is in Phase 3. In this example, Table 1 shows that this practice has completed 27 out of the possible 44 (or 61%) of the possible milestones. They have completed the requirements for Phases 1 and 2 (which put them in Phase 3) and are 69% of the way to completing Phase 3. They have started work in Phase 4 and are 31% of the way to completing that phase.

Table 2 shows that that they achieved 63 out of 111 or 57% of the possible total points. As Table 1 showed, they have completed the requirements for Phase 1 and 2 and have accumulated 72% of the total points towards completion of Phase 3. The practice has achieved 31% of the points towards completing Phase 4.

Table 3 indicates that 7 out of the 16 (or 44%) of the drivers have been complete.

Exhibit 9 – Scoring Example 1 – Practice in Phase 3: Phases 1 & 2 Complete

SUMMARY		#	Ct	Pct
Counts of Concepts Complete (Counting the Colors)				
Phase 1 =		1	1	100%
Phase 2 =		12	12	100%
Phase 3 =		13	9	69%
Phase 4 =		16	5	31%
Phase 5 =		2	0	0%
	TOTAL	*44*	*27*	*61%*

Adding Up the Score (Counting the Points 0 - 3)		#	Sum	Poss	Pct
Phase 1 =		1	3	3	100%
Phase 2 =		12	22	22	100%
Phase 3 =		13	23	32	72%
Phase 4 =		16	15	48	31%
Phase 5 =		2	0	6	0%
	TOTAL	*44*	*63*	*111*	*57%*

Total Number of Secondary Drivers/AIMs Complete	7
Total Number of Secondary Drivers/AIMs	16
% of Secondary Drivers/AIMs Complete	*44%*

E. Scoring Example 2

Exhibit 10 shows that the practice has completed the requirements for Phase 2, but has not yet finished Phase 1. By definition this would be a practice that is still in Phase 1. However they have completed the requirements for Phase 2 and are very close to completing the requirements for Phase 3. So once this practice puts together its plans and goals, it will likely jump from Phase 1 to Phase 4. We expect to see a number of practices who do not necessarily transform sequentially; this scoring method gives the assessor an opportunity to see exactly where the practice is in the transformation process.

Exhibit 10 – Practice in Phase 1: Completed Requirements for Phase 2

SUMMARY		#	Ct	Pct
Counts of Concepts Complete (Counting the Colors)				
Phase 1 =		1	0	0%
Phase 2 =		12	12	100%
Phase 3 =		13	12	92%
Phase 4 =		16	5	31%
Phase 5 =		2	0	0%
	TOTAL	***44***	***29***	***66%***

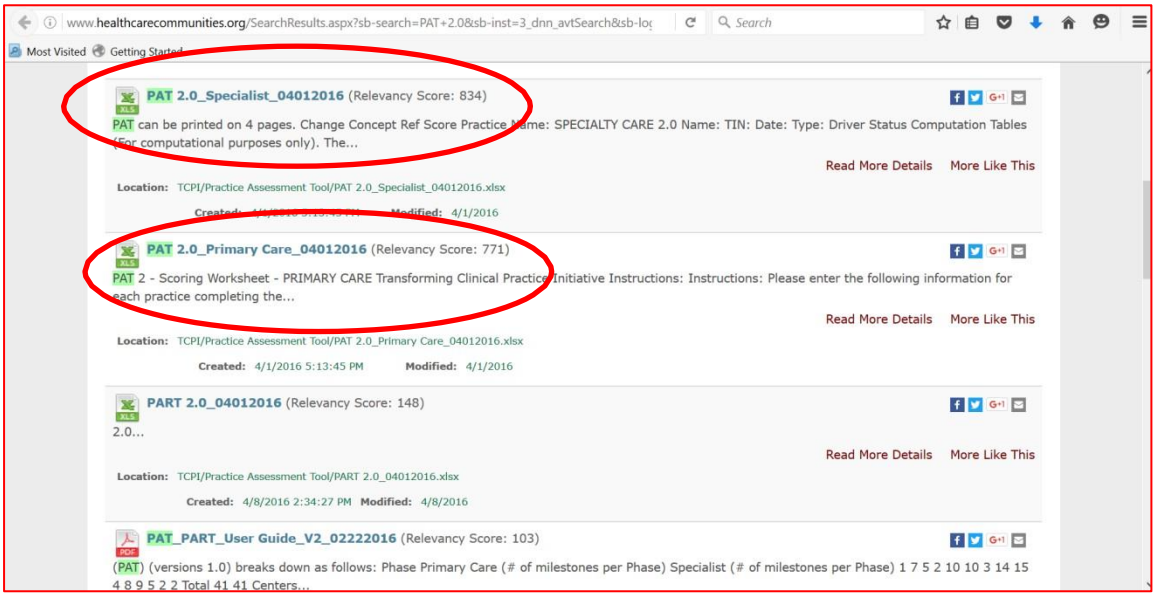
Adding Up the Score (Counting the Points 0 - 3)		#	Sum	Poss	Pct
Phase 1 =		1	0	3	0%
Phase 2 =		12	22	22	100%
Phase 3 =		13	30	32	94%
Phase 4 =		16	15	48	31%
Phase 5 =		2	0	6	0%
	TOTAL	***44***	***67***	***111***	***60%***

Total Number of Secondary Drivers/AIMs Complete	7
Total Number of Secondary Drivers/AIMs	16
% of Secondary Drivers/AIMs Complete	***44%***

F. Accessing the Practice Assessment Tools

1. Open a browser and enter or click on the following URL in the address bar:
   http://www.healthcarecommunities.org/Communities/MyCommunities/TCPI/TCPI/PracticeAssessmentTools.aspx?CategoryId=831909&EntryId=91536
   (Communities > My Communities > TCPI > TCPI > Practice Assessment Tools)
2. Select either the Primary Care PAT 2.0 or Specialty PAT 2.0 depending on the nature of the practice.

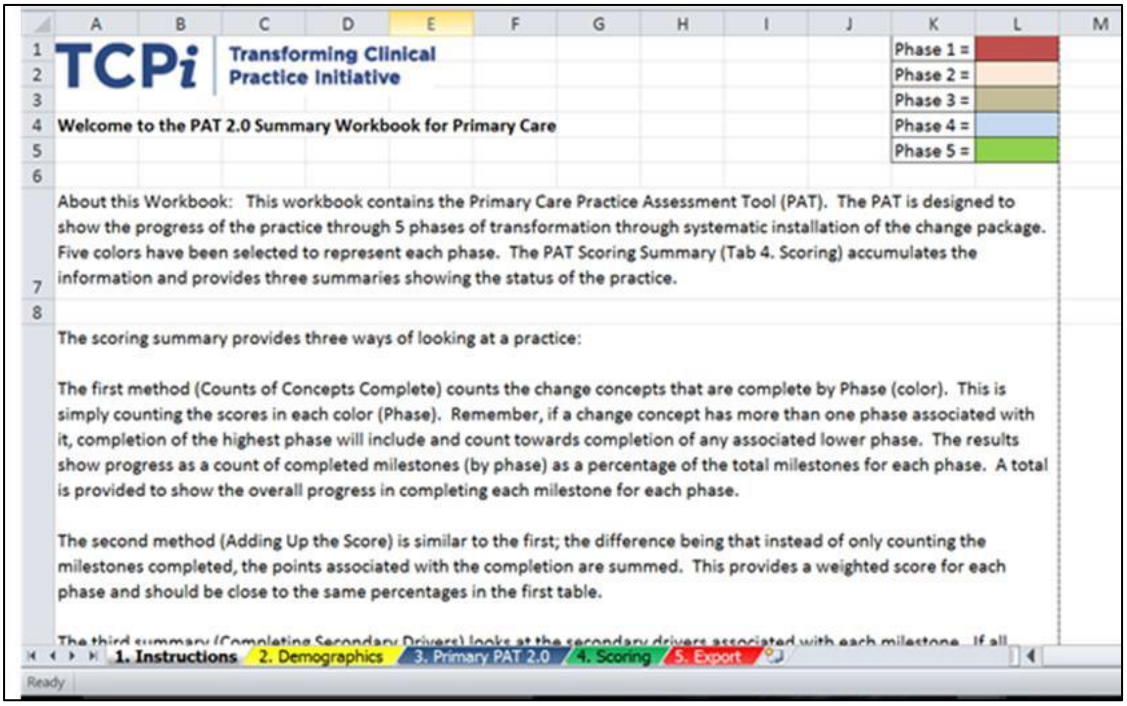
Exhibit 11 – Healthcare Communities PAT Files



G. Instructions for Completing the PAT 2.0 Excel Workbook

When you open the workbook, you will be greeted by five color coded tabs. The instructions for the workbook appear on the first tab and describe what to do.

