Practice Innovation Institute

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Provider and Health Plan Relationships on the Path to Accountable Care – Az HFMA One Day Event

February 24, 2017

Agenda for today's discussion

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Background:

- The Practice Innovation Institute is part of CMS' Transforming Clinical Practices Initiative (TCPI) designed to help practices prepare for value based care (14.6M in grant funding over 4 years)
  - Achieve large scale health transformation and prepare for Value Based Care (VBC)
  - Develop comprehensive quality improvement strategies through peer based learning networks
  - Reduce costs and eliminate unnecessary tests and procedures
- Arizona Health-e Connection (AzHeC) with the support of Mercy Care Plan (MCP) applied for and received 3.6M in Year 1 grant funding which started October 2015
- Practice assessments are performed in tandem with local QIN/QIO participant (HSAG)
- Practice Transformation Consultants as well as Health Information Technology staff collaborate with data analysts and clinical champions to create a business plan for each practice
- Highlights of key elements from CMS' TCPI change package are presented for practice approval and to establish transformation plan

Highlights

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- What is a Practice Innovation Institute?
- Practice communications
  - Assessment and results communications
- Population health tools
- Vision and goals of transformation
- Resources:
  - Support and Alignment Networks (SANs)
  - Quality Innovation Network – Quality Improvement Organizations (QIN – QIO)
  - Affinity Groups
  - Learning Opportunities (Pii Academy and beyond)

Welcome to the Practice Innovation Institute!

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By deciding to participate in Pii, you have given yourself access to a resource which will allow you to:

- Prepare your practice for success under the Quality Payment Program (formerly MACRA) and future value-based payment contracts
- Avoid penalties and payment reductions
- Improved reimbursement
- Get better member information with one connection
- Improve communication and care coordination with other providers
- Spend more time caring for your members and increase clinician joy in practice
- Get assistance with required reporting
- Take advantage of one-on-one consulting valued at more than $50k per practice
- Be a leader in state and national practice transformation efforts

Ultimately, this process will help you improve health outcomes for your members

Congratulations on becoming part of the Practice Innovation Institute team!

MIPS Performance Categories

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Scoring standard: 2017 performance period for the 2019 payment adjustment

Performance Category	Percentage of Overall MIPS Score
Quality:* Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set*	60 percent
Advancing Care Information: Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	25 percent
Clinical Practice Improvement Activities:^ Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn "full credit" in this category, and those participating in Advanced APMs will earn at least half credit.	15 percent
Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	0 percent

Practices participating in the Pii program will receive credit under MIPS for clinical practice improvement activities

For the transition year (2017), cost measures do not require reporting of any data by MIPS eligible clinicians to CMS

Note: *For a finalized list of quality measures, for primary care providers see Table A: Finalized Individual Quality Measures Available for MIPS Reporting in 2017 in the Quality Payment Program (QPP) Final Rule (pages 1,902 – 2,017). For a list of quality measures for reporting by specialty practices, see Table E: Finalized MIPS Specialty Measure Sets in the QPP Final Rule (pages 2,028 – 2,113)

**For a finalized list of eligible activities, see Table 8: Improvement Activities eligible for Advancing Care Information Performance Category Bonus in the QPP Final Rule (p707 – 713)

^For a finalized list of eligible improvement activities, see Table H: Finalized Improvement Activities Inventory in the QPP Final Rule (pages 2,157 – 2,171)

Practice Innovation Institute Aims and Activities

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Aim	How Pii will help your practice
Quality	• Assist practices in tracking and reporting on TCPI required process measures leading to improved outcomes (e.g., controlling high blood pressure, breast cancer screenings) • Work with practices to define additional measures that are important to their quality improvement goals for the specific populations being served.
Advancing Care Information	• Increase communication among members of the care team by connecting providers to the CareUnify tool, which will allow clinicians to assign specific tasks within care paths to providers in other practices • Increase interoperability and data sharing by connecting practices to the statewide Health Information Exchange (HIE)
Clinical Practice Improvement	• Work 1:1 with practice facilitators to build processes and capabilities within practices to successfully implement transformation objectives • Train practices on use of tools and demonstrate how to analyze and interpret new sets of data about their members
Cost Reduction	• Give practices the tools and knowledge they will need to make meaningful progress towards identifying and mitigating major cost drivers, including high ED utilizers and frequent hospital admissions • Through facilitation of increased provider communication via CareUnify and the HIE, reduce delivery of redundant services and coordinate care more effectively

