Transforming Clinical Practice Initiative Assessment (Specialists)
Field Testing (I)

Phase	Milestone Description	0	1	2	3
1.1	Practice has submitted a detailed plan that addresses how they will increase access to care, negotiate co-management of patients with other providers, coordinate care, reduce unnecessary hospitalizations, testing and procedures, and deliver patient centered care.	Practice has no plan that addressees how they will increase access to care, negotiate co-management of patients with other providers, coordinate care, reduce unnecessary hospitalizations, testing and procedures, or deliver patient centered care.	Practice is developing a detailed plan that addresses how they will increase access to care, negotiate co-management of patients with other providers, coordinate care, reduce unnecessary hospitalizations, testing and procedures, and deliver patient centered care.	Practice is in the advanced stages of developing a detailed plan that addresses how they will increase access to care, negotiate co-management of patients with other providers, coordinate care, reduce unnecessary hospitalizations, testing and procedures, and deliver patient centered care, but are not ready to submit the plan.	Practice is prepared to submit or has submitted a detailed plan that addresses how they will increase access to care, negotiate co-management of patients with other providers, coordinate care, reduce unnecessary hospitalizations, testing and procedures, and deliver patient centered care.
1.2	Practice participates in multidisciplinary learning collaborative to benefit from the learning of others, and to share best practices and lessons learned.	Practice does not participate in multidisciplinary learning collaborative to benefit from the learning of others or to share best practices and lessons learned.	Practice has researched joining multidisciplinary learning collaborative to benefit from the learning of others, and share best practices and lessons learned but has yet to participate in any collaboratives.	Practice is beginning to participate in a multidisciplinary learning collaborative to benefit from the learning of others and to share best practices and lessons learned.	Practice is consistently participating in a multidisciplinary learning collaborative to benefit from the learning of others and to share best practices and lessons learned.
1.3	Practice starts to perform an assessment of the clinical practice and starts to collect baseline data on comorbidities, referral patterns, utilization, quality, and outcomes measures, and identifies problem areas for improvement. Practice establishes measures, plans, and a baseline for intentionally minimizing unnecessary testing and procedures.	Practice has not started to perform an assessment of the clinical practice and has not started to collect baseline data on comorbidities, referral patterns, utilization, quality, or outcomes measures. Practice has not established measures, plans, or a baseline for intentionally minimizing unnecessary testing and procedures.	Practice is planning to perform an assessment of the clinical practice but has yet to develop a plan to collect baseline data on comorbidities, referral patterns, utilization, quality, and outcomes measures. Practice is planning how to identify problem areas for improvement. Practice is in the planning process of developing measures for intentionally minimizing unnecessary testing and procedures but has not yet developed plans or a baseline.	Practice is performing an assessment of the clinical practice and has developed a plan to collect baseline data on comorbidities, referral patterns, utilization, quality, and outcomes measures. Practice is working toward identifying problem areas for improvement. Practice has established measures and plans and is now establishing a baseline for intentionally minimizing unnecessary testing and procedures.	Practice is performing an assessment of clinical practice and is collecting baseline data on comorbidities, referral patterns, utilization, quality, and outcomes measures. Practice has identified problem areas for improvement. Practice has established measures, plans and a baseline for intentionally minimizing unnecessary testing and procedures.
1.4	The practice uses data to identify methods to reduce health care disparities.	The practice does not use data to identify methods to reduce health care disparities.	The practice collects data but has not identified methods to reduce health care disparities.	The practice collects data and is beginning to identify methods to reduce health care disparities.	The practice uses data and identifies methods that reduce health care disparities within the practice' population.

Phase	Milestone Description	0	1	2	3
2.1	Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry, practice management or EHR system to drive clinical practice improvement resulting in reduced unnecessary tests and hospitalizations.	Practice is not capturing or analyzing population, disease specific or relevant quality measures for utilization, billing data, or tests ordered from their registry, practice management or EHR system.	Practice is in the planning stage of capturing and analyzing population, disease specific and relevant quality measures for utilization, billing data and tests ordered from their registry, practice management or EHR system to drive clinical practice improvement resulting in reducing unnecessary tests and hospitalizations.	Practice has completed a plan for, but has yet to begin, capturing and analyzing population, disease specific and relevant quality measures for utilization, billing data and tests ordered from their registry, practice management or EHR system to drive clinical practice improvement resulting in reducing unnecessary tests and hospitalizations.	Practice has started to capture and analyze population, disease specific and relevant quality measures for utilization, billing data and tests ordered from their registry, practice management or EHR system to drive clinical practice improvement resulting in reducing unnecessary tests and hospitalizations.
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	The 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.	The practice has not identified community partners and other points of care that their patients are using.	The 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.	The 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.	The 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	The 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 identified improvements in care transition and processes enabled through exchange of essential health information to eliminate waste and decrease costs.	Practice is in the advanced stages of defining 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	The practice provides care management to at least 50% of highest risk patients (those that are clinically unstable).	Practice has no method for defining or identifying high risk patients.	Practice can identify at least one type of high risk patient and is planning care management services for the population.	Practice can identify more than one type of high risk patient populations and is developing care management strategies for each.	At least 50% of the practice's highest risk patients receive care management services.
2.7	The practice implements at least three specific care management strategies for patients in higher risk cohorts, samples may include, but are not limited to: o Integration of behavioral health o Self-management support for at	The practice has not implemented any specific care management strategies for patients in higher risk cohorts.	The practice has implemented one specific care management strategy for patients in higher risk cohorts.	The practice has implemented two specific care management strategies for patients in higher risk cohorts.	The practice has implemented three or more specific strategies for patients in higher risk cohorts.

