Instructions: Please enter as much of the following information as possible prior to completing the assessment.

Practice Information									Practice Supports Rural Communities (setting-type, tele-medicine, other methods) (Yes or No)
Date	**Location Name**	**TIN**	**NPI**	**Primary Care Practice Type**	**Practice Location Zip Code**	**Number of Clinicians within the Practice**	**Practice Setting (Rural, Urban, Suburban, Mix)**	**Baseline or Follow-up**	
(Ex.) 11/18/2015	Family Healthcare	12-3456789	1234567893	Neurology	12345	35	Suburban	Baseline	N

Patient Demographics												
Number of Patients that are:								**Percentage of patients that are:**				
Total Patients	**Hispanic or Latino**	**American Indian or Alaska Native**	**Asian**	**Black or African American**	**Native Hawaiian or Other Pacific Islander**	**White**	**Other**	**Primary language is English (%)**	**Medicare (%)**	**Medicaid (%)**	**Dual Eligible (%)**	**Living below poverty line (%)**
(Ex.) 3500	845	25	145	752	13	1717	3	80%	23%	32%	3%	27%

Transforming Clinical Practice Initiative Assessment (Primary Care Practices)
Final Version

Phase	Milestone Description	0	1	2	3	Response
1.1	Practice has submitted a plan within one month of joining Practice Transformation Network (PTN) that addresses specific goals of transformation, including aims.	Practice has not yet begun developing a detailed plan that addresses goals of transformation with specific aims.	Practice is beginning to develop a detailed plan that addresses goals of transformation with aims but plan is not yet detailed and aims are not yet specific.	Practice has developed a detailed plan that addresses goals of transformation with specific aims but is not ready to submit the plan.	Practice has developed [and submitted] a detailed plan that addresses goals of transformation with specific aims or can submit this plan upon request.	
1.2	Practice starts to perform a self-assessment and starts to collect baseline data on utilization and other quality and outcome measures and identifies problem areas for improvement.	Practice is not yet conducting self-assessments or collecting baseline data on utilization, quality or outcome measures. Practice is not identifying problem areas for improvement.	Practice is in the planning stage of developing a self-assessment and collecting baseline data on utilization, quality and outcome measures. Practice is planning how to identify problem areas for improvement.	Practice has performed a self-assessment but has yet to collect baseline data on utilization and other quality and outcome measures or identify problem areas for improvement.	Practice has performed a self-assessment and is collecting baseline data on utilization and other quality and outcome measures and is identifying problem areas for improvement.	
1.3	Practice trains > 50% of staff in improvement methods and tools (e.g. PDSA, Six Sigma, etc.).	Practice has not trained staff in improvement methods and tools.	Practice has begun training but has trained less than 25% of staff in improvement methods and tools.	Practice has trained greater than 25% of staff, but less than 50% of staff, in improvement methods and tools.	Practice has trained greater than 50% of staff in improvement methods and tools.	
1.4	Practice uses data to identify methods to reduce health care disparities.	Practice does not use data to identify methods to reduce health care disparities.	Practice collects data but has not identified methods to reduce health care disparities.	Practice collects data and is beginning to identify methods to reduce health care disparities.	Practice uses data and identifies methods that reduce health care disparities within the practice' population.	
1.5	Practice establishes measures, plans and a baseline for intentionally minimizing unnecessary testing and procedures, aligning where possible with "Choosing Wisely" measures (http://www.choosingwisely.org/about-us/).	Practice has not established any measures, plans or baselines for minimizing unnecessary testing and procedures.	Practice is in planning stage of establishing measures, plans and a baseline for minimizing unnecessary testing and procedures.	Practice is in the implementation phase of establishing measures, plans and baselines for minimizing unnecessary testing and procedures.	Practice has established measures, plans and a baseline for minimizing unnecessary testing and procedures.	
1.6	Staff understands the process of improvement and testing changes in workflows and is trained on optimal team-based practice.	Staff does not understand the process of improvement and testing changes in workflows and is not trained on optimal team-based practice.	Staff is beginning to understand the process of improvement and testing changes in workflows and begins to be trained on optimal team-based practice.	Staff better understands the process of improvement and testing changes in workflows and continues to be trained on optimal team-based practice.	Staff fully understands the process of improvement and testing changes in workflows and is fully trained on optimal team-based practice.	
1.7	Practice has established a systematic method for addressing and meeting the needs of patients/families to be active partners in care through measures of participation.	Practice has no mechanisms in place for addressing the needs of their patients/families to be active partners in care.	Practice is developing mechanisms for capturing information about what their patients/families perceive are their needs with the goal of becoming active partners in care.	Practice is implementing mechanisms to ensure that captured needs are being reviewed as part of the improvement initiative in order for patients/families to be active partners in care.	Practice has established a systematic method for addressing and meeting the needs of patients/families to be active partners in care through measures of participation.	
Phase 1 average score						