Phase One of Transformation

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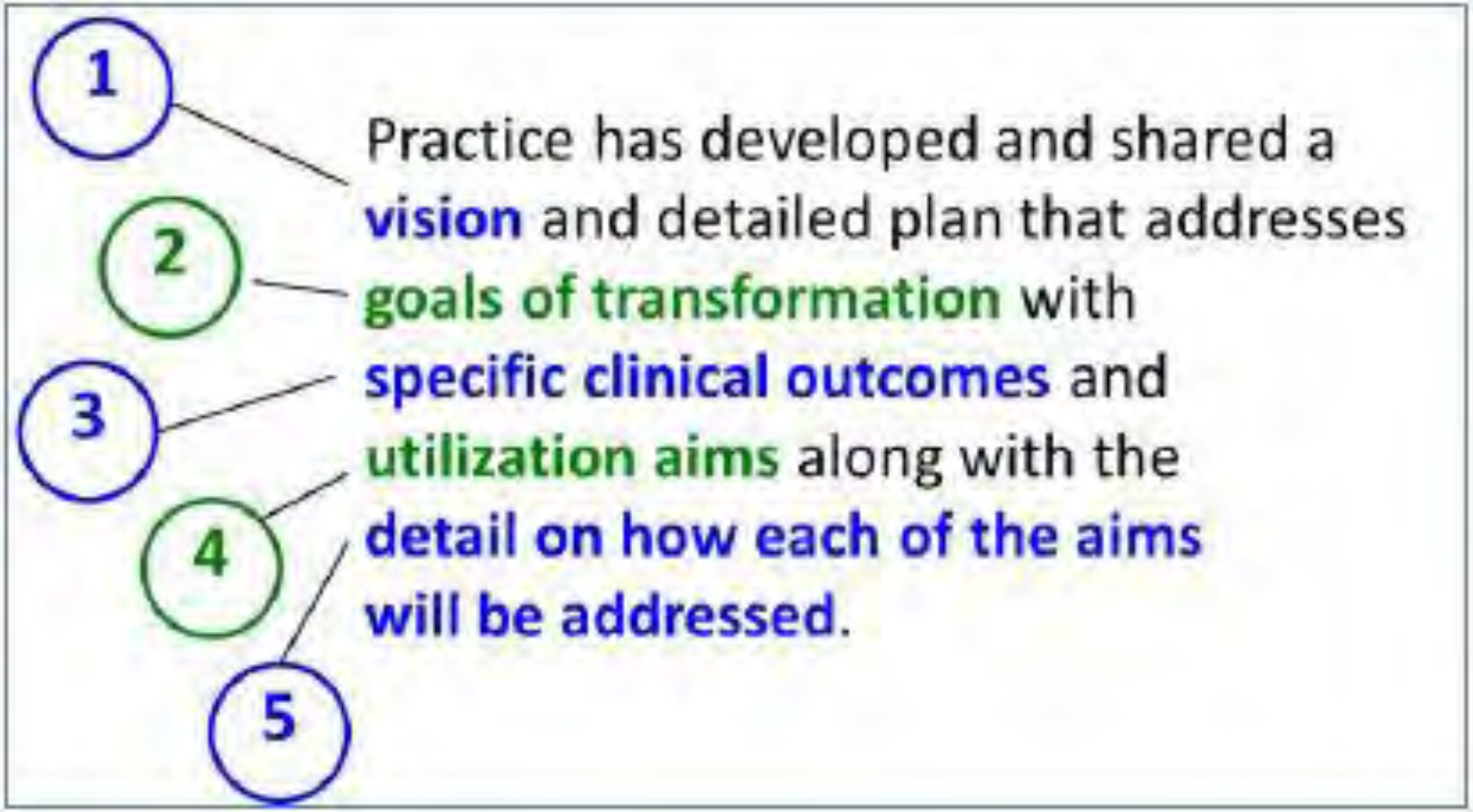

PTC to enter organization specific information from Business Analyzer-Demographics tab

Demographic Data Collected

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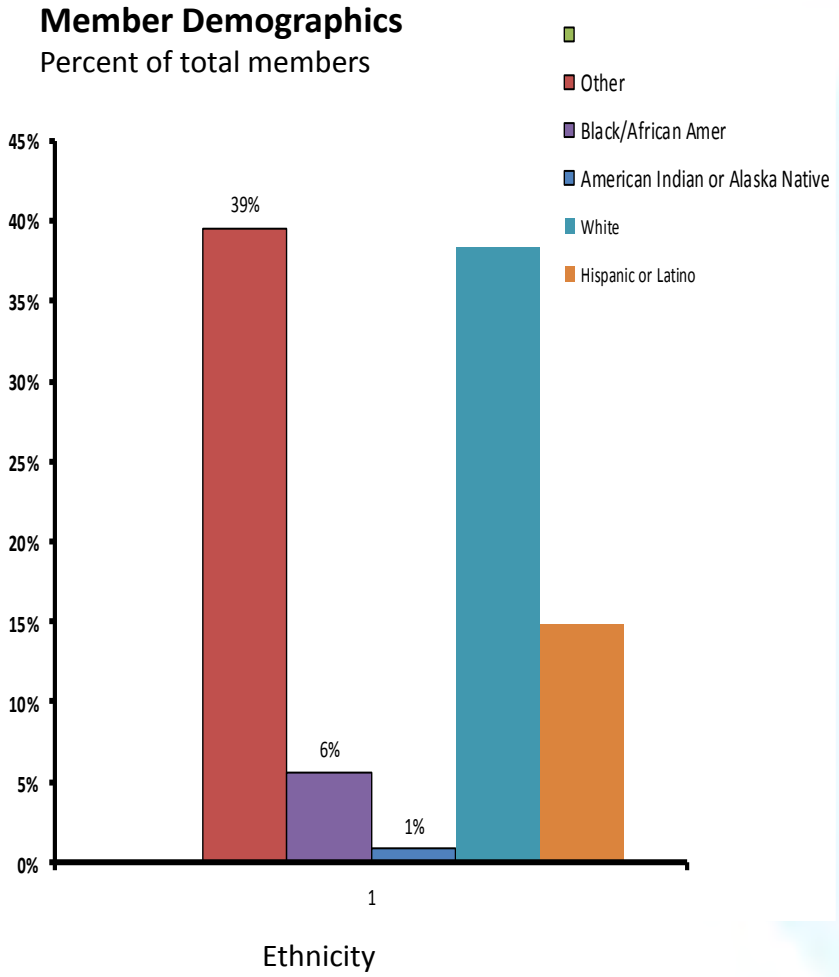