Exhibit 12 – Primary Care PAT 2.0 Workbook Instruction Tab

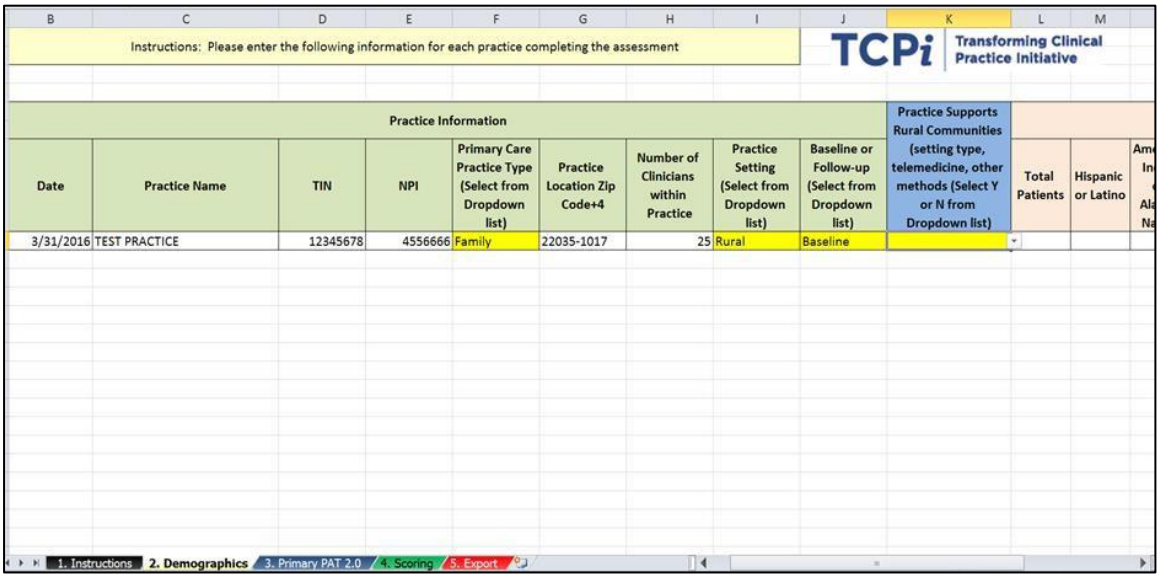


The grey tab is the Instructions, the yellow tab is where you fill in the Demographics, the blue tab (for primary care) or pink tab (for specialist) is where you fill in the PAT score, the green tab is the printable "Scoring" summary and the red tab is to "Export" the values to the Practice Assessment Report Template (PART). A description of the content found on each tab is as follows:

1. Instructions: Read over the instructions to familiarize yourself with the layout and structure for completing the PAT 2.0.

2. Demographics: After you read the instructions, you put in the demographic data for the practice in Tab 2 as shown in Exhibit 13. This is essentially the same process used in PAT 1.0. Some important points to note:
    a. The yellow shaded boxes indicate the use of a drop down selection.
    b. For practices with multiple NPI numbers, enter each number in the NPI box with the number separated by a semi-colon (;).
    c. CMS recognizes the Urban and Rural designation as defined by HRSA.

Exhibit 13 – PAT 2.0 Demographics Tab (Tab 2)



Instructions: Please enter the following information for each practice completing the assessment

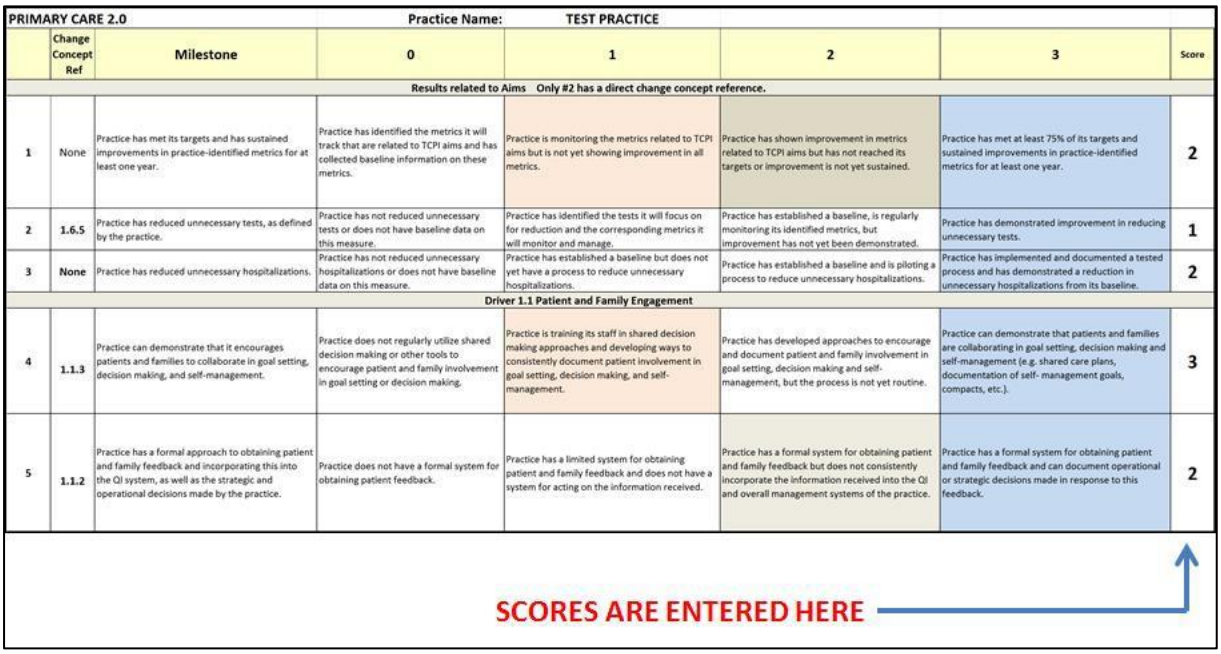
TCPi Transforming Clinical Practice Initiative

Practice Information												
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)	Practice Supports Rural Communities (setting type, telemedicine, other methods (Select Y or N from Dropdown list)	Total Patients	Hispanic or Latino	Am In Al Na
3/31/2016	TEST PRACTICE	12345678	4556666	Family	22035-1017	25	Rural	Baseline				

1. Instructions | 2. Demographics | 3. Primary PAT 2.0 | 4. Scoring | 5. Export

3. Primary or Secondary PAT 2.0: The actual score is entered Tab 3, the Primary Care (or Specialist) tab. Exhibit 14 highlights where the score is entered in the far right column of the tool (column H). The score corresponds to the description that best fits the current state of the practice.

Exhibit 14 – PAT Primary Care (Tab 3)



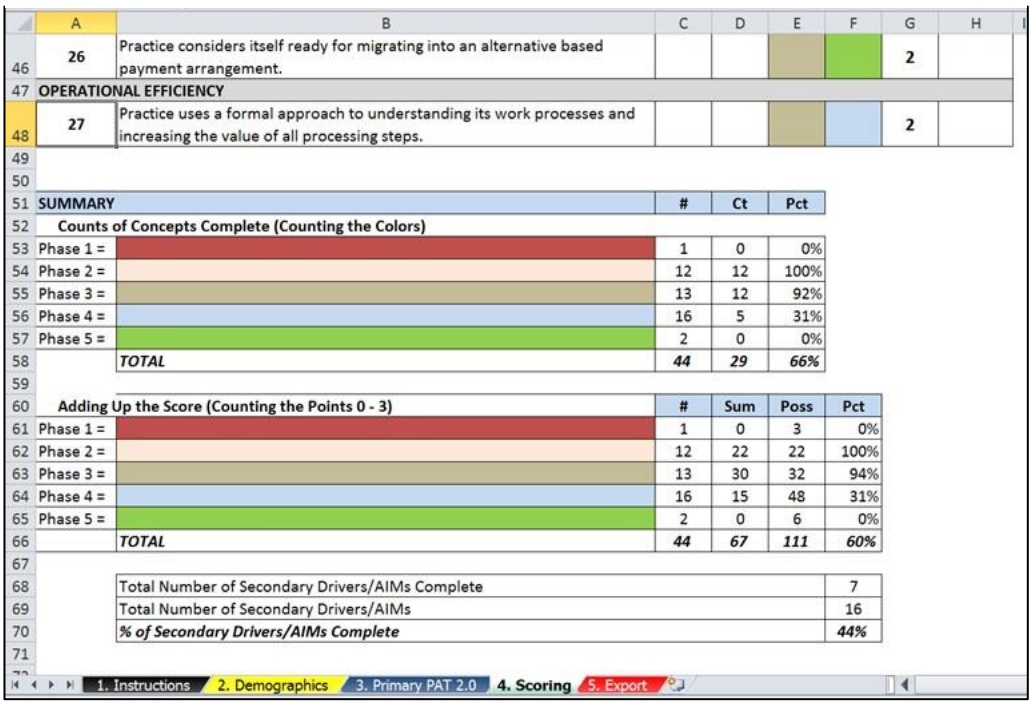
PRIMARY CARE 2.0 Practice Name: TEST PRACTICE

	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
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.	1
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.	2
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.).	3
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.	2

SCORES ARE ENTERED HERE

4. Scoring Summary: Once you have scored the practice, you can print the two-page summary in Tab 4, the scoring summary. Exhibit 15 shows the scores summarized into the three scoring tables discussed earlier.

