Practice Transformation Network

Manage Population Health

Get More Revenue

Coordinate Care

Qualify for PCMH

NATIONAL RURAL
ACCOUNTABLE CARE CONSORTIUM

www.NationalRuralConsortium.org
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Who is the Consortium?

• The National Rural Accountable Care Consortium is a non-profit organization that supports rural healthcare transformation.

• Formed by rural providers to avoid being left behind.

• Awarded $31 million TCPI grant in 2015 to assist 525 rural health systems to prepare for value-based payments.
Green = ACOs
Blue = TCPI
Our Triple Aim

Provide Better Care

Improve Financial Performance

Lower Per Capita 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 funding by the Transforming Clinical Practices Initiative (TCPI).
Set Up Your Billable Care Coordination Service

- Train, certify, and mentor your care coordinators
- Implement the necessary IT infrastructure
- Provide a federally-funded 24/7 nurse advice hotline
- Bill Medicare $42 PMPM
Redesign Your Practice to 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
Qualify You for Patient-Centered Medical Home

- Develop physician-led care teams
- Facilitate coordinated, integrated care
- Promote culture of quality and safety
- Increase access to primary care

- Get paid PCMH bonuses
Increase Your Revenue to Preserve Your Future

• Increase local utilization
• Maximize additional population health payments
• Prevent value-based payment penalties
• Identify the right advanced payment models for your community
• Join a non-binding CIN to gain more revenue
## Mammoth Hospital

**NRACO Qtly Reporting Results**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Metric Name</th>
<th>2014</th>
<th>2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>At-Risk Population Coronary Artery Disease</td>
<td>CAD-2 Lipid Control**</td>
<td>Eligible: 11</td>
<td>Measure Met: 9</td>
<td>Performance: 61.82%</td>
</tr>
<tr>
<td>At-Risk Population Coronary Artery Disease</td>
<td>CAD-7 ACE or ARB with Diabetes or LVSD</td>
<td>Eligible: 7</td>
<td>Measure Met: 5</td>
<td>Performance: 71.43%</td>
</tr>
<tr>
<td>At-Risk Population Coronary Artery Disease</td>
<td>CAD-Composite</td>
<td>Eligible: 11</td>
<td>Measure Met: 7</td>
<td>Performance: 63.64%</td>
</tr>
<tr>
<td>Care Coordination/Patient Safety</td>
<td>CARE-1 Medication Reconciliation**1</td>
<td>Eligible: 2</td>
<td>Measure Met: 2</td>
<td>Performance: 100.00%</td>
</tr>
<tr>
<td>Care Coordination/Patient Safety</td>
<td>CARE-2 Fall Screening</td>
<td>Eligible: 5</td>
<td>Measure Met: 1</td>
<td>Performance: 20.00%</td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>Depression remission 12 months</td>
<td>Eligible: 3</td>
<td>Measure Met: 0</td>
<td>Performance: 0.00%</td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-7 Eye Exam</td>
<td>Eligible: 4</td>
<td>Measure Met: 3</td>
<td>Performance: 75.00%</td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-13 High Blood Pressure Control**2</td>
<td>Eligible: 4</td>
<td>Measure Met: 2</td>
<td>Performance: 50.00%</td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-14 LDL-C Control in Diabetes</td>
<td>Eligible: 4</td>
<td>Measure Met: 2</td>
<td>Performance: 50.00%</td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-15 Hemoglobin A1c Control</td>
<td>Eligible: 4</td>
<td>Measure Met: 0</td>
<td>Performance: 0.00%</td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-16 Daily Aspirin or Antiplatelet with IVD</td>
<td>Eligible: 1</td>
<td>Measure Met: 1</td>
<td>Performance: 100.00%</td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-17 Tobacco Non-Use**2</td>
<td>Eligible: 4</td>
<td>Measure Met: 3</td>
<td>Performance: 75.00%</td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-2 HA1c Poor Control**3 (lower score)</td>
<td>Eligible: 4</td>
<td>Measure Met: 1</td>
<td>Performance: 25.00%</td>
</tr>
<tr>
<td>At-Risk Population Diabetes</td>
<td>DM-Composite</td>
<td>Eligible: 4</td>
<td>Measure Met: 0</td>
<td>Performance: 0.00%</td>
</tr>
<tr>
<td>At-Risk Population Heart Failure</td>
<td>HF-6 Beta-Blocker Therapy for LVSD</td>
<td>Eligible: 5</td>
<td>Measure Met: 4</td>
<td>Performance: 80.00%</td>
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<tr>
<td>At-Risk Population Hypertension</td>
<td>HTN-2 Controlling High Blood Pressure</td>
<td>Eligible: 15</td>
<td>Measure Met: 9</td>
<td>Performance: 60.00%</td>
</tr>
<tr>
<td>At-Risk Population Ischemic Vascular Disease</td>
<td>IVD-1 LDL-C Control**</td>
<td>Eligible: 9</td>
<td>Measure Met: 4</td>
<td>Performance: 44.44%</td>
</tr>
<tr>
<td>At-Risk Population Ischemic Vascular Disease</td>
<td>IVD-2 Use of Antithrombotic</td>
<td>Eligible: 9</td>
<td>Measure Met: 9</td>
<td>Performance: 100.00%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-05 Breast Screening</td>
<td>Eligible: 32</td>
<td>Measure Met: 20</td>
<td>Performance: 62.50%</td>
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<tr>
<td>Preventative Health</td>
<td>PREV-06 Colorectal Cancer Screening</td>
<td>Eligible: 36</td>
<td>Measure Met: 18</td>
<td>Performance: 50.00%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-07 Influenza Immunization</td>
<td>Eligible: 16</td>
<td>Measure Met: 3</td>
<td>Performance: 18.75%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-08 Pneumonia Vaccination</td>
<td>Eligible: 25</td>
<td>Measure Met: 9</td>
<td>Performance: 36.00%</td>
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<tr>
<td>Preventative Health</td>
<td>PREV-09 Body Mass Index Screening</td>
<td>Eligible: 21</td>
<td>Measure Met: 17</td>
<td>Performance: 80.95%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-10 Tobacco Use Screening</td>
<td>Eligible: 20</td>
<td>Measure Met: 20</td>
<td>Performance: 100.00%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-11 High Blood Pressure Screening</td>
<td>Eligible: 36</td>
<td>Measure Met: 26</td>
<td>Performance: 72.22%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>PREV-12 Clinical Depression Screening</td>
<td>Eligible: 19</td>
<td>Measure Met: 3</td>
<td>Performance: 15.79%</td>
</tr>
</tbody>
</table>

**Grand Total**

- Eligible: 304
- Measure Met: 175
- Performance: 57.57%
- Eligible: 207
- Measure Met: 173
- Performance: 83.57%
- Change: 26.01%
Eligibility

• PHYSICIANS, PA’s and NP’s
• Rural PPS Hospitals
• Critical Access Hospitals (CAHs)
• RHCs, FQHCs
• Rural Fee-for-Service Clinics
• Urban rural network providers
• Not already part of any Medicare Shared Savings program (MSSP, CPCI, etc.)
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
  • Divisional workshops, and

(Travel for regional & divisional workshops is reimbursed through the grant)
Questions? Ready to Join?

Go to www.nationalruralaco.com
Click on Apply Now

OR contact:
info@nationalruralaco.com

OR go to our webinar:
March 11, 12 PM Pacific
www.readytalk.com, 5004777