Practice Transformation Network (PTN) Fact Sheet

The National Rural Accountable Care Consortium (Consortium) is a non-profit organization that supports primary care practice transformation to improve care, reduce unnecessary healthcare costs, and improve patient satisfaction, while also improving the financial performance and sustainability of the participating practices.

In September 2015, the Consortium received a four-year cooperative agreement for up to $31 million from the Centers for Medicare & Medicaid Innovation (CMMI) Transforming Clinical Practices Initiative (TCPI). With this funding, the Consortium has established a Practice Transformation Network (PTN) that will assist more than 7,000 small and safety net practices transition from fee-for-service payment models to value-based payment models including:

- Advanced payment models, such as Medicare, Medicaid and commercial Accountable Care Organizations (ACO's)
- Physician's Quality Reporting System (PQRS)
- Value-Based Modifiers (VBM's)
- Merit-Based Incentive Program System (MIPS)

It provides free, direct training and support for Practice Managers and Care Coordinators to facilitate value-based care, while providing the population health management infrastructure to support better care, lower costs, higher clinician and patient satisfaction and improved practice. *The Network supports participating clinicians with the following **free** services and resources:*

Set up your billable care coordination service for Medicare Patients

Train, certify and mentor your Care Coordinators to manage the chronically ill:

Practices provide a nurse to serve as the Care Coordinator (CC) for the chronically ill Medicare patients in the practice. After completing a six-week online course, the Care Coordinator will be tested and certified in a local workshop using the Iowa Chronic Care Consortium's curriculum. He/she will belong to a regional learning cohort with regular mentoring and support calls and quarterly skill improvement workshops. These skills can be easily scaled to serve all payors in population health programs.

Implement the necessary infrastructure to qualify for Chronic Care Management (CCM) and Transitions of Care Management (TCM) Medicare billing:

The Network will integrate data from the practices' Electronic Health Record (EHR) to the Lightbeam Health Population Management Solution to facilitate care coordination and quality improvement using flat files at no cost to the practice. Lightbeam Care Management software will provide evidence-based care plans available to all members of the care team 24/7, supported by a 24-hour advice nurse hotline – a requirement for billing Medicare for Chronic Care Management – and identify high risk

patients and gaps in care, create work queues and provide all necessary documentation of services for Medicare CCM and TCM billing.

Redesign your practice to manage population health

Report and improve ambulatory quality scores:

Ambulatory quality scores will have significant impact on payment going forward. The Network will promote the reporting of the 34 Medicare Shared Savings Program ACO Quality Measures, which cover the basics of preventive care, patient satisfaction, care coordination and chronic disease management. Experts will work with the staff to implement quality improvement initiatives, identify reporting gaps and redesign front office workflows to maximize quality performance and value-based payments.

Practice Managers and Care Coordinators will attend quarterly quality improvement workshops to improve quality scores and performance under value-based payments. After a didactic session, practice staff will work with quality improvement experts to design an implementation plan appropriate for the individual practice, with project managers and support staff following up to help overcome barriers and keep the practice on track in the program.

Measure patient satisfaction at the point of care:

Tablet-based patient satisfaction surveys will be deployed in each clinic. Practices will be provided with monthly reports of results to identify areas of potential improvement on this important metric that typically comprises 25% or more of the total quality score in value-based payments.

Increase practice revenue and clinician satisfaction

Increase practice revenue:

Many of the activities that increase quality scores (Annual Wellness Visits, Smoking Cessation Counseling, Obesity Counseling, Chronic Care Management, Advanced Care Planning and many more) also generate significantly more revenue for the practice. The Network's quality improvement workshops will work with staff to implement these programs under the supervision of the billing clinicians -- improving quality, revenue and clinician satisfaction.

Maximize additional population health payments:

Once the systems are in place to manage patients and report quality, practices are eligible for additional payments from commercial payors, Medicare Advantage plans, and Medicaid managed care organizations. Participants are offered no-risk, no-cost participation in a state-based clinically integrated network of like-minded independent practices, who will be offered opportunities to participate in enhanced payment models with multiple payors to get paid for managing population health.

Identify the right advanced payment models for your community:

Every practice has unique attributes that must be well understood in the context of advanced payment models. Whether it is bundled payments, accountable care organizations, comprehensive primary care initiatives, community care organizations or clinically integrated networks, the options are many and the pace of change is relentless. The Network subsidizes annual divisional leadership meetings that bring policymakers, clinicians and hospital administrators together to learn from each other, become fully educated on advanced payment options and develop strategic and operational plans that work for everyone.

Qualifying Network Participants:

Physicians • PAs • NPs • Critical Access Hospitals (CAHs) • Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs) • Rural Fee-for-Service Clinics • Urban Fee-for-Service Practices

NOTE: Practice cannot already be part of any Medicare Shared Savings program (MSSP, Pioneer, NextGen, CPCI, etc.) and cannot be currently participating in any other CMMI Practice Transformation Network. Bundled payment participants are not excluded from participating.

Requirements:

The PTN is funded by a Centers for Medicare & Medicaid Innovation cooperative agreement and provides support, training, travel and programs at ***no cost*** to Providers. Providers are required to provide an in-house Care Coordinator and Practice Manager to attend quarterly quality improvement workshops to remain in the program. Through active participation in our PTN program, participants will gain the skills and knowledge that will allow them to move into the shared savings program of their choice, which may include an Accountable Care Organization (ACO), Medicare Advantage Plan, private-payor programs, or new emerging models from CMS. If not fully satisfied, the practice can terminate participation at any time with no penalty.

To apply, visit: www.NationalRuralACO.com/ApplyNow

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