Transforming Clinical Practice Initiative Assessment (Primary Care Practices)
Final Version

Phase	Milestone Description	0	1	2	3	Response
2.1	Practice produces real time reports on how providers and/or care teams are meeting quality, financial and/or utilization goals to enhance patient experience of care, eliminate waste and decrease costs.	Practice does not produce real time reports on how providers and/or care teams are meeting quality, financial and/or utilization goals.	Practice is in the planning stage of capturing information on how providers and/or care teams are meeting quality, financial and/or utilization goals to enhance patient experience of care, eliminate waste and decrease costs.	Practice collects data but has yet to begin producing real time reports on how providers and/or care teams are meeting quality, financial and/or utilization goals to enhance patient experience of care, eliminate waste and decrease costs.	Practice produces real time reports on how providers and/or care teams are meeting quality, financial and/or utilization goals to enhance patient experience of care, eliminate waste and decrease costs.	
2.2	Practice develops plan to incorporate Meaningful Use (MU) into their operational redesign.	Practice does not have plans to incorporate MU into their operational redesign.	Practice is developing plans to incorporate MU into their operational redesign.	Practice is piloting plan to incorporate MU into their operational redesign.	Practice has implemented a tested plan to incorporate MU into their operational redesign.	
2.3	Practice has identified community partners and other points of care that their patients are using and has a formal agreement in place with these partners.	Practice has not identified community partners and other points of care that their patients are using.	Practice has identified community partners and other points of care that their patients are using but has no formal agreement in place with these partners yet.	Practice has identified and reached out to community partners and other points of care that their patients are using and is now formalizing agreements with these partners.	Practice has identified community partners and other points of care that their patients are using and has a formal agreement in place with these partners.	
2.4	Practice has defined improvements in care transition and processes enabled through exchange of essential health information to eliminate waste and decrease costs.	Practice has not defined improvements in care transition and processes enabled through exchange of essential health information to eliminate waste and decrease costs.	Practice has developed a plan to define improvements in care transition and processes enabled through exchange of essential health information to eliminate waste and decrease costs.	Practice beginning to define improvements in care transition and processes enabled through exchange of essential health information to eliminate waste and decrease costs and is working to make improvements.	Practice has clearly defined improvements in care transitions and clear processes enabled through exchange of essential health information to eliminate waste and decrease costs.	
2.5	At least 50% of the practice's patients have a main clinical point of contact at the practice for their health care needs (i.e. empanelment to provider and care teams).	None of the practice's patients have a main clinical point of contact at the practice for their health care needs and practice has no means of creating one.	Practice has begun work to create point of contact for patients but less than 25% of the practice's patients have a main clinical point of contact at the practice for their health care needs (i.e. empanelment to provider and care teams).	Between 25%-49.99% of the practice's patients have a main clinical point of contact at the practice for their health care needs (i.e. empanelment to provider and care teams).	At least 50% of the practice's patients have a main clinical point of contact at the practice for their health care needs (i.e. empanelment to provider and care teams).	
2.6	Practice provides care management to at least 50% of patients at highest risk of hospitalizations and/or complications from chronic conditions (those that are clinically unstable).	Practice has no method for defining or identifying patients at highest risk of hospitalizations and/or complications from chronic conditions.	Practice can identify at least one type of patient at high risk of hospitalization and/or complications from chronic conditions and is planning care management services for the population.	Practice can identify more than one type of patient population at high risk of hospitalization and/or complications from chronic conditions and is developing care management strategies for each.	At least 50% of the practice's patients at highest risk of hospitalization and/or complications from chronic conditions receive care management services.	
2.7	Practice implements at least three specific care management strategies for patients in higher risk cohorts, examples may include, but are not limited to: o Integration of behavioral health o Self-management support for at least three high risk conditions o Medication management and review	Practice has not implemented any specific care management strategies for patients in higher risk cohorts.	Practice has implemented one specific care management strategy for patients in higher risk cohorts.	Practice has implemented two specific care management strategies for patients in higher risk cohorts.	Practice has implemented three or more specific strategies for patients in higher risk cohorts.	