Exhibit 15 – Three Tables at Bottom of Page 2 of the Scoring Summary (Tab 4)



	A	B	C	D	E	F	G	H
46	26	Practice considers itself ready for migrating into an alternative based payment arrangement.					2	
47	OPERATIONAL EFFICIENCY							
48	27	Practice uses a formal approach to understanding its work processes and increasing the value of all processing steps.					2	

	SUMMARY		#	Ct	Pct
52	Counts of Concepts Complete (Counting the Colors)				
53	Phase 1 =		1	0	0%
54	Phase 2 =		12	12	100%
55	Phase 3 =		13	12	92%
56	Phase 4 =		16	5	31%
57	Phase 5 =		2	0	0%
58		*TOTAL*	*44*	*29*	*66%*

	Adding Up the Score (Counting the Points 0 - 3)		#	Sum	Poss	Pct
61	Phase 1 =		1	0	3	0%
62	Phase 2 =		12	22	22	100%
63	Phase 3 =		13	30	32	94%
64	Phase 4 =		16	15	48	31%
65	Phase 5 =		2	0	6	0%
66		*TOTAL*	*44*	*67*	*111*	*60%*

68	Total Number of Secondary Drivers/AIMs Complete	7
69	Total Number of Secondary Drivers/AIMs	16
70	*% of Secondary Drivers/AIMs Complete*	*44%*

1. Instructions | 2. Demographics | 3. Primary PAT 2.0 | 4. Scoring | 5. Export

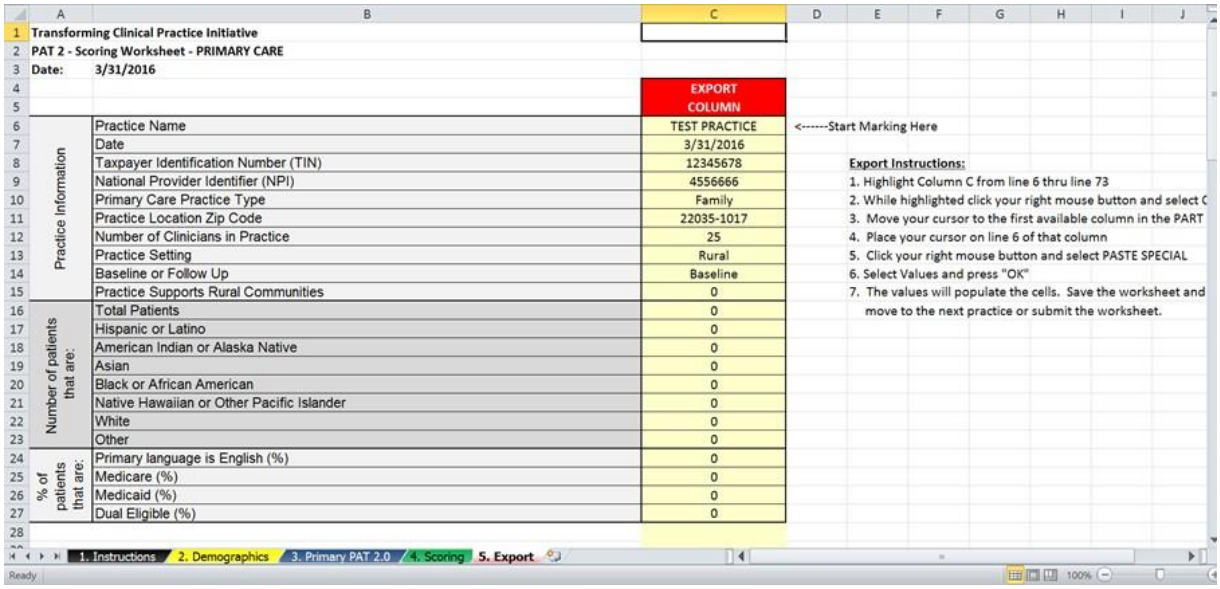
One of the benefits of this version of the PAT 2.0 is its alignment with the change package. All 15 secondary drivers are accounted for with a 16th (the first one) assessing progress on certain aims. If a practice is scored a three on all of the milestones associated with a particular driver, it is reasonable to conclude that the change package driver has been successfully implemented by the practice. When the requirements for each driver are complete, you will see the word "Complete" show up in the "driver status" column on the summary scoring sheet as shown on Exhibit 16. The worksheet counts these and displays the total number of completed drivers at the bottom of page two of the scoring sheet.

Exhibit 16 – Scoring Sheet Showing Completed Drivers

Transforming Clinical Practice Initiative					Name:	TEST PRACTICE	
PAT 2 - Scoring Worksheet - PRIMARY CARE					TIN:	1234567	
Date: 3/31/2016					Type:	Follow-up	
Milestone #	Milestone score: 0= Not Yet; 1=Getting Started; 2=Implementing, Partially Operating; 3=Functioning, Performing	0	1	2	3	Score	Driver Status
AIMS							Complete
1	Practice has met its targets and has sustained improvements in practice-identified metrics for at least one year.					3	
2	Practice has reduced unnecessary tests, as defined by the practice.					3	
3	Practice has reduced unnecessary hospitalizations.					3	
PFE							Complete
4	Practice can demonstrate that it encourages patients and families to collaborate in goal setting, decision making, and self-management.					3	
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	

5. Export: When you are ready, select tab 5 and copy and paste your results to the Practice Assessment Report Template. The instructions for this are shown on Tab 5. Exhibit 17 shows the Export Tab which is where you will select the information to copy. **Please note, this step is only relevant to the PTNs.**

Exhibit 17 – Date Export Tab (Tab 5)



1	Transforming Clinical Practice Initiative		
2	PAT 2 - Scoring Worksheet - PRIMARY CARE		
3	Date: 3/31/2016		
4			
5		EXPORT COLUMN	
6	Practice Information	Practice Name	TEST PRACTICE
7		Date	3/31/2016
8		Taxpayer Identification Number (TIN)	12345678
9		National Provider Identifier (NPI)	4556666
10		Primary Care Practice Type	Family
11		Practice Location Zip Code	22035-1017
12		Number of Clinicians in Practice	25
13		Practice Setting	Rural
14		Baseline or Follow Up	Baseline
15		Practice Supports Rural Communities	0
16	Number of patients that are:	Total Patients	0
17		Hispanic or Latino	0
18		American Indian or Alaska Native	0
19		Asian	0
20		Black or African American	0
21		Native Hawaiian or Other Pacific Islander	0
22		White	0
23		Other	0
24	% of patients that are:	Primary language is English (%)	0
25		Medicare (%)	0
26		Medicaid (%)	0
27		Dual Eligible (%)	0
28			

<----Start Marking Here

Export Instructions:
1. Highlight Column C from line 6 thru line 73
2. While highlighted click your right mouse button and select C
3. Move your cursor to the first available column in the PART
4. Place your cursor on line 6 of that column
5. Click your right mouse button and select PASTE SPECIAL
6. Select Values and press "OK"
7. The values will populate the cells. Save the worksheet and move to the next practice or submit the worksheet.

1. Instructions | 2. Demographics | 3. Primary PAT 2.0 | 4. Scoring | 5. Export

After selecting the Export tab, you are now ready to begin the process of putting the practice information into the PART. The following describes that process.