Phase	Milestone Description	0	1	2	3
	least three high risk conditions o Medication management and review				
2.8	Monthly reporting includes updating information about the practice's risk stratification methodology, empanelment status, risk stratification data, and other activities.	The practice is not prepared to report monthly on the practice's risk stratification methodology, empanelment status, risk stratification data, or other activities.	The practice is developing a plan to report monthly on the practice's risk stratification methodology, empanelment status, risk stratification data, and other activities.	The practice is nearly prepared to report monthly on the practice's risk stratification methodology, empanelment status, risk stratification data, and other activities.	The 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.	The 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.	The 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.	The 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.	The 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	The practice develops care coordination agreements with other care providers that cover 15% of their patients and defines co-management responsibilities with other care providers.	The practice has not developed care coordination agreements with other care providers.	The practice has developed care coordination agreements and defined co-management responsibilities with other care providers, and 0-7.5% of their patients are covered.	The practice has developed care coordination agreements and defined co-management responsibilities with other care providers, and 7.51%-14.99% of their patients are covered.	The practice has developed care coordination agreements and defined co-management responsibilities with other care providers, and 15% or more of their patients are covered.
2.11	The practice identifies ways to improve care transitions, care processes, workflow; and ways to eliminate waste and decrease costs that are enabled through the exchange of essential health information (electronically or otherwise).	The practice does not identify ways to improve care transitions, care processes, workflow; or ways to eliminate waste and decrease costs.	The practice is developing a plan to identify ways to improve care transitions, care processes, workflow; and ways to eliminate waste and decrease costs that are enabled through the exchange of essential health information (electronically or otherwise).	The practice has developed a plan, but has not yet implemented the plan, to identify ways to improve care transitions, care processes, workflow; and ways to eliminate waste and decrease costs that are enabled through the exchange of essential health information (electronically or otherwise).	The practice identifies ways to improve care transitions, care processes, workflow; and ways to eliminate waste and decrease costs that are enabled through the exchange of essential health information (electronically or otherwise).
2.12	The practice uses data to analyze potential disparities in care and develops action plans allowing the practice to identify individual patients needing intervention.	The practice does not use and/or have data to analyze potential disparities in care.	The practice has identified and is beginning to collect data to analyze potential disparities in care but has yet to develop an action plan that allows the practice to identify individual patients needing intervention.	The practice is using data to analyze potential disparities in care and has identified disparities in care to be addressed through action plans that will allow the practice to identify patients needing intervention.	The practice uses data to analyze potential disparities in care and has developed action plans that identify individual patients needing intervention.

Phase	Milestone Description	0	1	2	3
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 and hospitalizations by at least 25% from baseline.	The practice has not reduced unnecessary tests and hospitalizations from baseline.	The practice has reduced unnecessary tests and hospitalizations by 0 to 12.49% from baseline.	The practice has reduced unnecessary tests and hospitalizations by 12.5%-24.99% from baseline	The practice has reduced unnecessary tests and hospitalizations by 25% or more from baseline.
3.3	Practice has involved patients, families or staff in quality improvement initiatives.	The practice has not involved patients, families and staff in quality improvement initiatives.	The practice is in the planning process on how to involve patients, families and staff in quality improvement initiatives.	The practice is reaching out to patients, families and staff for involvement in quality improvement initiatives.	The practice involves patients, families and staff in quality improvement initiatives.
3.4	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.
3.5	Practice routinely creates and/or maintains shared care plans and utilizes shared decision making tools to incorporate patient preferences and goals in care management processes.	Practice does not create or maintain shared care plans or utilize shared decision making tools to incorporate patient preferences and goals in care management processes.	Practice is developing a plan to create and/or maintain shared care plans and utilize shared decision making tools to incorporate patient preferences and goals in care management processes.	Practice has incorporated shared decision making tools 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 and utilizes shared decision making tools to incorporate patient preferences and goals in care management processes.
3.6	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.
3.7	Practice has increased the number of patients who have received the appropriate health screenings and completion of referrals.	Practice has not increased the number of patients who have received the appropriate health screenings and completion of referrals, 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 and completion of referrals but is developing a plan to drive an increase.	Practice has not increased the number of patients who have received the appropriate health screenings and completion of 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 received the appropriate health screenings and completion of referrals.