Phase	Milestone Description	0	1	2	3	Response
2.8	Monthly reporting for PTN review includes updating information about the practice's risk stratification methodology, empanelment status, risk stratification data, and other activities.	Practice is not prepared to report monthly on the practice's risk stratification methodology, empanelment status, risk stratification data, or other activities.	Practice is developing a plan to report monthly on the practice's risk stratification methodology, empanelment status, risk stratification data, and other activities.	Practice is nearly prepared to report monthly on the practice's risk stratification methodology, empanelment status, risk stratification data, and other activities.	Practice is fully prepared to report monthly on the practice's risk stratification methodology, empanelment status, risk stratification data, and other activities.	
2.9	Practice will incorporate regular improvement methodology to execute change ideas in a rapid cycle and uses a plan-do-study-act (PDSA) quality improvement cycle of small scale tests of change in the practice setting.	Practice does not incorporate regular improvement methodology to execute change ideas in a rapid cycle and does not use a PDSA quality improvement cycle of small scale tests of change in the practice setting.	Practice is planning how to incorporate regular improvement methodology to execute change ideas in a rapid cycle and planning how to use a PDSA quality improvement cycle of small scale tests of change in the practice setting.	Practice is beginning to incorporate regular improvement methodology to execute change ideas in a rapid cycle and the use of a PDSA quality improvement cycle of small scale tests of change in the practice setting.	Practice fully incorporates regular improvement methodology to execute change ideas in a rapid cycle and uses a PDSA quality improvement cycle of small scale tests of change in the practice setting.	
2.10	Practice uses data to analyze potential disparities in care and develops action plans to identify individual patients needing intervention to improve overall practice performance.	Practice does not collect data on disparities of care and/or develop action plans to identify individual patients needing intervention.	Practice is planning data collection on disparities of care in order to develop action plans to identify individual patients needing intervention to improve overall practice performance.	Practice has begun collecting data on disparities of care and is drafting action plans to identify individual patients needing intervention to improve overall practice performance.	Practice uses data to analyze potential disparities in care and develops action plans to identify individual patients needing intervention to improve overall practice performance.	
Phase 2 average score						

