NATIONAL RURAL
ACCOUNTABLE CARE CONSORTIUM

PRACTICE TRANSFORMATION NETWORK TRAINING

2016 PROGRAM OVERVIEW

As healthcare rapidly transforms to new value-based payment systems, your level of success will be dramatically improved by participation in Practice Transformation Network training. Your Practice Transformation Network provides you with a comprehensive training program for executive leadership, trustees, clinicians, care coordinators, IT staff and practice managers. Through frequent webinars, local quality improvement workshops and leadership summits, we will help you better manage your population, improve quality scores and patient satisfaction and achieve financial success. Many of these meetings can be attended real time or at your own convenience, using our online portal. All trainings are offered at no cost, and reasonable travel costs will be reimbursed.

VALUE-BASED TRAINING FOR YOUR TEAM

We have a lot to learn together. The faster we can all get up to speed, the sooner we will begin to realize the benefits of the new value-based payment systems. Our program offers targeted, timely information that is available real-time or on-demand. We recommend the following participation for each role in your organization:

Executive Leadership should attend the Orientation Webinar, Annual Delivery System Reform Workshop and Monthly CEO Cohort Calls.

Care Coordinators should attend the Orientation Webinar, Quarterly Quality Improvement Workshops, All Program Webinars (Live or On Demand) and Monthly Care Coordinator Cohort Calls.

IT Staff should attend the Orientation and Lightbeam Webinars.

Practice Managers should attend the Orientation Webinar, Quarterly Quality Improvement Workshops, All Program Webinars (Live or On Demand), and Monthly Practice Manager Cohort Calls.

Clinicians should attend the Orientation Webinar, Annual Delivery System Reform Workshop, Evidence-Based Medicine Webinars, Monthly Physician Cohort Calls.

PARTICIPATION REQUIREMENTS

In order to be successful in value-based payments, practices must optimize workflow to promote population health and maximize quality scores, care coordinators must manage the chronically ill, patients must be satisfied with their experience of care and clinician incentives and support must be aligned.

Our program will deliver the results you need to be successful. We recommend you participate in all offerings, but you *must* participate in at least one practice transformation program (Care Coordination, Quality Improvement or Patient Satisfaction).

We ask you to select our preventive health measures for your Meaningful Use Clinical Quality Measures, so we can show the impact of our program on your quality scores with an easily generated report. We will also require you to participate in a periodic assessment of your practice. If you don't like the program for any reason, you can leave at any time without penalty. There is no cost for participation.

A calendar of all events can be found through the Healthcare Communities Portal page. You can go at your own pace, engaging in as many of the programs you want.

ORIENTATION WEBINAR: WELCOME TO PRACTICE TRANSFORMATION TRAINING

FOR LEADERS, CLINICIANS, PRACTICE MANAGERS, CARE COORDINATORS, IT STAFF

Get a complete overview of all programs, learn what is expected from you and your practice, and discover how you can be successful in the program.

WHERE TO LEARN

PTN Introduction/Orientation Webinar – Attend live the third Wednesday of every month at 12:00 p.m. PT or view a pre-recorded version at your convenience.
Log on to www.readytalk.com, Code 5004770 and call 303-248-0285, Code 5004770.

To view past webinar recordings at your own pace, please login to your account on www.nationalruralaco.swankhealthcare.com.

CARE COORDINATION
FOR CARE COORDINATORS AND IT STAFF

Everything you need to know to help chronically ill patients get the care they need, build market share and begin billing Medicare for new Chronic Care Management and Transitions of Care Management codes.

PROGRAM DESCRIPTION

The essential element for value-based payment success is the coordination of care for patients with multiple chronic diseases. Special attention will be paid to managing the chronically ill, promoting evidence-based practices and helping patients learn self-management of their disease. Patients with two or more chronic conditions will be encouraged to participate in your Care Coordination program, resulting in better outcomes, lower per capita costs and better alignment with the 20% of your patients that comprise 80% of healthcare spending in your community.

Generally led by a nurse in your practice or community, the Care Coordination program will use both local and virtual care teams of pharmacists, mental health professionals, advice nurses, nutritionists and community resources to support this fragile population. They will take the burden off of the physicians in the clinics and the emergency room by providing the support needed to manage their disease and avoid unnecessary hospitalizations and readmissions.

Regular physician visits will be supported by clear patient goals to maximize compliance and adherence to the care plan. Referrals will be tracked and accompanied by patient data and care coordination support, ensuring a closed loop of information and the avoidance of wasteful, duplicate procedures.

The care coordinator will use the Lightbeam Care Management module to develop care plans, track patients' progress and document their work for Chronic Care Management billing. Lightbeam predictive analytics will be used to create patient registries to identify patients who can benefit from Care Coordination.

Our evidence-based Nurse Advice Hotline has 24/7 access to the electronic care plan through Lightbeam, enabling you to successfully bill Medicare $42 for each patient your care coordinator provides care management support for a minimum of 20 minutes per month. Our Care Coordinator mentors, cohort calls, training, workshops and certification are all designed to develop this important skill within your practice.