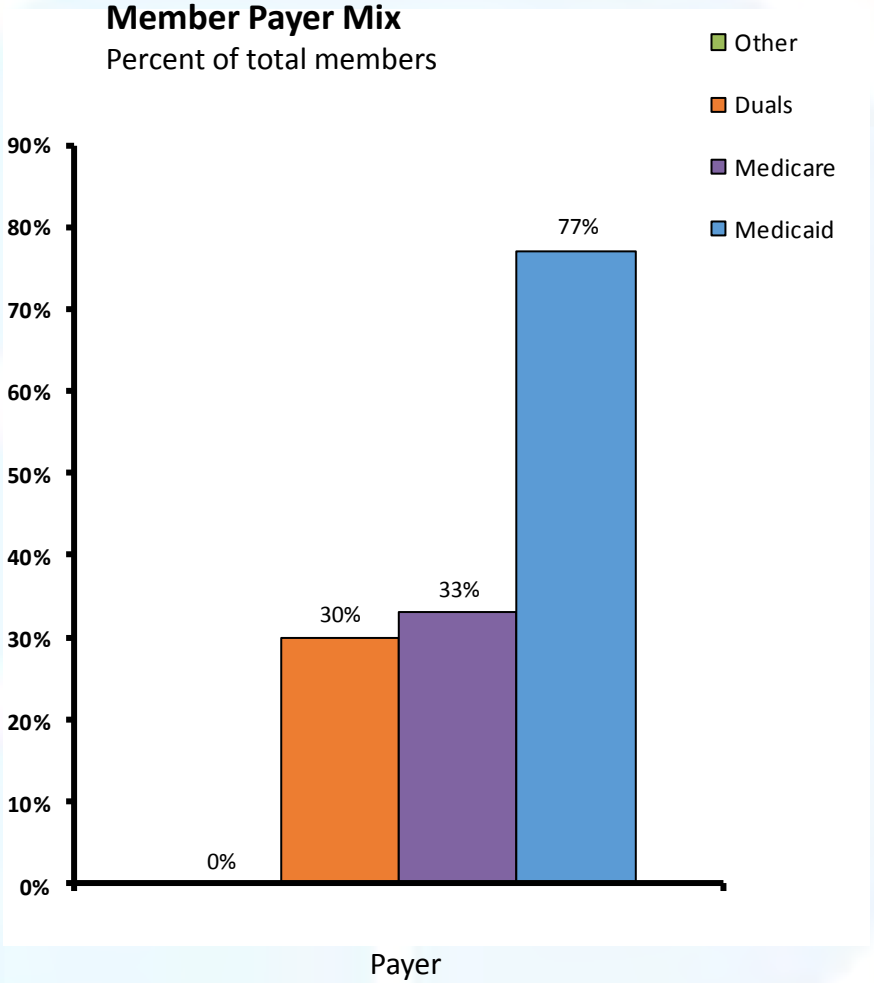

PTC to pull pictoral from Care Unify Implementation workbook in Sharepoint

(Name of organization) includes (#of) clinicians across (# of) sites

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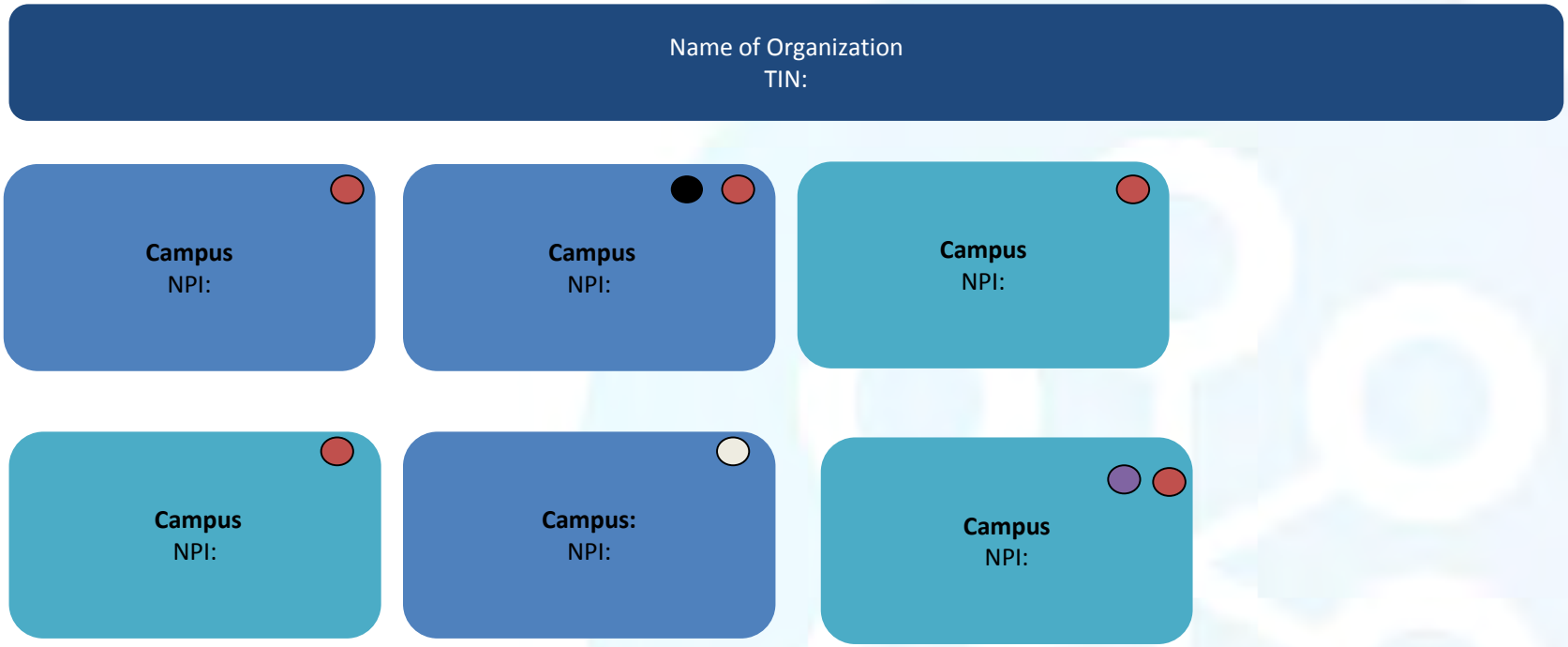

FQHC/FQHC LA
FACT Team
Primary Care
Behavioral Health only
SMI Clinic
Integrated Health Home
ACT Team
MACT Team

PTC to pull practice assessment summary from business analyzer

Initial Practice Assessment Summary- Primary Care

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Initial practice assessment summary –

Pii business plan

PAT date:	3/28/2016
Next assessment date:	9/28/2016

Does this accurately reflect internal views on ability to succeed under new contract models?