Phase	Milestone Description	0	1	2	3	Response
3.1	Practice is optimizing reports in registry, practice management, or EHR system to drive clinical practice improvement on a monthly basis.	Practice is not optimizing reports in registry, practice management, or EHR system to drive clinical practice improvement on a monthly basis.	Practice is developing a plan to optimize reports in registry, practice management, or EHR system to drive clinical practice improvement on a monthly basis.	Practice has developed a plan to optimize reports in registry, practice management, or EHR system to drive clinical practice improvement, but is not yet doing this on a monthly basis.	Practice is optimizing reports in registry, practice management, or EHR system to drive clinical practice improvement on a monthly basis.	
3.2	Practice has reduced unnecessary tests, as defined by the practice, by at least 25% from baseline, aligning where possible with "Choosing Wisely" measures (http://www.choosingwisely.org/about-us/).	Practice has not reduced unnecessary tests from baseline.	Practice has reduced unnecessary by 0 to 12.49% from baseline.	Practice has reduced unnecessary tests by 12.5%-24.99% from baseline	Practice has reduced unnecessary tests by 25% or more from baseline.	
3.3	Practice has involved patients and/or families in quality improvement initiatives.	The practice has not involved patients and/or families in quality improvement initiatives.	The practice is in the planning process of how to involve patients and/or families in quality improvement initiatives.	The practice is reaching out to patients and/or families for involvement in quality improvement initiatives.	The practice involves patients and/or families in quality improvement initiatives.	
3.4	Practice has involved staff in quality improvement initiatives.	The practice has not involved staff in quality improvement initiatives.	The practice is in the planning process of how to involve staff in quality improvement initiatives.	The practice is reaching out to staff for involvement in quality improvement initiatives.	The practice involves staff in quality improvement initiatives.	
3.5	Practice sets clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes, and accountability.	The practice has set no clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes, and accountability.	The practice is identifying expectations and roles to optimize efficiency, outcomes, and accountability.	The practice has identified relevant expectations and roles for the majority of staff to optimize efficiency, outcomes, and accountability, and is currently communicating these to staff.	The practice is routinely measuring team performance according to expectations and roles to optimize efficiency, outcomes, and accountability.	
3.6	Practice routinely creates and/or maintains shared care plans to incorporate patient preferences and goals in care management processes.	Practice does not create or maintain shared care plans to incorporate patient preferences and goals in care management processes.	Practice is developing a plan to create and/or maintain shared care plans to incorporate patient preferences and goals in care management processes.	Practice has incorporated shared care plans into electronic clinical practice support tools to incorporate patient preferences and goals in care management processes, but the process is not yet routine.	Practice routinely creates and/or maintains shared care plans to incorporate patient preferences and goals in care management processes.	
3.7	Practice routinely utilizes shared decision making tools to incorporate patient preferences and goals in care management processes.	Practice does not utilize shared decision making tools to incorporate patient preferences and goals in care management processes.	Practice is developing a plan to utilize shared decision making tools to incorporate patient preferences and goals in care management processes.	Practice utilizes shared decision making tools to incorporate patient preferences and goals in care management processes, but the process is not yet routine.	Practice routinely utilizes shared decision making tools to incorporate patient preferences and goals in care management processes.	

Phase	Milestone Description	0	1	2	3	Response
3.8	Practice routinely exchanges essential health information with other members of care team outside of the practice.	Practice does not exchange essential health information with other members of care team outside of the practice.	Practice is developing a plan to exchange essential health information with other members of care team outside of the practice.	Practice is establishing formal agreements for sharing information with providers outside of the practice.	Practice routinely exchanges essential health information with other members of care team outside of the practice.	
3.9	Practice has increased the number of patients who have received the appropriate health screenings, aligning where possible with "Choosing Wisely" measures (http://www.choosingwisely.org/about-us/).	Practice has not increased the number of patients who have received the appropriate health screenings and has yet to develop a plan to drive an increase.	Practice has not increased the number of patients who have received the appropriate health screenings but is developing a plan to drive an increase.	Practice has not increased the number of patients who have received the appropriate health screenings but has developed a plan to drive an increase. The practice is currently implementing this plan but does not have results.	Practice has increased the number of patients who have received the appropriate health screenings.	
3.10	Practice has increased the number of patients who have completed referrals.	Practice has not increased the number of patients who have completed referrals, and has yet to develop a plan to drive an increase.	Practice has not increased the number of patients who have completed referrals but is developing a plan to drive an increase.	Practice has not increased the number of patients who have completed referrals but has developed a plan to drive an increase. The practice is currently implementing this plan but does not have results.	Practice has increased the number of patients who have completed referrals.	
3.11	Practice has a formal written vision related to care coordination.	Practice has not developed a formal or informal vision related to care coordination.	Practice has a vision related to care coordination, but it has yet to be formally documented in writing.	Practice has a vision related to care coordination and has drafted the vision in writing but has yet to have the draft adopted by the practice.	Practice has a formal written vision related to care coordination that the practice has adopted.	
3.12	Practice ensures that patients are able to see their provider or care team whenever possible.	Practice has no plan in place to ensure patients are able to see their provider or care team whenever possible.	Practice is developing a plan to ensure patients are able to see their provider or care team whenever possible.	Practice is implementing their plan to ensure patients are able to see their provider or care team whenever possible but is not yet consistently accomplishing this goal.	Practice has implemented and refined their plan and is consistently ensuring that patients are able to see their provider or care team whenever possible.	
3.13	Practice links patients with appropriate community resources to facilitate referrals.	Practice does not link patients with community resources to facilitate referrals.	Practice is identifying resources and establishing communication with them to link patients with appropriate community resources to facilitate referrals.	Practice is implementing a plan to link patients with appropriate community resources to facilitate referrals but is not yet consistently accomplishing this goal.	Practice has implemented and refined their plan and consistently links patients with appropriate community resources to facilitate referrals.	
3.14	Practice follows up with patients within 48 hours after an emergency room visit or hospital discharge (a phone call constitutes follow up).	Practice does not follow up with patients within 48 hours after an emergency room visit or hospital discharge.	Practice is establishing a method for reliable communication with the hospital about discharging patients.	Practice is implementing a plan to follow up with patients within 48 hours after an emergency room visit or hospital discharge but is not yet consistently accomplishing this goal.	Practice has implemented and refined its plan and is consistently following up with patients within 48 hours after an emergency room visit or hospital discharge.	
Phase 3 average score						