Phase	Milestone Description	0	1	2	3
3.8	Practice has identified high risk patients and has ensured they are receiving appropriate care and case management services.	Practice has not identified high risk patients and has not ensured they are receiving appropriate care and case management services.	Practice is beginning the process of identifying high risk patients and developing a plan to ensure they are receiving appropriate care and case management services.	Practice has identified high risk patients and is in the initial phases of implementing a plan to ensure they are receiving appropriate care and case management services.	Practice has identified high risk patients and has a fully developed and implemented plan to ensure they are receiving appropriate care and case management services.
3.9	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.
3.10	Practice links a patient to a provider and care team so both the patients and team recognize each other as partners in care.	Practice does not link patients to a provider or care team to establish each party as partners in care.	Practice is developing a plan to link patients to a provider or care team so both patients and team recognize each other as partners in care.	Practice is implementing their plan to link patients to a provider or care team so both patients and team recognize each other as partners in care.	Practice is successfully linking patients to a provider and care team so both the patients and team recognize each other as partners in care.
3.11	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.
3.12	Practice links patients with 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 community resources to facilitate referrals.	Practice is implementing a plan to link patients with 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 community resources to facilitate referrals.
3.13	Practice tracks and supports patients when they obtain services outside the practice.	Practice does not track and support patients when they obtain services outside the practice.	Practice is in initial stages of developing a plan to track and support patients when they obtain services outside the practice.	Practice is implementing a plan to track and support patients when they obtain services outside the practice but is not yet consistently accomplishing this goal.	Practice has implemented and refined its plan and is consistently tracking and supporting patients when they obtain services outside the practice.
3.14	Practice follows up with patients within 24 hours after an emergency room visit or hospital discharge.	Practice does not follow up with patients within 24 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 24 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 24 hours after an emergency room visit or hospital discharge.

Phase	Milestone Description	0	1	2	3
3.15	The practice develops care coordination agreements with other care providers that cover 30% of their patients and defines co-management responsibilities with other care providers.	The practice has not developed care coordination agreements with other care providers.	The practice has developed care coordination agreements and defined co-management responsibilities with other care providers, and 0-14.99% of their patients are covered.	The practice has developed care coordination agreements and defined co-management responsibilities with other care providers, and 15%-29.99% of their patients are covered.	The practice has developed care coordination agreements and defined co-management responsibilities with other care providers, and 30% or more of their patients are covered.
3.16	Practice routinely exchanges essential health information (electronically or otherwise) with other members of care team outside of 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 (electronically or otherwise) with other members of care team outside of practice.	Practice has begun initial attempts to exchange essential health information (electronically or otherwise) with other members of care team outside of practice, but process is not yet routine.	Practice routinely exchanges essential health information with other members of care team outside of the practice.
3.17	Practice has reduced unnecessary hospitalizations, tests, and procedures by at least 15% from baseline.	The practice has not reduced unnecessary hospitalizations, tests or procedures from baseline.	The practice has reduced unnecessary hospitalizations, tests and procedures by 0 to 7.5% from baseline.	The practice has reduced unnecessary hospitalizations, tests and procedures by 7.51%-14.99% from baseline	The practice has reduced unnecessary hospitalizations, tests and procedures by 15% or more from baseline.

Transforming Clinical Practice Initiative Assessment (Specialists)
Field Testing (I)

Phase	Milestone Description	0	1	2	3
4.1	Practice uses utilization reports 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.	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 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 tests and hospitalizations by at least 20% from baseline.	Practice has not reduced unnecessary tests or hospitalizations from baseline or does not have baseline data on this measure.	Practice is developing a method for capturing and reviewing tests and hospitalization use.	Practice is capturing data and piloting a process to reduce unnecessary tests and hospitalizations and has established a baseline.	Practice has implemented and documented a tested process to reduce unnecessary tests and hospitalizations by at least 20% from baseline.
4.5	Practice has a process in place for identifying 90% of high risk patients 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 patients when they obtain services outside of the practice on a monthly basis.	Practice does not track patients when they obtain services outside of the practice.	Practice is beginning to develop a process to track patients when they obtain services outside of the practice.	Practice is beginning to track 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
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.
4.9	The practice develops care coordination agreements with other care providers that cover 50% of their patients and defines co-management responsibilities with other care providers.	The practice has not developed care coordination agreements with other care providers.	The practice has developed care coordination agreements and defined co-management responsibilities with other care providers, and 0-24.99% of their patients are covered.	The practice has developed care coordination agreements and defined co-management responsibilities with other care providers, and 25%-49.99% of their patients are covered.	The practice has developed care coordination agreements and defined co-management responsibilities with other care providers, and 50% or more of their patients are covered.
4.10	Practice has reduced unnecessary hospitalizations, tests, and procedures by at least 20% from baseline.	The practice has not reduced unnecessary hospitalizations, tests or procedures from baseline.	The practice has reduced unnecessary hospitalizations, tests and procedures by 0 to 9.99% from baseline.	The practice has reduced unnecessary hospitalizations, tests and procedures by 10.0%-19.99% from baseline	The practice has reduced unnecessary hospitalizations, tests and procedures by 20% or more from baseline.

Phase	Milestone Description	0	1	2	3
5.1	Practice has tracked and sustained prior improvements in key metrics for at least one year.	Practice does not track key metrics.	Practice is developing a plan to track and sustain key metrics.	Practice is tracking improvements in key metrics.	Practice has tracked and sustained prior improvements in key 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.