Practice information

Assessment date:	3/28/2016
Taxpayer Identification Number (TIN):	26-4681471
Pathway	TBD

Summary of practice assessment results

Grouped by primary driver

Group	Primary driver	Driver abbreviation	Summary score	Max score	Provider level
A	Person and Family-Centered Care Design	PFCCD	25	42	Intermediate
B	Continuous, Data-Driven Quality Improvement	CDDQI	8	18	Intermediate
C	Sustainable Business Operations	SBO	7	15	Intermediate
D	TCPI Aims	TCPI Aims	4	6	Intermediate

Grouped by phase of transformation

Phase	Phase description	% of phase complete in last assessment	% of phase complete	Provider level
1	Setting aims	N/A	66.7%	In-progress
2	Using data to drive care	N/A	61.5%	In-progress
3	Achieve progress on aims	N/A	53.3%	In-progress
4	Achieve benchmark status	N/A	16.7%	In-progress
5	Thrive as a business via pay for value approaches	N/A	-	In-progress

Based on the self reported scores and the results of an initial assessment, (Name of organization) is currently in Phase 1 of transformation

Making Sense of Quality Measures

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TCPI	HRSA	HEDIS
CHILDHOOD IMMUNIZATIONS NQF 38	CHILDHOOD IMMUNIZATIONS IID-8	CHILDHOOD IMMUNIZATION STATUS
CERVICAL CANCER SCREENING NQF 32	CERVICAL CANCER SCREENING C-15	CERVICAL CANCER SCREENING
COLORECTAL CANCER SCREENING NQF 34	COLORECTAL CANCER SCREENING C-16	COLORECTAL CANCER SCREENING
CONTROL HIGH BLOOD PRESSURE NQF18	HYPERTENSION BP CONTROL HDS-12	CONTROLLING HIGH BLOOD PRESSURE
DIABETES HbA1c POOR CONTROL >9% NQF59	DIABETES CONTROL HbA1c >9% D-5.1	COMPREHENSIVE DIABETES CARE
INFLUENZA IMMUNIZATION NQF 41	OLDER ADULT INFLUENZA VACCINE	FLU VACCINATIONS FOR ADULTS 65+
INFLUENZA IMMUNIZATION NQF 41	ADULT INFLUENZA VACCINE	FLU VACCINATIONS FOR ADULTS 18-64
PNEUMOCOCCAL VACCINE STATUS NQF43	OLDER ADULT PNEUMOCOCCAL VACCINE	PNEUMOCOCCAL VACINE FOR OLDER ADULTS
BREAST CANCER SCREENING NQF 2372	BREAST CANCER SCREENING	BREAST CANCER SCREENING
OPTIMAL ASTHMA CONTROL NQF N/A		MEDICATION MGT FOR PEOPLE W/ ASTHMA
FOLLOW UP AFTER MENTAL HEALTH HOSPITALIZATION NQF 576		FOLLOW UP AFTER MENTAL HEALTH HOSPITALIZATION
ED USE FOR MINOR HEAD TRAUMA		EMERGENCY DEPARTMENT UTILIZATION
ANTI DEPRESSANT MEDICATION MANAGEMENT NQF 105		ANTI DEPRESSANT MEDICATION MANAGEMENT
TOBACCO USE: SCREENING & CESSATION NQF28		MEDICAL ASSISTANCE WITH TOBACCO USE AND CESSATION
USE OF IMAGE STUDIES FOR LOW BACK PAIN NQF52		USE OF IMAGING STUDIES FOR LOW BACK PAIN
UNPLANNED HOSPITAL READMISSION WITHIN 30 DAYS		PLAN ALL-CAUSE READMISSIONS AND HOSPITALIZATION FOR PREVENTABLE COMPLICATIONS
DEPRESSION UTILIZATION OF PHQ-9 NQF 712		UTILIZATION OF THE PHQ-9 TO MONITOR DEPRESSION SYMPTOMS FOR ADULTS & ADOLESCENTS
SCREENING FOR CLINICAL DEPRESSION AND FOLLOW UP NQF 418		UTILIZATION OF THE PHQ-9 TO MONITOR DEPRESSION SYMPTOMS
BMI SCREENING AND FOLLOW UP NQF 421		ADULT BMI ASSESSMENT
FALLS: SCREENING FOR FUTURE FALL RISK NQF101		FALL RISK MANAGEMENT

(Name of organization's) Contract Information: Integrated Health Home (IHH) and SMI Clinic (1 of 3)

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PTC to update-This is a placeholder for relevant contract information

Incentives for measurement period 1/1/17 – 9/30/17

Measure	Agency of measure	Performance indicato				Included in contract	
		Baseline / MPS	Target 1			IHH	SMI
Hospitalization: # of psychiatric hospital admissions		XXX	20% reduction	N/A	Claims	✓	✓
Hospitalization: # of medical hospital admissions		XXX	20% reduction	N/A	Claims	✓	✓
Emergency Room Utilization: utilization of ED		XXX	20% reduction	N/A	Claims	✓	✓
Employment: # of members who are competitively employed		XXX	5% increase	N/A		✓	✓
Homelessness: # of members who are homeless		XXX	15% reduction	N/A		✓	✓