Phase	Milestone Description	0	1	2	3	Response
4.1	Practice uses utilization reports (e.g. number of same day appointments, number of patients triaged after hours, 24/7 access to care, etc.) on a monthly basis and continuously makes clinical improvement changes.	Practice does not use utilization reports or continuously make clinical improvement changes.	Practice is beginning to use utilization reports but without consistency and makes clinical improvement changes on an inconsistent basis.	Practice is beginning to pilot a process to use utilization reports on a monthly basis and continuously make clinical improvement changes.	Practice has implemented and documented a tested process to use utilization reports on a monthly basis and continuously makes clinical improvement changes.	
4.2	Practice has continued to decrease the “no show” rate over time.	Practice has not decreased the "no show" rate over time or does not collect information on “no show” rates.	Practice is collecting information about "no shows" to understand the cause(s) of the "no show" rate.	Practice is piloting processes to decrease the "no show" rate over time.	Practice has successfully implemented and documented tested processes that decrease the "no show" rate over time.	
4.3	Practice submits utilization reports to the Practice Transformation Network (PTN) on a monthly basis.	Practice does not submit utilization reports to PTN.	Practice is developing a process to submit utilization reports to PTN on a monthly basis.	Practice is piloting a process to submit utilization reports to PTN on a monthly basis.	Practice has successfully implemented and documented a tested process to submit utilization reports to PTN on a monthly basis.	
4.4	Practice has reduced unnecessary hospitalizations by at least 20% from baseline, aligning where possible with “Choosing Wisely” measures (http://www.choosingwisely.org/about-us/).	Practice has not reduced unnecessary hospitalizations from baseline or does not have baseline data on this measure.	Practice is developing a method for capturing and reviewing hospitalization use.	Practice is capturing data and piloting a process to reduce unnecessary hospitalizations and has established a baseline.	Practice has implemented and documented a tested process to reduce unnecessary hospitalizations by at least 20% from baseline.	
4.5	Practice has a process in place for identifying 90% of patients at high risk of hospitalization and/or complication from chronic conditions on a monthly basis.	Practice does not have a process for identifying high risk patients.	Practice is developing a process for identifying high risk patients on a monthly basis.	Practice is piloting a process for identifying high risk patients on a monthly basis but, to date, has not successfully identified 90% of these patients.	Practice has successfully implemented and documented a tested process that identifies 90% of high risk patients on a monthly basis.	
4.6	Practice has ensured that 75% of high risk patients are receiving appropriate care and case management services as part of their continuous practice improvement plan.	Practice does not have a continuous practice improvement plan to ensure high risk patients are receiving appropriate care and case management services.	Practice is developing a continuous practice improvement plan to ensure high risk patients are receiving appropriate care and case management services.	Practice is testing a continuous practice improvement plan to ensure high risk patients are receiving appropriate care and case management services.	Practice has implemented and documented a tested continuous practice improvement plan that ensures 75% of high risk patients are receiving care and case management services.	
4.7	Practice tracks and supports patients when they obtain services (i.e. community resources) outside of the practice on a monthly basis.	Practice does not track or support patients when they obtain services outside of the practice.	Practice is beginning to develop a process to track and support patients when they obtain services outside of the practice.	Practice is beginning to track and support at least one type of outside practice utilization.	Practice routinely reviews outside utilization data and ensures inclusion of outside treatment information in electronic records.	