II. Practice Assessment Report Template (PART) 2.0

NOTE: The remainder of this guide is relevant to PTNs, only. QIN-QIOs should follow the instructions for submitting deliverables to DDST, as outlined in an attachment to a listserv message distributed by the QINNCC on Wednesday, April 6, 2016.

A. Accessing the PART 2.0

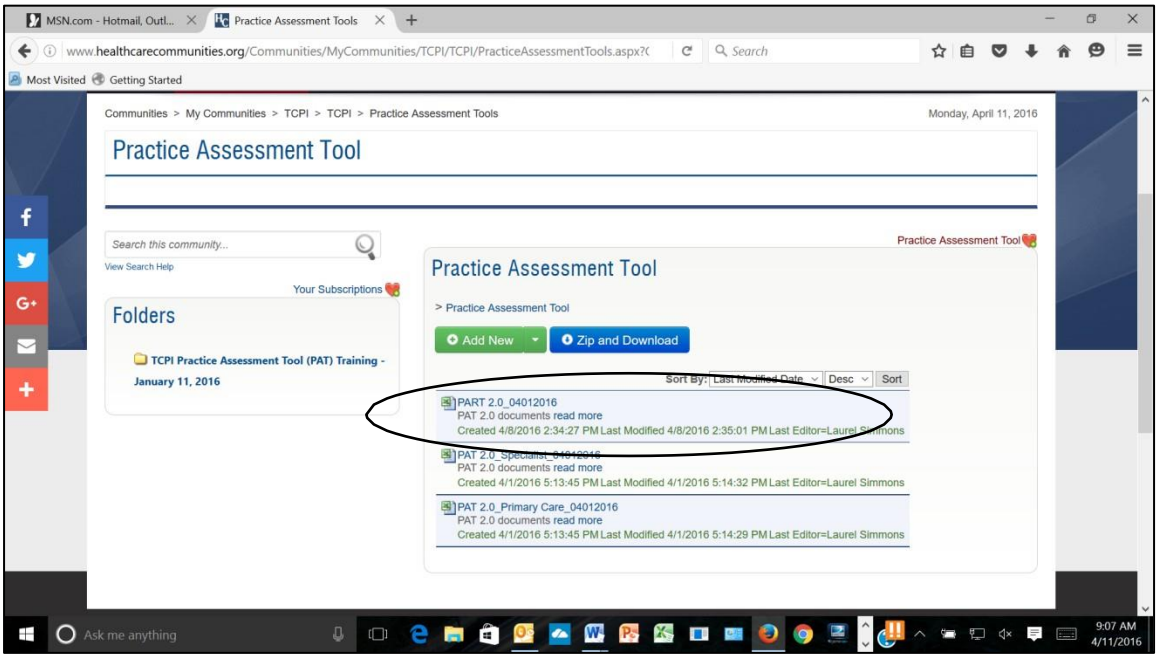
1. Open a browser and enter or click on the following URL in the address bar:

   http://www.healthcarecommunities.org/Communities/MyCommunities/TCPI/TCPI/PracticeAssessmentTools.aspx?CategoryId=831909&EntryId=91536

   (Communities > My Communities > TCPI > TCPI > Practice Assessment Tools)

2. Select the Excel File PART2.0_4012016.

Exhibit 18 – The PART 2.0 File on Healthcarecommunities.org



B. Naming Conventions

1. After downloading your Templates, rename your PTN PART file using the following naming convention: [**Your PTN Acronym**]**_PART_MMYYYY.xls**
2. Use the acronym provided in Table 1 to identify your PTN in the fields indicated in the above naming conventions

Table 1: PTN Acronym Naming Conventions

PTN Name	PTN Acronym
Arizona Health-e Connection	AZHEC
Baptist Health Systems, Inc.	BHSALA
Children's Hospital of Orange County	CHOC
Community Care of North Carolina, Inc.	CCNC
Community Health Center Association of Connecticut, Inc.	CHCACT
Consortium for Southeastern Hypertension Control	COSEHC
Colorado Department of Health Care Policy & Financing	Colorado
Health Partners Delmarva, LLC	HPD
Iowa Healthcare Collaborative	IHC
Local Initiative Health Authority of Los Angeles County	LA
Maine Quality Counts	MQC
Mayo Clinic	Mayo
National Council for Behavioral Health	NatCouncil
National Rural Accountable Care Consortium	NRACO
New Jersey Innovation Institute	NJII
New Jersey Medical & Health Associates dba CarePoint Health	CarePoint
New York eHealth Collaborative	NYeC

PTN Name	PTN Acronym
New York University School of Medicine	NYU
Pacific Business Group on Health	PBGH
PeaceHealth Ketchikan Medical Center	PeaceHealth
Rhode Island Quality Initiative	RIQI
The Trustees of Indiana University	IU
University of Massachusetts Medical School	UMass
University of Washington	UofWash
Vanderbilt University Medical Center	Vand
Vizient (VHA/UHC Alliance Newco, Inc.)	VHAUHC
VHQC	VHQC
VHS Valley Health Systems, LLC	VHS
Washington State Department of Health	WDOH

C. Filling Out the Practice Assessment Report Template (PART)

1. Select the file **PART 2.0_04012016.xls**
2. Rename the file using the following naming convention: [**Your PTN Acronym]_PART_MMYYYY.xls**
3. Open the PTN PART Template

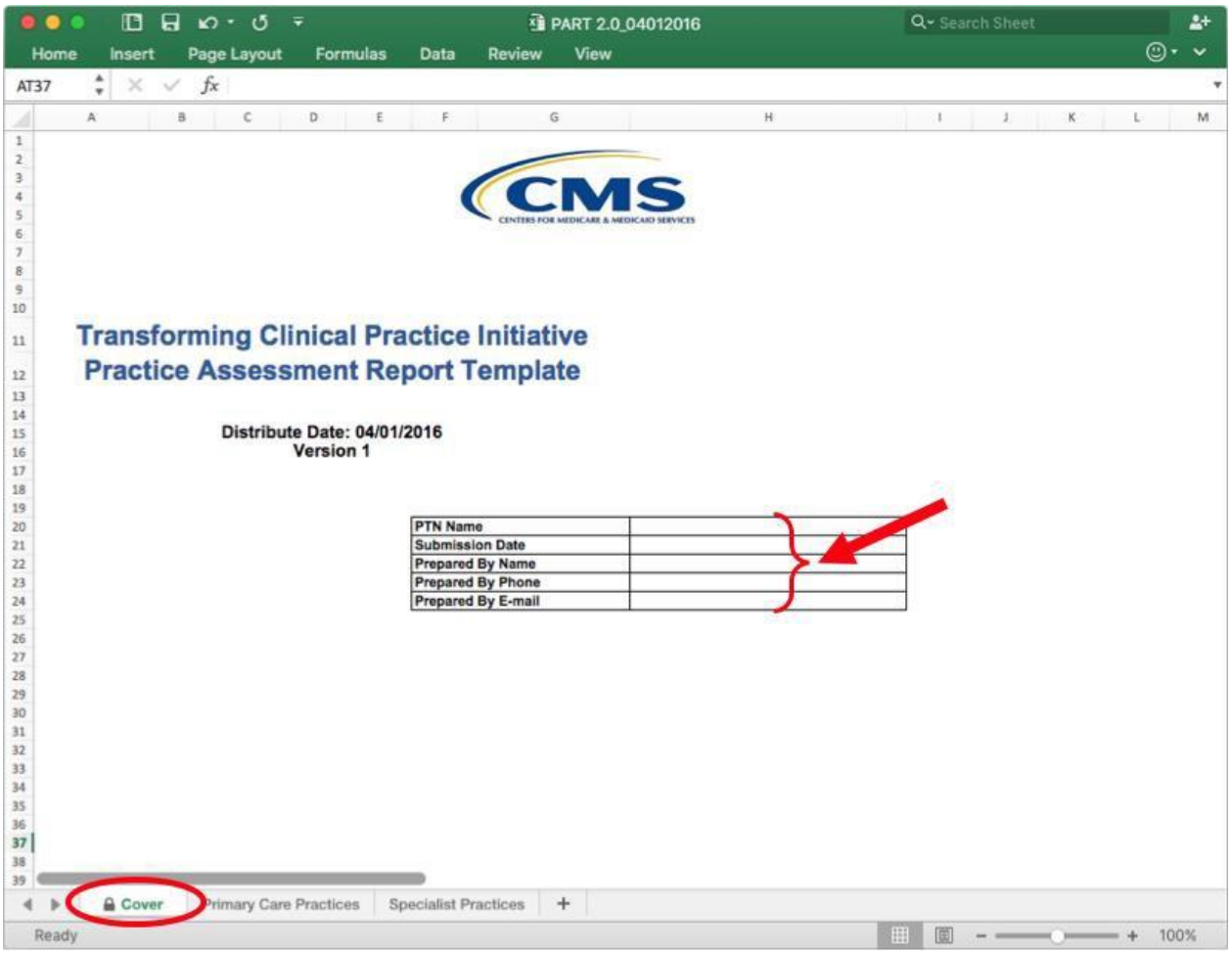
The spreadsheet will open on the *Cover* tab