Source: Mercy Maricopa

Pii – Clinical Outcome and Utilization Measures

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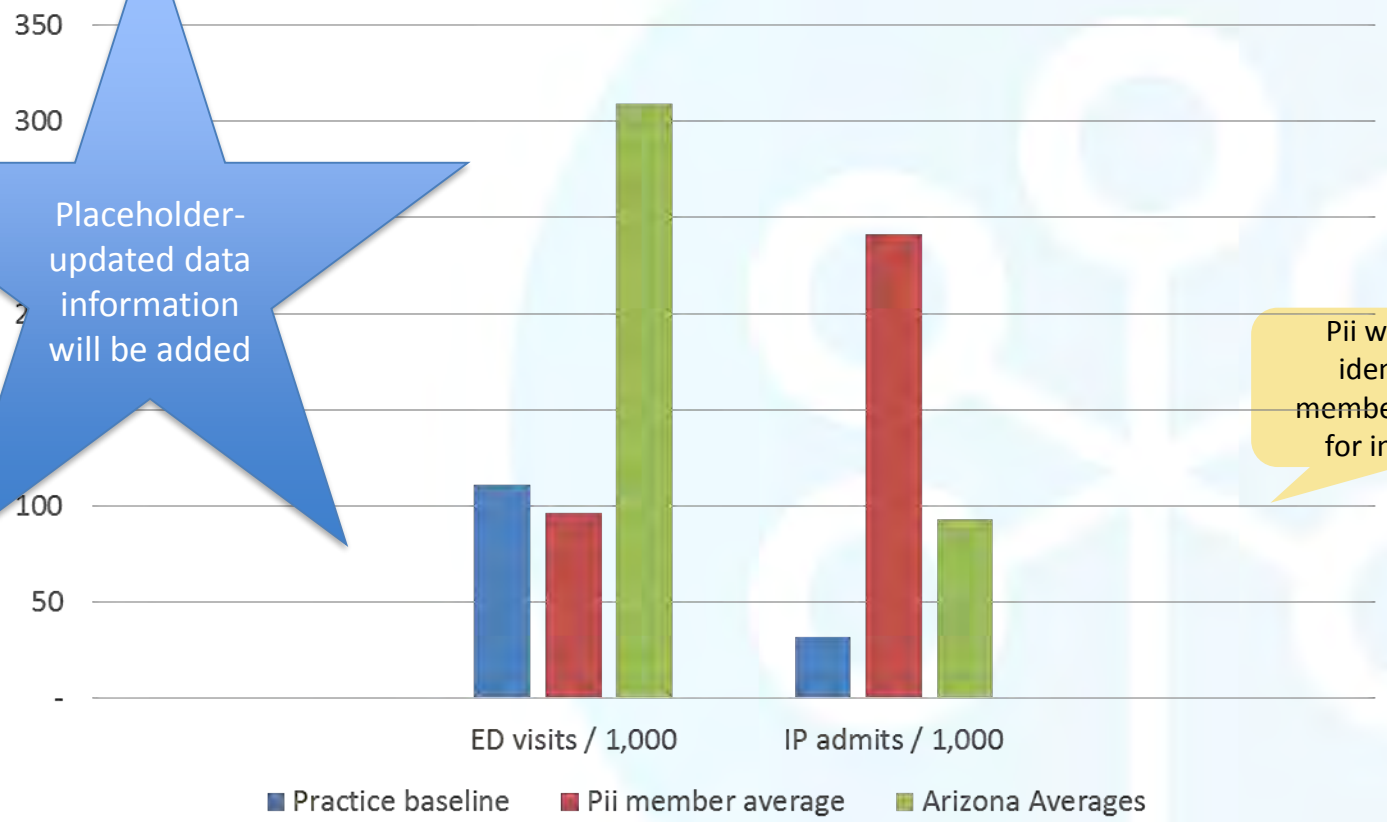
Pii Performance Scorecard – Adults
Reporting period 10/1/14 – 9/30/15**

PTC to enter information from Baseline Summary Report if available

Placeholder- updated data information will be added



Pii will help you identify these members and target for intervention

Note: *Timeframe 2014 calendar year; **Most current full year of data available; full year used to account for seasonality
Source: MCP claims data; Kaiser Family Foundation; AHA Annual Survey

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Population Health Tools

Health Information Exchange (HIE) activities are supported by (name of group) participation in the Statewide Health Integration Project (SHIP)

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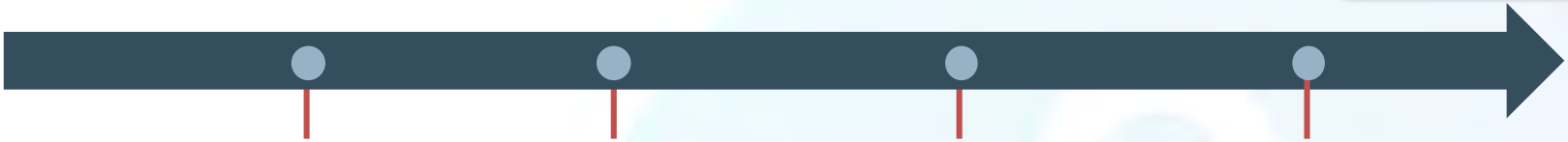
PTC coordinates with HIT personnel to capture dates

Process for connecting to the AzHeC health information exchange (HIE):



	Workflow completed	Provider portal and secure email set up	Alerts and notifications of ER visits, lab results, etc. enabled	HIE interface established
Estimated completion date	X/XXXX	X/XXXX	X/XXXX	X/XXXX

By connecting with the HIE, your practice will improve its ability to identify gaps in care and target members for intervention; for example:

- Alerts and notifications can help facilitate following up with members after ED visits
- Access to lab results can help prevent unnecessary duplicate testing
- The population health reporting tool can help your practice track progress on key quality and cost measures

As the HIE tools are implemented in the coming months, the Pii team will be available to help you incorporate these tools into your practice

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Vision and Goals of Transformation

TCPI AIMS, GOALS AND DRIVERS

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TCPI AIMs/Goals

(1) Support more than 140,000 clinicians in their practice transformation work.