Phase	Milestone Description	0	1	2	3	Response
4.8	Practice has a process in place to link patients with care providers and care teams so both patients and care teams recognize each other as partners in care.	Practice does not have a process in place to link patients with care providers and care teams.	Practice is beginning to develop a process to link patients with care providers and care teams so both patients and care teams recognize each other as partners in care.	Practice is testing a process to link patients with care providers and care teams so both patients and care teams recognize each other as partners in care.	Practice has implemented and documented a tested process to link patients with care providers and care teams so both patients and care teams recognize each other as partners in care.	
Phase 4 average score						

Phase	Milestone Description	0	1	2	3	Response
5.1	Practice has tracked and sustained prior improvements in practice identified metrics for at least one year.	Practice does not track practice identified metrics.	Practice is developing a plan to track and sustain practice identified metrics.	Practice is tracking improvements in practice identified metrics.	Practice has tracked and sustained prior improvements in practice identified metrics for at least one year.	
5.2	Practice has developed business acumen in the various types of alternative payment models including understanding of shared savings models with and without risk, various contracting arrangements that a practice might consider and how to evaluate the pros and cons for the population they serve.	Practice has not developed business acumen in the various types of alternative payment models.	Practice has identified resources for educating staff in principles of business management, including understanding of shared savings models with and without risk, various contracting arrangements that a practice might consider and how to evaluate the pros and cons for the population they serve.	Practice is providing education and practice data on business metrics, including understanding of shared savings models with and without risk, various contracting arrangements that a practice might consider and how to evaluate the pros and cons for the population they serve.	Practice is performing well on metrics of business management, including understanding of shared savings models with and without risk, various contracting arrangements that a practice might consider and how to evaluate the pros and cons for the population they serve.	
Phase 5 average score						

Assessment line	FAQ	Response
1.3	What is a PDSA cycle? What is Six Sigma? What is Team-Based Care?	The **Plan-Do-Study-Act (PDSA)** cycle is shorthand for testing a change — by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented learning. http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx **Six Sigma** is a disciplined, data-driven approach and methodology for eliminating defects (driving toward six standard deviations between the mean and the nearest specification limit) in any process – from manufacturing to transactional and from product to service. **Team Based Care** : The definition of "team-based care" for all care settings that is most widely accepted and consistent with the World Health Organization principles of primary health care and inclusive of the six IOM aims for improvement is as follows: The provision of comprehensive health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers on shared goals within and across settings to achieve care that is safe, effective, patient-centered, timely, efficient, and equitable. [Source: Naylor MD, Coburn KD, Kurtzman ET, et al. Team-Based Primary Care for Chronically Ill Adults: State of the Science. Advancing Team-Based Care. Philadelphia, PA: American Board of Internal Medicine Foundation; 2010.]
1.7, 2.2	How are "disparities" defined?	According to the HHS National Partnership for Action to End Health Disparities, health disparity is defined as a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion. For more information, see the following website: http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34
3.2	How are "unnecessary tests" defined?	This will be a practice-specific target as targets for this are expected to vary by clinician type (primary care, specialist) and the practice's mix of patients (with respect to age, and disease prevalence). For these assessment lines, practices should align unnecessary tests where possible with "Choosing Wisely" measures. For more information, visit (http://www.choosingwisely.org/about-us/).