4. On Row 20, fill in your "PTN Name", using the PTN acronym provided in Table 1 on the previous page.
5. On Row 21, fill in the "Submission Date" in Column H using the naming convention: MM/DD/YY
6. On Row 22, fill in the "Prepared By Name" in Column H with the first and last name of the person preparing the PTN's PART for submission

7. On Row 23, fill in the "Prepared By Phone" Number with the Phone Number of the person listed as the preparer in Column H, using the naming convention: (555) 555-5555
8. On Row 24, fill in the "Prepared By E-mail" with the E-mail Address of the person listed as the preparer in Column H

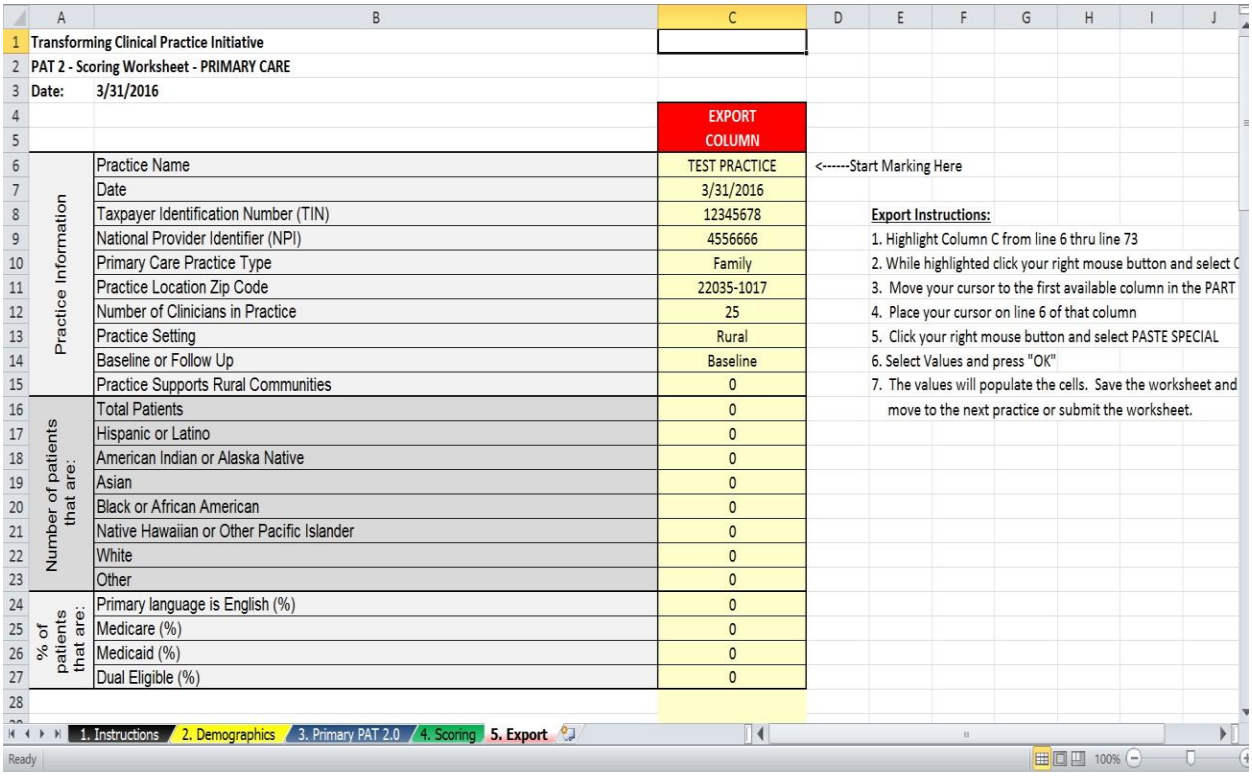
Step 4 through Step 8 are shown in **Exhibit 19**

Exhibit 19: PART Cover Tab



9. Click on either the *Primary Care Practices* **or** *Specialist Practices* tab as applicable to the type of practice assessment you will be transferring from your PAT 2.0 to the PART
10. Copy the export column from your PAT 2.0 as shown in Exhibit 20.

Exhibit 20: Copying PAT Results



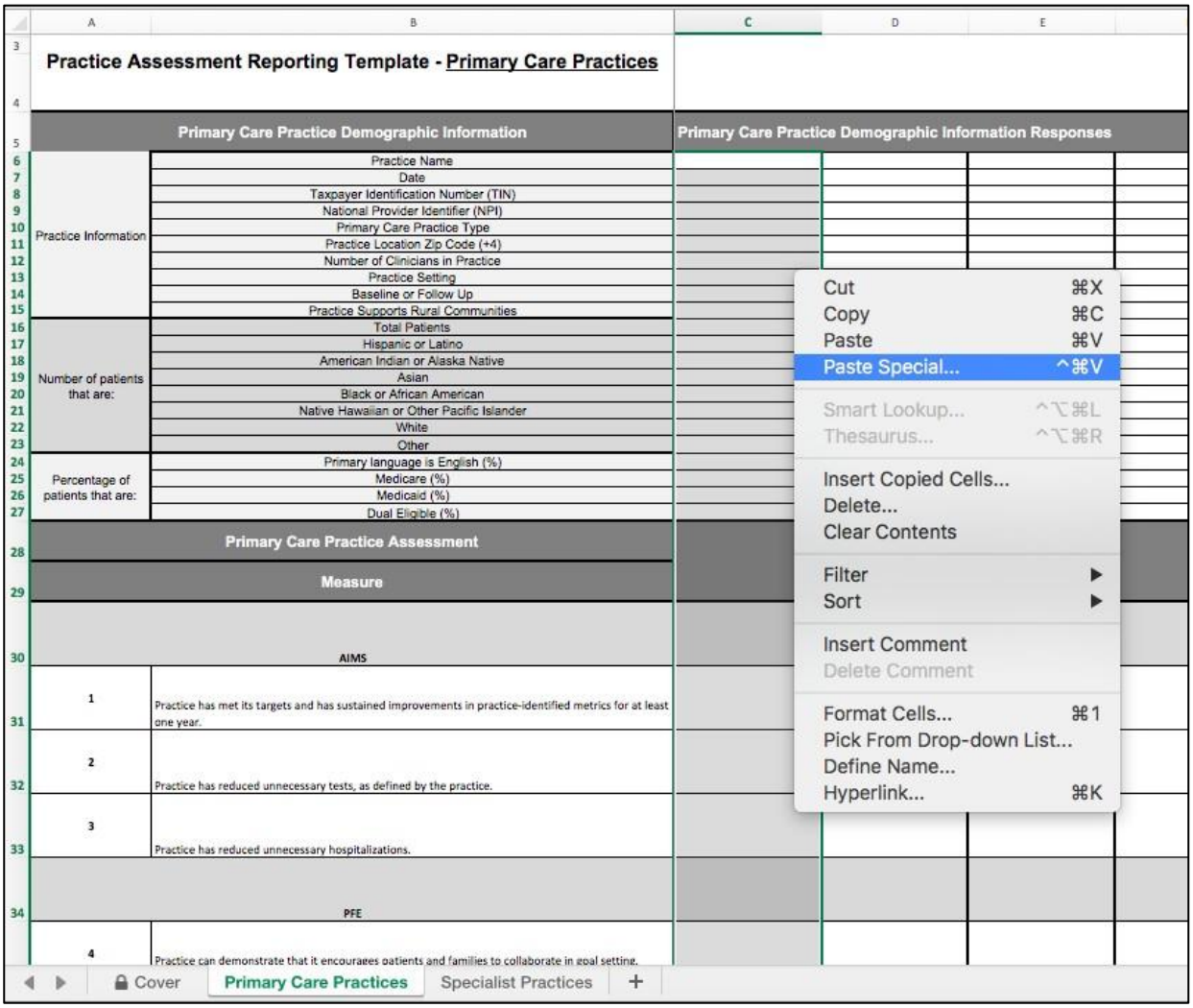
	A	B	C	D	E	F	G	H	I	J
1	Transforming Clinical Practice Initiative									
2	PAT 2 - Scoring Worksheet - PRIMARY CARE									
3	Date:	3/31/2016								
4			EXPORT COLUMN							
5										
6	Practice Information	Practice Name	TEST PRACTICE	<------Start Marking Here						
7		Date	3/31/2016							
8		Taxpayer Identification Number (TIN)	12345678	Export Instructions:						
9		National Provider Identifier (NPI)	4556666	1. Highlight Column C from line 6 thru line 73						
10		Primary Care Practice Type	Family	2. While highlighted click your right mouse button and select C						
11		Practice Location Zip Code	22035-1017	3. Move your cursor to the first available column in the PART						
12		Number of Clinicians in Practice	25	4. Place your cursor on line 6 of that column						
13		Practice Setting	Rural	5. Click your right mouse button and select PASTE SPECIAL						
14		Baseline or Follow Up	Baseline	6. Select Values and press "OK"						
15		Practice Supports Rural Communities	0	7. The values will populate the cells. Save the worksheet and						
16	Number of patients that are:	Total Patients	0	move to the next practice or submit the worksheet.						
17		Hispanic or Latino	0							
18		American Indian or Alaska Native	0							
19		Asian	0							
20		Black or African American	0							
21		Native Hawaiian or Other Pacific Islander	0							
22		White	0							
23		Other	0							
24	% of patients that are:	Primary language is English (%)	0							
25		Medicare (%)	0							
26		Medicaid (%)	0							
27		Dual Eligible (%)	0							
28										