(2) Build the evidence based on practice transformation so that effective solutions can be scaled.

(3) Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients.

(4) Reduce unnecessary hospitalizations for 5 million patients.

(5) Sustain efficient care delivery by reducing unnecessary testing and procedures.

(6) Generate $1 to $4 billion in savings to the federal government and commercial payers.

(7) Transition 75% of practices completing the program to participate in Alternative Payment Models

Primary Drivers	Secondary Drivers
Patient and Family-Centered Care Design	1.1 Patient & family engagement 1.2 Team-based relationships 1.3 Population management 1.4 Practice as a community partner 1.5 Coordinated care delivery 1.6 Organized, evidence based care 1.7 Enhanced Access
Continuous, Data-Driven Quality Improvement	2.1 Engaged and committed leadership 2.2 Quality improvement strategy supporting a culture of quality and safety 2.3 Transparent measurement and monitoring 2.4 Optimal use of HIT
Sustainable Business Operations	3.1 Strategic use of practice revenue 3.2 Staff vitality and joy in work 3.3 Capability to analyze and document value 3.4 Efficiency of operation

Sample Change Package

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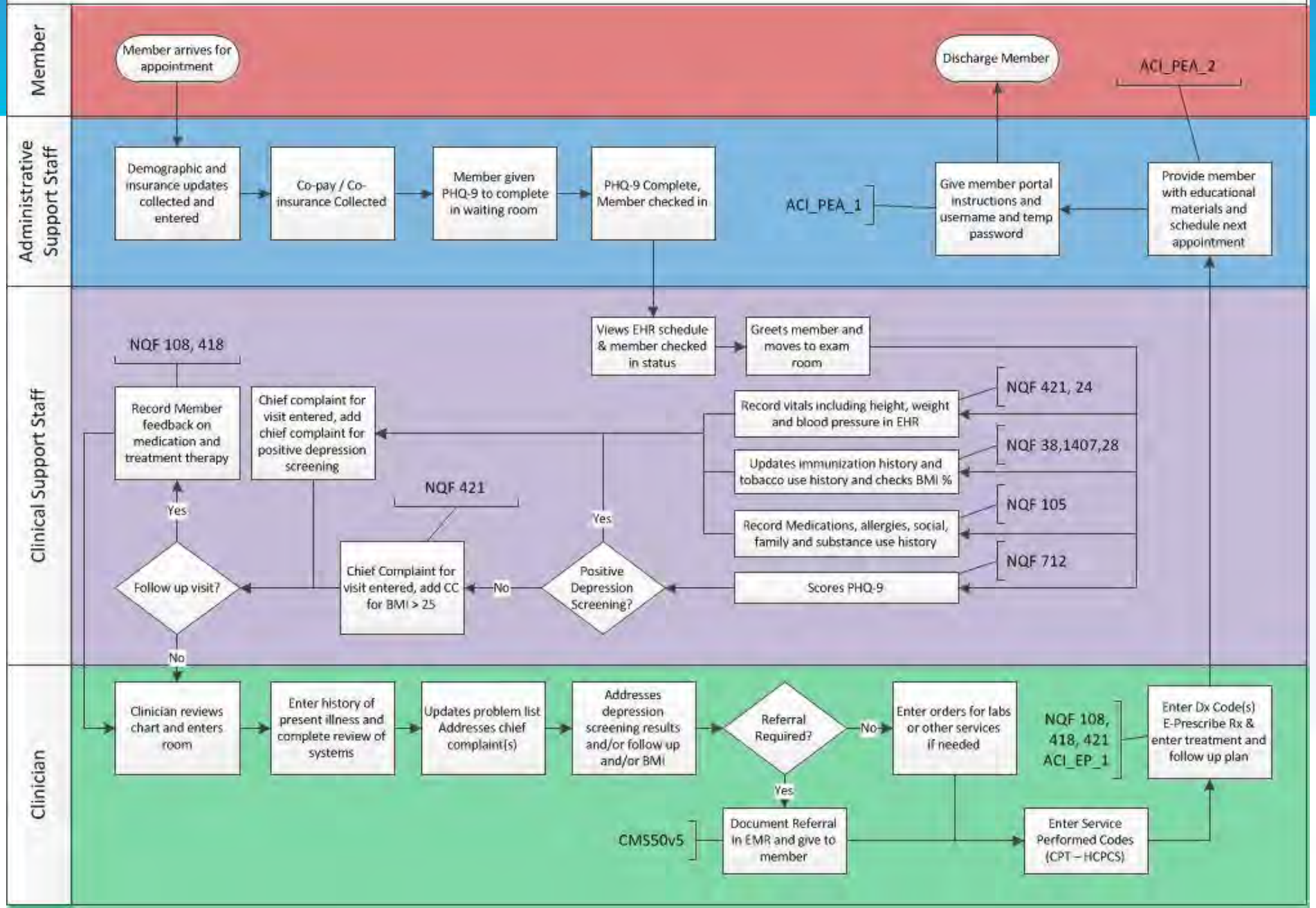
PRACTICE AIMS	QUALITY MEASURES	PRIMARY DRIVER	CHANGE PACKAGE ACTIONS
Population management	• Preventative Care & Screening: BMI Screening & Follow Up Plan • Weight Assessment & Counseling for Children & Adolescents • Tobacco Use & Cessation Intervention • Tobacco Use and help with Quitting Among Adolescents • Clinical Depression Screening & Follow Up Plan • Immunizations for Adolescents • Childhood Immunization Status	Patient & Family Centered Care Design	• Assign to Panels • Assign Accountability • Stratify Risk • Develop Registries • Identify Care gaps
Coordinated Care Delivery	• Closing the Referral Loop: Receipt of Specialist Report • Anti-Depressant Medication Management	Patient & Family Centered Care Design	• Manage Care Transitions • Establish Medical Neighborhoods • Coordinate Care • Ensure Quality referrals • Manage Medication Reconciliation
Organized, Evidence Based Care	• ADHD Follow Up Care for Children on ADHD Medication • Anti-Depressant Medication Management • Child & Adolescent Major Depressive Disorder (MDD) – Suicide Risk Assessment • Depression Utilization of PHQ-9 Tool • Bipolar Disorder & MDD: Appraisal for Alcohol / Substance Use	Patient & Family Centered Care Design	• Consider the Whole Person • Plan Care • Implement Evidence - Based Protocols • Decrease Care Gaps • Reduce Unnecessary Tests

