Establish Your Value-Based Infrastructure at No Cost.
What is a Practice Transformation Network (PTN)?

• The Practice Transformation Network (PTN) program is designed to help small and safety net providers transition from fee-for-service payment models to advanced payment models, and also to be able to succeed under the new guidelines for the Physician’s Quality Reporting System (PQRS) and the Value-Based Modifiers (VBM).

• This program is funded by the Transforming Clinical Practices Initiative (TCPI).
HOW DO WE TRANSITION FROM VOLUME TO VALUE?

E & M Procedures

2015 → 2016 → 2017 → 2018 → 2019

AWV
TCM - CCM
TCPI Program Elements that Drive Success in Quality Payment Program (QPP) and Population Health

**Billable Prevention Services:**
- Annual Wellness Visits
- Chronic Care Management – Transitional care Management
- Advanced Care Planning
- Behavioral Counseling
- Depression Screening
- Mental Health Support

**Coding:**
- HCC 101

**Quality:**
- Process
- Pre-visit Planning
- Patient Satisfaction
Step One: Set up your Care Coordination Program

EDUCATION: Attend Care Coordination Webinar
ACTION: Designate a Care Coordinator

• Certify your coordinators with the Clinical Health Coach (CHC) Training program offered by the Iowa Chronic Care Consortium.
  • A 27-hour on-line and self-paced program.
• Participate in hands-on Regional Workshops held quarterly.
Step Two: Develop Your Billable Chronic Care Management (CCM) Service

EDUCATION: Attend Chronic Care Management Webinar
ACTION: Download Consent Form and Support Materials

- Train and Certify your Care Coordinators as Clinical Health Coaches (CHC)
- Implement the necessary IT infrastructure for access to Care plans in Lightbeam
- Provide a federally-funded 24/7 nurse advice hotline
- Bill Medicare $42 PMPM
Lightbeam Data Support

Action for Success: Designate a person as Super User for Lightbeam – Webinar training instruction for Care Planning.

Lightbeam Health Data Software

- For 24/7 access to your patient’s care plan
- Allows for CCM billing
Care Management

### Alzheimer's Disease Care Plan - Case ID 20

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Step Three: 24-Hour Nurse Advice Hotline

EDUCATION:  Attend 24hr Nurse Advice Hotline Webinar
ACTION:  Complete Survey on PTN resources page

• 24-hour telephonic access to medical advice for Medicare patients.
• Necessary for your billable care coordination program’s after-hours coverage.
Step Four: Point-of-Service Patient Satisfaction Survey Tool and Tablet

EDUCATION: Attend webinar about survey tool and tablet.
ACTION: Complete Survey posted on PTN resources page.

• Each practice is eligible to receive single use tablet for patients to complete satisfaction survey & receive feedback.
• Tablets will be deployed within 60 days of enrollment.
Step 5: Preparing to become a Patient-Centered Medical Home (PCMH)

**ACTION:** Complete Practice Baseline Assessment

**EDUCATION:** Attend webinar about PCMH.

**ACTION:** Complete Plan-Do-Study-Act activities.

- Assessment is aligned with PCMH goals and track’s your practice performance.
- Conducted by NRACC Quality Specialist or your state’s QIO/QIN with your leadership.
- Lays the foundation to apply for certification as a PCMH. PCMH elements are built into quarterly training workshops in a Plan, Do, Study, Act (PDSA) format.
Step 6: Practice Workflow Redesign

EDUCATION / ACTION:
Schedule staff to attend one Regional Workshop per quarter.

• Your practice will receive easy-to-implement workflow tools.
• We will work together to create custom implementation plan – tailored to your practice’s needs and challenges.
OUTCOMES: Redesign Your Practice to Better Manage Population Health

• Modify clinic workflow to address care gaps
• Provide data to identify cost-savings opportunities
• Report and improve ambulatory quality scores
• Measure patient satisfaction at the point of care (Tablet)
• Get paid quality bonuses
OUTCOMES: Improved Billing and New/Increased Revenue Streams

Action for Success: Actively participate in program activities – PDSAs, Workflows, Trainings, and Workshops.

• Program activities designed to reduce cost and improve quality.
• Maximize additional population health payments
• Prevent value-based payment penalties
• Improve financial stability of local health systems.
In Summary, TCPI is the First Step of a Strategic Plan for Practice Transformation

- Optimize Quality MIPS Incentive - Develop Pop Health Infrastructure (TCPI)
- Form Clinically Integrated Networks (CIN) with Other Independents
- Form -Join ACO's - MSSP, Commercial and Medicaid
- Participate in Advanced APM – PCMH, Bundled Payments, CPC+
TCPI Participation Requirements

• Participants must appoint or hire an in-house care coordinator (will bill Medicare for new services)
• Active participation in the program, including attendance at:
  • Training webinars
  • Regional workshops
    (Travel for regional & divisional workshops is reimbursed through the grant)
Questions? – Next Steps

Go to www.nationalruralaco.com
Click on Apply Now to get ready for the future.

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THANK YOU!