1. Instructions | 2. Demographics | 3. Primary PAT 2.0 | 4. Scoring | 5. Export

Ready 100%

11. Select the next open column in either the PART's Primary Care or Specialist tab (as applicable), shown in **Exhibit 21.**
    a. Begin pasting in Column C of the PART Primary Care or Specialist tab. As you include subsequent PAT results, choose the next column to the right, Column D, then Column E, and so forth.

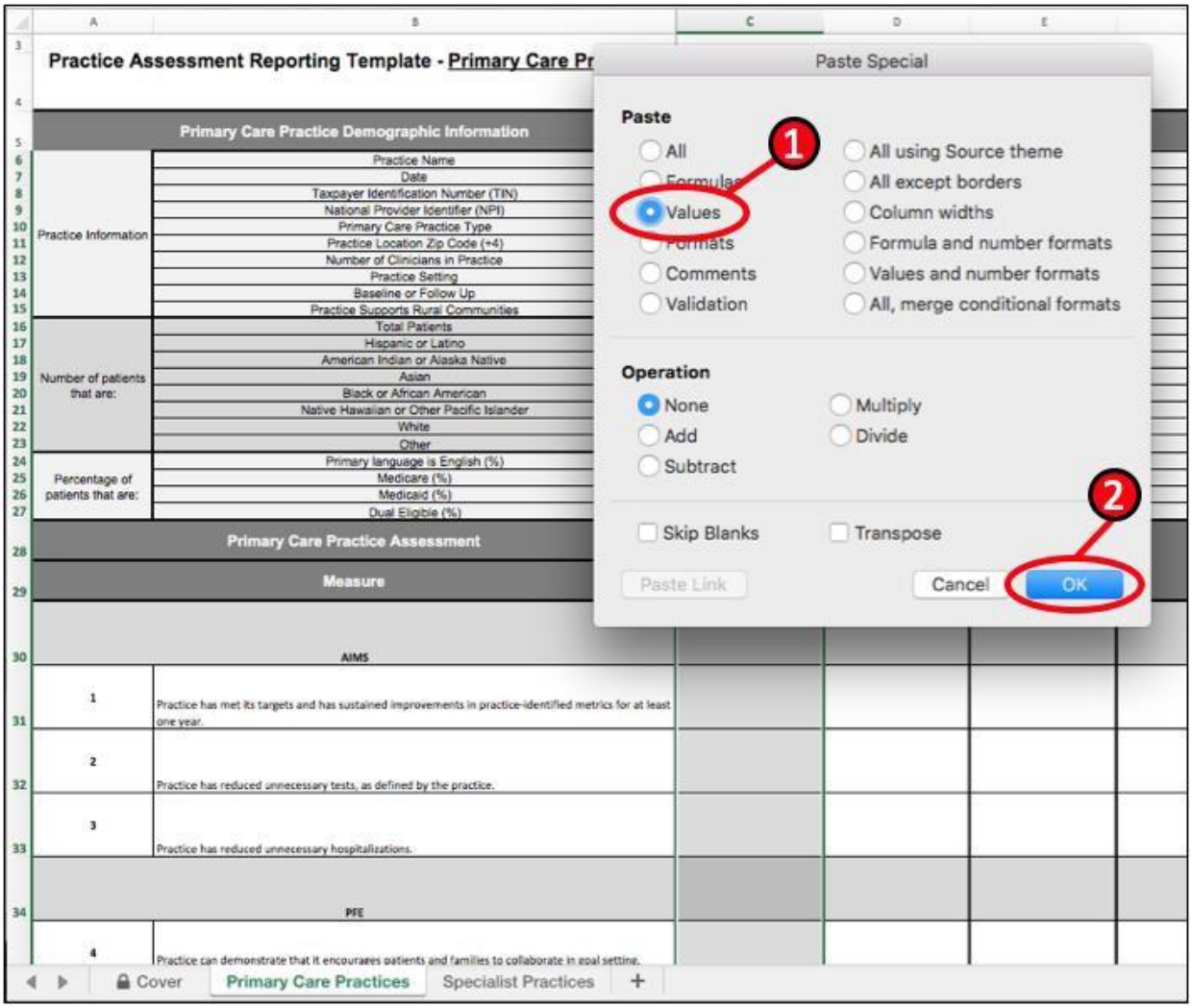
Exhibit 21: Selecting the Column in the PART



12. Right click on and choose “Paste Special”

13. Select "Values" under the Paste menu and then "OK" to populate the cells with the PAT results

Exhibit 22: Pasting PAT 2.0 Results



14. Copy and Paste Special each PAT 2.0 into the columns in the PART Primary Care or Specialist Tab, as appropriate (See **Exhibit 23**)

Exhibit 23: Pasting Multiple PAT 2.0 Results

Practice Assessment Reporting Template - Primary Care Practices

		Primary Care Practice Demographic Information	Primary Care Practice Demographic Information Responses		
Practice Information		Practice Name	TEST PRACTICE	SAMPLE PRACTICE	
		Date	3/31/16	3/31/16	
		Taxpayer Identification Number (TIN)	12345678	87654321	
		National Provider Identifier (NPI)	4556666	6778888	
		Primary Care Practice Type	Family	Pediatric	
		Practice Location Zip Code (+4)	22035-1017	20005-1234	
		Number of Clinicians in Practice	25	14	
		Practice Setting	Rural	Urban	
		Baseline or Follow Up	Baseline	Baseline	
		Practice Supports Rural Communities	No	No	
Number of patients that are:		Total Patients	0	0	
		Hispanic or Latino	0	0	
		American Indian or Alaska Native	0	0	
		Asian	0	0	
		Black or African American	0	0	
		Native Hawaiian or Other Pacific Islander	0	0	
		White	0	0	
		Other	0	0	
Percentage of patients that are:		Primary language is English (%)	0.00	0.00	
		Medicare (%)	0.00	0.00	
		Medicaid (%)	0.00	0.00	
		Dual Eligible (%)	0.00	0.00	
Primary Care Practice Assessment					
Measure					
AIMS				Complete	
1	Practice has met its targets and has sustained improvements in practice-identified metrics for at least one year.		2	3	
2	Practice has reduced unnecessary tests, as defined by the practice.		1	3	
3	Practice has reduced unnecessary hospitalizations.		2	3	
PFE				Complete	
4	Practice can demonstrate that it encourages patients and families to collaborate in goal setting, decision making, and self-management.		3	3	
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.		2	3	

Cover | Primary Care Practices | Specialist Practices | +

15. Save the file (making sure to use the naming convention: [Your PTN Acronym]_PART_MMYYYY as described in **Step 2**)

D. Submitting PART File

1. To submit your PART file, you will first confirm that you have saved the file using the naming convention: [**Your PTN Acronym**]**_PART_MMYYYY.**