Office Visit Process with Measures



Key Components of Empanelment

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1. Identify members most likely to benefit from empanelment.
2. Assess the risks and needs of each member
3. Develop a care plan together with the member/family
4. Teach the member/family about the disease and their management, including medication management
5. Coach the member/family how to respond to worsening symptoms in order to avoid the need for hospital admissions
6. Track how the member is doing over time
7. Revise the care plan as needed

Tools for Transforming Behaviors

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Let's talk BMI

Who can help your family eat right to stay at a healthy weight?

we can!
Ways to Enhance Children's Activity & Nutrition
A Program of the National Institutes of Health

Child & Adolescent MDD, Suicide Risk Assessment and Use of PHQ-9 Tool

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "√" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite —being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
	Not difficult at all _____
	Somewhat difficult _____
	Very difficult _____
	Extremely difficult _____

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS Ask questions that are bold and underlined	Since Last Visit YES	NO
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?***		
6) Suicide Behavior ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

Pediatric & Adolescent Care Plan Tool

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Action Plan

Child's Name

Date Of Birth

Parents/Caregivers

Primary Diagnosis

Secondary Diagnosis

Secondary Diagnosis(s)

Original Date of Plan

Updated Last

Main Concerns/ Goals	Current Plans/ Actions	Person(s) Responsible	Date Complete?

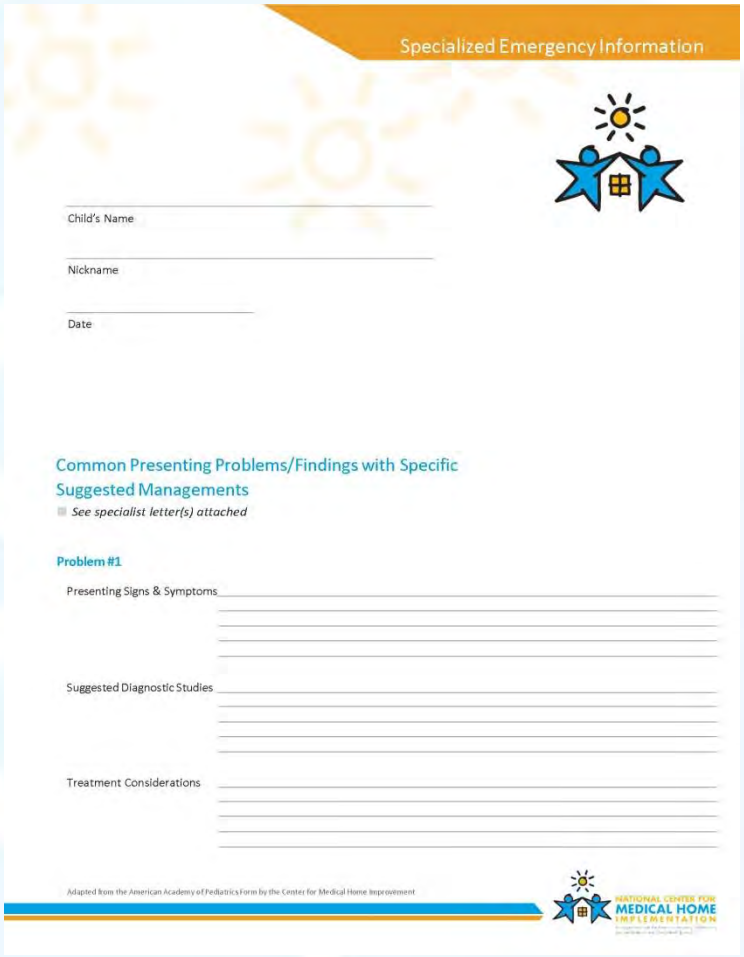
Parent/Caregiver Signature

Clinician Signature

Name of Care Coordinator

Developed by the Center for Medical Home Improvement and the National Center for Medical Home Implementation

NATIONAL CENTER FOR MEDICAL HOME IMPLEMENTATION



Specialized Emergency Information

Child's Name

Nickname

Date

Common Presenting Problems/Findings with Specific Suggested Managements

See specialist letter(s) attached

Problem #1

Presenting Signs & Symptoms

Suggested Diagnostic Studies

Treatment Considerations

Adapted from the American Academy of Pediatrics Form by the Center for Medical Home Improvement

NATIONAL CENTER FOR MEDICAL HOME IMPLEMENTATION

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Learning Opportunities

Upcoming Conferences

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Behavioral Health Integration Module 4
Learning Module 4: Measuring and Improving Care for Depression

When	TBD
Overview	The Integrating Behavioral Health into Primary Care series of modules offers a review of key concepts and tools that support the integration of physical and mental health care. Primary care practices are increasingly being called upon to address mental health needs as a part of treating the whole person. In this module, Tina Frontera, Chief Operating Officer, Minnesota Community Measurement*, will share her experience measuring and reporting all aspects of care for depression, including screening, follow-up, response and remission. The presenter will review the importance of universal screening, and share her story of statewide measurement, from selecting a measure and collecting data for performance comparison and improvement, to identifying variation between practices and aligning with other initiatives. This module is intended for PTN practice advisors and other staff, as well as clinics participating in a PTN; specifically, those interested in how Behavioral Health Integration can support Change Tactics related to Continuous, Data-Driven Quality (2.3.1).
What you will learn	•Specific tools for measuring depression screening, follow-up, response, and remission •About a specific regional initiative on depression screening, and how it aligns with national initiatives •Strategies for collecting and reporting data for performance comparison •How measurement is essential to improving mental health *Minnesota Community Measurement is the measure steward for three National Quality Forum endorsed measures: Six and Twelve Months Remission + Utilization of PHQ-9
Registration link	NRHI SAN: Behavioral Health Integration Module 4: Measuring and Improving Care for Depression