CARE COORDINATION (CONTINUED)
FOR CARE COORDINATORS AND IT STAFF

TOOLS PROVIDED
Nurse Advice Hotline Questionnaire
Care Coordinator Questionnaire
Quarterly Quality Improvement Workshops
Lightbeam Health Care Management Module
Sample Care Coordinator Care Plans
24-Hour Nurse Advice Hotline with Access to your Electronic Care Plans
Iowa Chronic Care Consortium Online Training Program
In-Person Health Coach Certification
Chronic Care Management Billing and Coding Workflows and Assistance
Individual Care Coordinator Mentoring
Care Coordinator Cohort Calls

WHERE TO LEARN
Quality Improvement Workshops
Iowa Chronic Care Consortium Online Training Program
Webinars On Demand
Care Coordinator Cohort Calls

WEBINAR AND WORKSHOP TOPICS
Transitions of Care Management/Chronic Care Management Overview
Establishing Your Nurse Advice Hotline
Chronic Care Management Billing for Medicare
Lightbeam Health Care Management Module
Iowa Chronic Care Consortium Training Program

NOTE: THE NURSE ADVICE HOTLINE CAN BE EXPANDED FOR PATIENTS BEYOND MEDICARE FOR A FEE OF $0.25 PER PATIENT PER MONTH.

QUALITY IMPROVEMENT
FOR PRACTICE MANAGERS, CARE COORDINATORS, IT STAFF

Optimize your workflow to improve quality scores, patient outcomes and practice revenues.

PROGRAM DESCRIPTION

High quality scores show your community that you have implemented critical patient-centered processes that promote prevention, wellness and standards of care for high risk populations, and will have a dramatic impact on your payments under delivery system reform. This program is designed to help you attain the highest level of quality scores with the least amount of wasted effort and confusion.

We begin with teaching your staff our version of the Medicare Wellness Visits at your Local Quality Improvement Workshop, which addresses 100% of your preventive measures and 50% of the Clinical Quality Measures used by Accountable Care Organizations. Successfully implementing this program for at least half of your Medicare patients will help keep your community healthy, extend life-expectancy, prevent progression of silent diseases and generate significant income. We will develop an individual work plan for your practice and follow up to help your staff implement the programs that will get your quality scores into the top percentiles with the least amount of disruption to your practice.

Once your staff has mastered optimizing prevention and wellness, we will work with your practice managers to redesign workflows to manage Diabetics, patients with Heart Disease, Ischemic Vascular Disease, Pulmonary Disease and other diseases that are routinely measured for value-based payments.

We will interface your Electronic Health Record and monitor your progress using the Lightbeam Health Quality Reporting module. If data is not being collected or recording properly, our Quality Improvement Specialists will help you modify your workflow to ensure your quality scores reflect your work.

On a monthly basis, practice managers can participate in cohort calls to share best practices, and learn from their peers about how they are able to overcome barriers, innovate solutions and share their successes. Pre-recorded webinars are also available for more information.

QUALITY IMPROVEMENT (CONTINUED)
FOR PRACTICE MANAGERS, CARE COORDINATORS, IT STAFF

TOOLS PROVIDED
IT Questionnaire
Quarterly Quality Improvement Workshops
Lightbeam Health Quality Reporting Module
Lightbeam EHR Interface
Quality Improvement Specialists
Practice Manager Cohort Calls
Practice Assessments

WHERE TO LEARN
Quality Improvement Workshops
Webinars On Demand
Practice Manager Cohort Calls

WEBINAR AND WORKSHOP TOPICS
Using Lightbeam to Improve Quality Measures – *Recommended for IT Staff*
Prevention and Wellness
Billing and Coding for Value-Based Payments
Post-Acute Care
Diabetes
CHF
Vascular Disease Pulmonary Disease
Behavioral and Mental Health

PATIENT ENGAGEMENT
FOR PRACTICE MANAGERS

Improve patient satisfaction and engagement in management of their health, and increase compliance, loyalty and market share.

PROGRAM DESCRIPTION

Value-based payments are heavily weighted toward patient satisfaction, which frequently comprises up to 25% of your total quality score and quality score payment. CMS requires patients to be surveyed for population health programs about their experience in the ambulatory setting – asking them whether they are getting timely care and access to specialists, how the provider communicated and whether they felt included in the decision- making, whether they were given educational materials and support that promoted their health and asking them to rate their provider and their overall health status. Getting high results in patient satisfaction often translates to better patient loyalty and engagement in managing their disease, resulting in better outcomes and financial performance.

We provide a brief in-office survey using electronic tablets so that you can get inexpensive, real-time feedback from your patients about their experience of care. You can view your results at any time, and we also email monthly patient satisfaction reports to your practice manager. We will also focus a local quality improvement workshop specifically on patient satisfaction, so that your practice manager can learn best practices to achieve the highest possible rating.

TOOLS PROVIDED

Patient Satisfaction Survey Questionnaire
Patient Satisfaction Survey Tablets
Patient Satisfaction Survey Reports
Patient Satisfaction Quality Improvement Workshop
Practice Assessments
Practice Manager Cohort Calls

WHERE TO LEARN

Quality Improvement Workshops Webinars On Demand
Practice Manager Cohort Calls

WEBINAR TOPICS

Patient Satisfaction Survey Implementation
Patient Centered Medical Homes

CLINICALLY INTEGRATED NETWORKS
FOR EXECUTIVE LEADERSHIP AND CLINICIANS

Join other independent organizations in your state to take advantage of value-based contracts that will reward you for high quality and managing cost.