If you have filled in more than one PART file to accommodate the submission of more than 100 assessments in a given month, please be sure to upload all of these files at the same time in a single submission

2. Open your internet browser. Enter the following URL into the address bar:
3. http://www.healthcarecommunities.org/Communities/MyCommunities/TCPI/PTNSANStaff/DataHu b.aspx

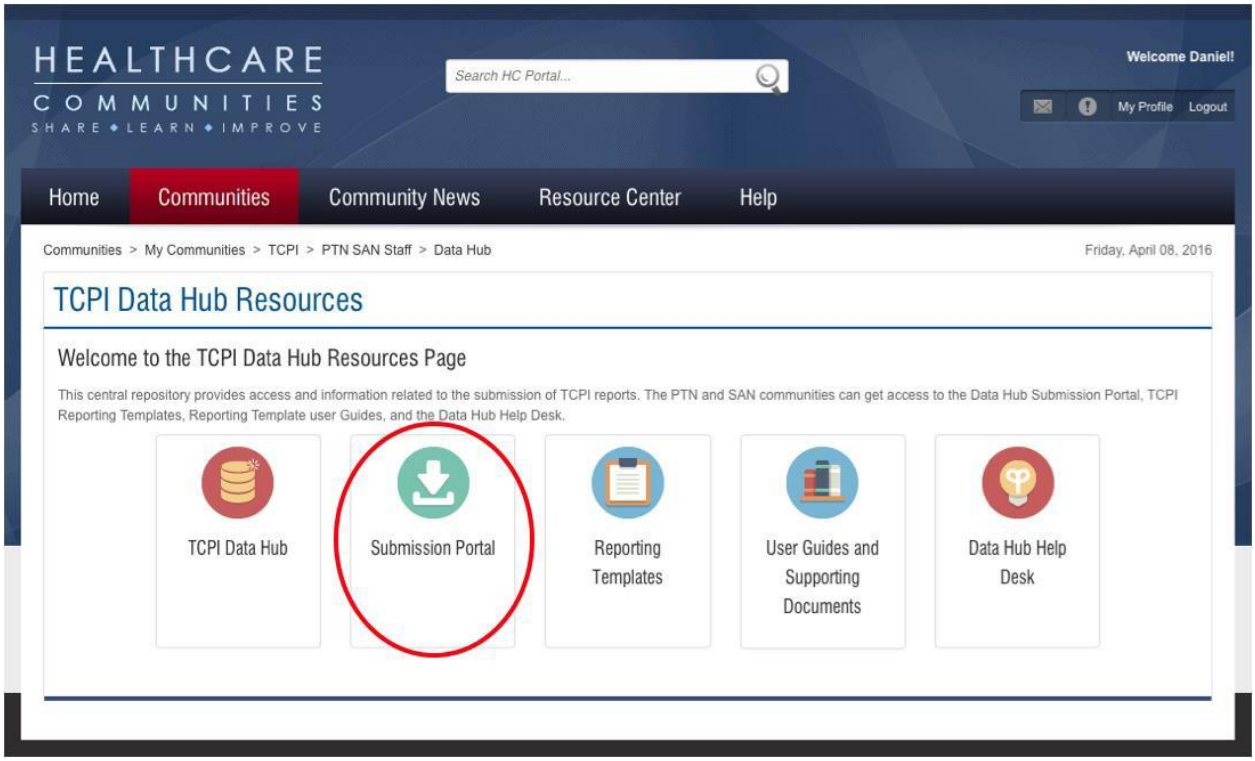
Press *Enter* on your keyboard

Or go to: www.healcarecommunities > My Communities > TCPI > PTN SAN Staff > Data Hub

The user will be directed to the Healthcare Communities website's TCPI Data Hub Resources page.

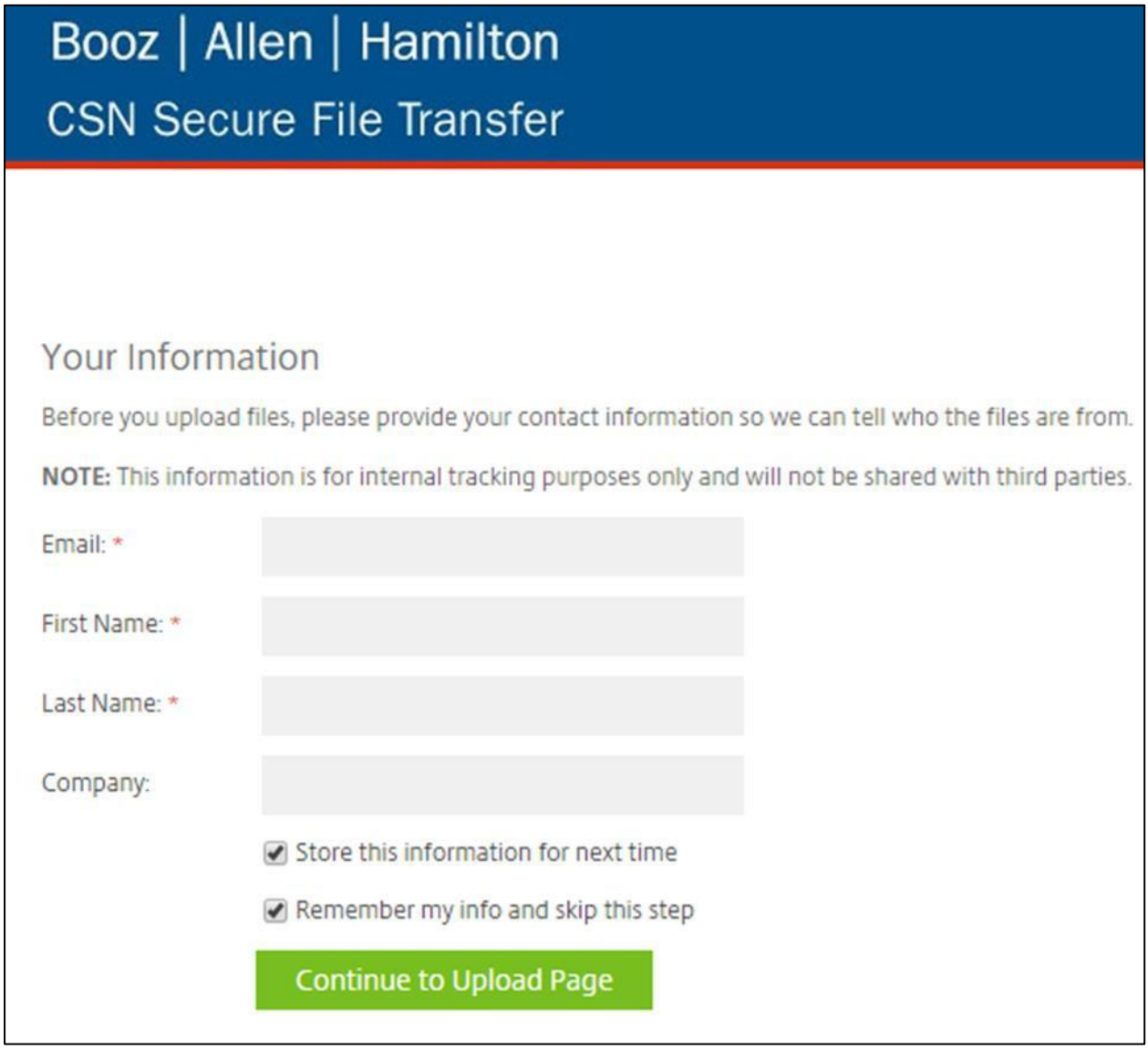
4. Click on the Submission Portal icon, shown in Exhibit 24.

Exhibit 24: TCPI Data Hub Resources Page, Submission Portal Icon



The user will be directed to Booz Allen Hamilton's CSN Secure File Transfer website, shown in Exhibit 25.