TCPi Transforming Clinical Practice Initiative

nrhi Network for Regional Healthcare Improvement | High-Value Care Support and Alignment Network

Goals of the "Pii Academy" Roadmap to Transformation

1. Providing education to support practice transformation
    - Training modules: Use modules to deliver educational materials in a logical sequence based on the Practice Assessment Tool (PAT), practice need, and progress along the change drivers
    - Seminars: All enrolled practices will be offered webinars via the TCPI website
    - Conferences: Pii Academy will offer conferences in conjunctions with the SANs, local and regional universities and academic groups to address the learning needs of the practices, clinicians and member advisory groups
2. Creating a learning healthcare system (LHS)
    - A LHS is based on cycles which include using data and analytics to generate knowledge, using this knowledge to give feedback to all stakeholders, and basing continual behavioral change around the knowledge gained
    - Partnerships across the healthcare community (e.g., academic institutions, educators, member advisory groups) will help practices turn data from routine clinical care into knowledge and knowledge into guidance for physicians at the point of care
    - These partnerships will also help bring technology, applications, telemedicine and other innovative approaches to transform care, particularly for vulnerable populations.
3. Developing centers of learning and innovation
    - Our practices represent unique populations of members and clinical services that serve diverse member populations with various mental health and physical health needs.
    - We can use learnings from caring for these populations to drive regional centers of learning and innovation

If organization has primary and specialty care-follow the primary care intro curriculum

Introductory Curriculum

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In the next 6 months, PIR's aims will be addressed by focusing on 5 key milestones:

	Area of focus / milestones	Driver	Goal
1	Practice has an organized approach to improvement	Data Driven Quality Improvement	Continuous, Data-Driven Quality Improvement
2	Practice establishes clear roles for each member of the care team	Team Based Care	Person and Family-Centered Care Design
3	Practice assigns members to a provider panel	Population Health / Empanelment	Person and Family-Centered Care Design
4	Practice identifies member risk level	Population Health / Empanelment	Person and Family-Centered Care Design
5	Practice has met its targets and has sustained improvements in practice-identified metrics for at least one year.	Engaged Leadership and Joy in Work	TCPI Aims

1 Milestone 1

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Milestone Description:	• Practice uses an organized approach (e.g. use of PDSAs, Model for Improvement, Lean, FMEA, Six Sigma) to identify and act on improvement opportunities
Relevant Learning materials:	• Steps Forward Modules – Quality Improvement module
Role of Technology:	• Practice management software can help standardize day-to-day operations and can provide a centralized way to schedule appointments, assign tasks to team members, generate reports, etc.
Next Steps:	• Assign an owner / practice champion for this change driver • date to complete module training with your PTC – *Pi Institute* *ntire team engaged in quality improvement activities* Module with PTC and discuss concrete ways to incorporate learnings into practice operation

PTC to enter score from business analyzer-Block 1 Curriculum

Practice PAT score
1

Transformation Timeline

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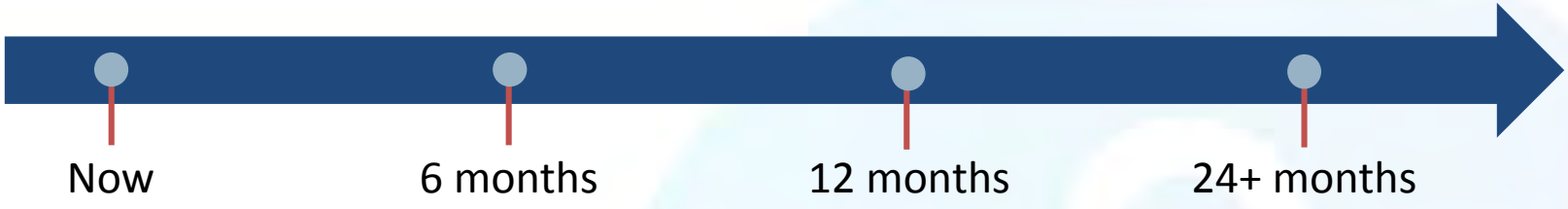

Now

- Execute against this business plan
- Review A&Ns which will help you standardize your practice's response to ED visits and hospital admissions
- Receive training on these tools so that you are able to effectively access and interpret member data

6 months

- Continue training on the tools and updating customized care paths to reflect your members' needs
- Establish connectivity with the statewide HIE
- Pii will perform a new PAT to check in on progress and develop an updated business plan

12 months

- Gain access to and training on the population health analytics and reporting tool
- Pii will perform a new PAT to check in on progress and develop an updated business plan

24+ months

- Continue to engage with your PTC to integrate new tools and capabilities into your practice's workflow
- Pii will perform a new PAT every 6 months to check in on progress and develop an updated business plan

Resources

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Healthcare Communities
http://www.healthcarecommunities.org/HCLogin/tabid/1234/Default.aspx?returnurl=%2fCommunities%2fMyCommunities%2fTCPI%2fPTNSANStaff%2fDataHub.aspx

Practice Innovation Institute
http://www.healthcarecommunities.org/Communities/MyCommunities/TCPI/PTN/PracticeInnovationInstitute.aspx

ACP Practice Advisor
https://www.practiceadvisor.org/about

Steps Forward Modules
https://www.stepsforward.org

Next Steps

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