PROGRAM DESCRIPTION

The key to accessing value-based payments is critical mass. Payors are reluctant to engage with individual practices due to the high variability of healthcare spending. Most require thousands of attributed lives to participate in their programs. Our provider-owned and governed Clinically Integrated Networks allow you to access extra payments, claims data and other resources to help support your patients. We aggregate independent providers in your state to take advantage of these contracts, providing the legal structure and documents, leadership and governance model that has been tested in dozens of Accountable Care Organizations that aggregate unaffiliated and independent providers.

Our professional negotiator will develop value-based contracts on behalf of the Network members, which each practice is free to either accept or reject. These contracts typically pay an additional care coordination fee and have a quality reporting and bonus component in addition to a shared savings component. These contracts do not affect existing reimbursement in any way. We do not negotiate rates and we do not bind anyone to risk-bearing contracts.

TOOLS PROVIDED

Entity Formation
Legal Documents
Payor Negotiations
Governance Support

WHERE TO LEARN

Clinically Integrated Network Webinar
Clinically Integrated Network Conference Calls
Clinically Integrated Network Meetings

DELIVERY SYSTEM REFORM
FOR EXECUTIVE LEADERSHIP, TRUSTEES, CLINICIANS

Learn about new payment models that reward you for improving the health and well-being of the community, and how to adapt and succeed under Delivery System Reform.

PROGRAM DESCRIPTION

The pace of change in healthcare payment is unprecedented. New policies and acronyms are introduced constantly, making it very hard for leaders, clinicians and board members to keep apprised of the changes while still serving their patients' needs.

We will review all of the policies that are currently in development and proposed, and give you specific instructions about how you can engage in developing those new policies and programs to ensure they work for you and your patients. We will notify you of these proposed policies by email, and have policy update webinars to keep you abreast of where change is going and to give you an opportunity to provide feedback to policy makers.

We also provide a local annual Delivery System Reform workshop for clinicians and trustees to clearly explain all of the different value-based programs and payments under Medicare. These are designed to enable you to bring your entire board and the majority of your clinicians together so that we can facilitate conversations among you about how to approach these new models of care and payment. We will provide advice from top legal firms and nationally recognized leaders about how you should modify your contracts, programs and policies to keep pace with delivery system reform and work with your teams to develop an individual work plan for your community health system.

TOOLS PROVIDED

Policy Update Emails
Policy Update Webinars
Annual Delivery System Reform Workshop
Practice Assessments
Sample Physician Contracts

WHERE TO LEARN

Policy Update Emails
Policy Update Webinars
Delivery System Reform Workshop

QUALITY IMPROVEMENT WORKSHOPS SCHEDULE

Workshop dates and locations are subject to change

	Meeting Location: City, State	Workshop #2
1	Reno, Nevada	July 11, 2016
2	Jackson, Mississippi	July 12, 2016
3	Missoula, Montana	July 12, 2016
4	Tupelo, Mississippi	July 13, 2016
5	San Jose, California	July 13, 2016
6	Billings, Montana	July 14, 2016
7	Eugene, Oregon	July 15, 2016
8	Glendive, Montana	July 15, 2016
9	Raleigh, North Carolina	July 15, 2016
10	Columbus, Ohio	July 19, 2016
11	Denver, Colorado	July 19, 2016
12	Sioux Falls, South Dakota	July 19, 2016
13	Indianapolis, Indiana	July 20, 2016
14	Albuquerque, New Mexico	July 21, 2016
15	Minneapolis, Minnesota	July 21, 2016
16	Charleston, West Virginia	July 22, 2016
17	Des Moines, Iowa	July 22, 2016
18	Atlanta, Georgia	July 26, 2016
19	Boise, Idaho	July 26, 2016
20	Bismarck, North Dakota	July 26, 2016
21	Montgomery, Alabama	July 27, 2016
22	Chicago, Illinois	July 28, 2016
23	Spokane, Washington	July 28, 2016
24	Ellensburg, Washington	July 29, 2016
25	Savannah, Georgia	July 29, 2016
26	Albany, New York	August 2, 2016
27	Gaylord, Michigan	August 2, 2016
28	Honolulu, Hawaii	August 2, 2016
29	Lubbock, Texas	August 2, 2016
30	Concord, New Hampshire	August 3, 2016
31	Austin, Texas	August 4, 2016
32	Kalamazoo, Michigan	August 4, 2016
33	Anchorage, Alaska	August 5, 2016
34	Houston, Texas	August 5, 2016
35	Louisville, Kentucky	August 5, 2016
36	Oklahoma City, Oklahoma	August 9, 2016
37	Tallahassee, Florida	August 10, 2016
38	Kansas City, Missouri	August 11, 2016
39	St. Louis, Missouri	August 12, 2016
40	Tampa, Florida	August 12, 2016