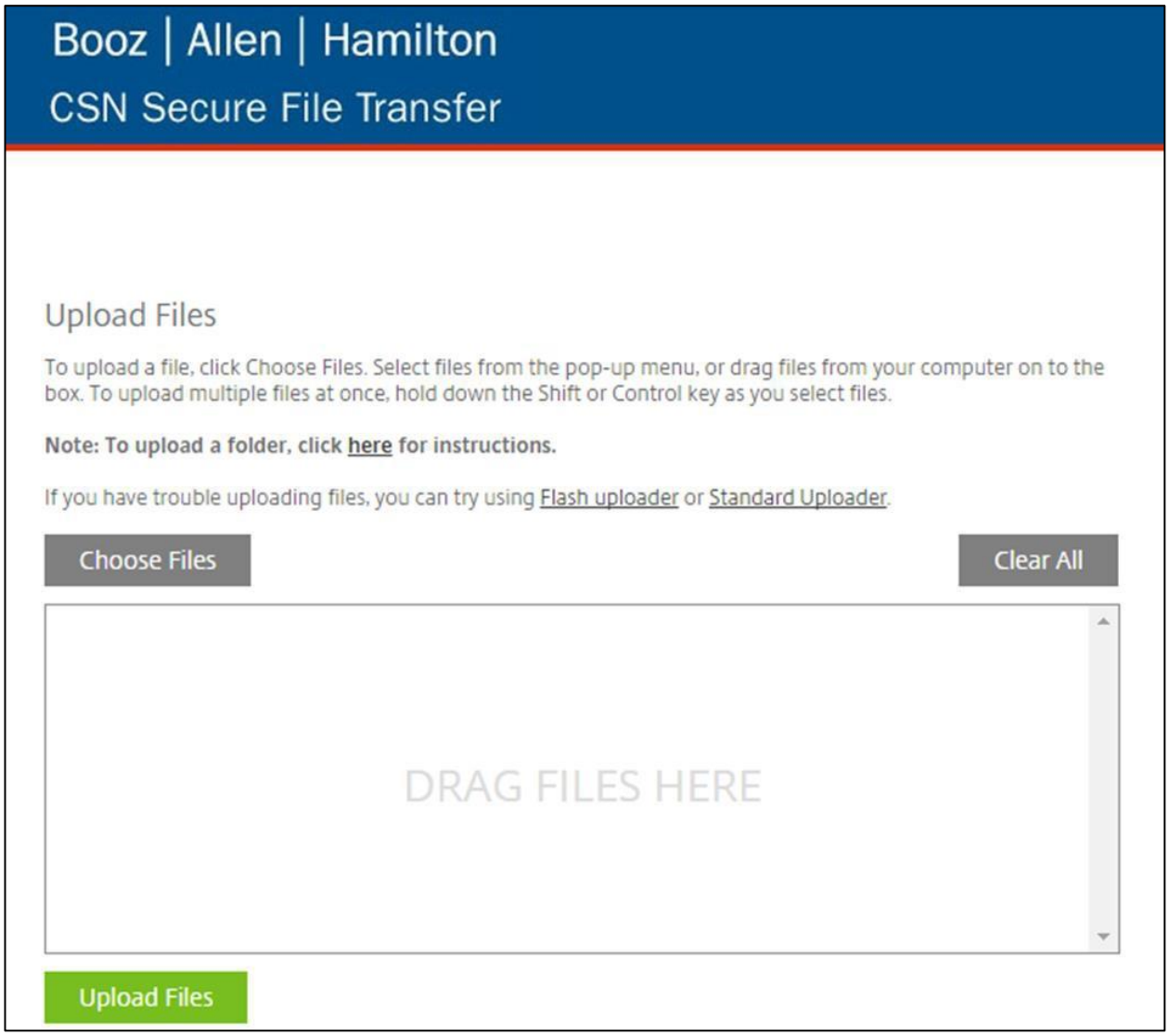
Exhibit 25: Booz Allen Hamilton CSN Secure File Transfer Page, Your Information



5. Enter the information shown in Exhibit 25, used for tracking purposes only:
   a. User's "Email" address
   b. User's "First Name"
   c. User's "Last Name"
   d. User's "Company", referring to your PTN name, using the PTN acronym provided in Table 5 of this document
   e. Select "Store this information for next time" to ensure the fields are populated during your next session
   f. Select "Remember my info and skip this step" to ensure you are automatically logged into the Submission portal

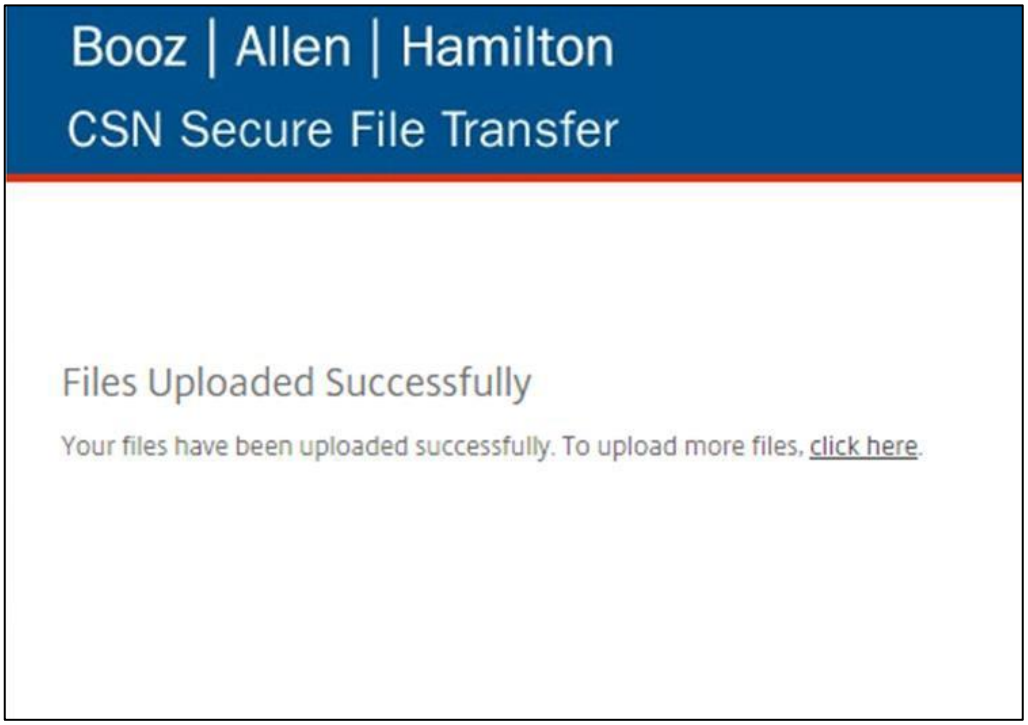
6. Click “Continue to Upload Page”
7. On the Upload Page, drag the file from your computer to the field that reads “Drag Files Here” s shown in Exhibit 26

Exhibit 26: Booz Allen Hamilton CSN Secure File Transfer Page, Upload Files



8. When you see your file in the field, click “Upload Files”
9. When your submission is uploaded, you will see the following screen indicating that “Your files have been uploaded successfully”, shown in Exhibit 27

Exhibit 27: Booz Allen Hamilton CSN Secure File Transfer Page, Successful Upload Notification



Thank you for submitting your data!

E. Data Reporting & Submission Help Desk Support

If you have questions regarding your data reporting that is not addressed in the User Guides, the FAQs, by reviewing recordings of the Practice Assessment Reporting Template training, or your CMS Project Officer, the Data Support and Feedback Report (DSFR) Team Help Desk is here to help you. You may contact the DSFR Team Help Desk by emailing DSFR-Help@bah.com with the following information:

- Your PTN Name, using the PTN acronym provided in Table 5 of this document
- The Submitter Name, using the first and last name of the person requesting support from the Help Desk
- The Submitter's E-mail Address
- The Submitter's Phone Number
- Description of the request

The DSFR Team Help Desk can also be reached at (844) 341-2481. Please be sure to include the same information listed above in your voicemail.

The DSFR Team Help Desk is available from 8:30am to 6:30pm EST on weekdays, excluding Federal Holidays, and will respond to all requests within 24 (weekday) hours.

III. Support for PAT Completion, Reporting, and Data Submission

We hope that this User Guide is able to address any questions you may have regarding completion of the PAT or about how the results are to be reported. FAQs and recordings of the Practice Assessment Reporting Template training are also available on the TCPI portal.

A. For PTN's

Should you still have questions after consulting these resources, you can direct these questions to the TCPI Solutions Center, accessed by clicking the Solutions Center button found on each community's home page. The Solutions Center can also be accessed by sending an email to Help@healthcarecommunities.org. The email should include your PTN name, your contact information, and your question or request.

B. For QIN/QIO's

Questions can be directed to questions the NCC at the following link:

https://app.smartsheet.com/b/form?EQBCT=29409b7777374d8c9e62fe742af2c500