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ACCOUNTABLE CARE CONSORTIUM

# Creating a Financially Sustainable Care Coordination Strategy

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# Welcome!

- Maeve McClellan, MPH, CPHQ
- Director, NRACC
- Formerly of the...
  - National Rural Health Research Center
  - Oregon Office of Rural Health
  - Current NRHA Rural Health Congress Member
  - Proud Golden Gopher Alum from UMN



# The Challenge...

- We know care coordination is effective but...
  - Could lead to decreased inpatient volume
  - Most CMS billing focus payments on the primary care setting
  - Many current successful programs are grant funded

How do you make care coordination sustainable for your community?

# Objectives

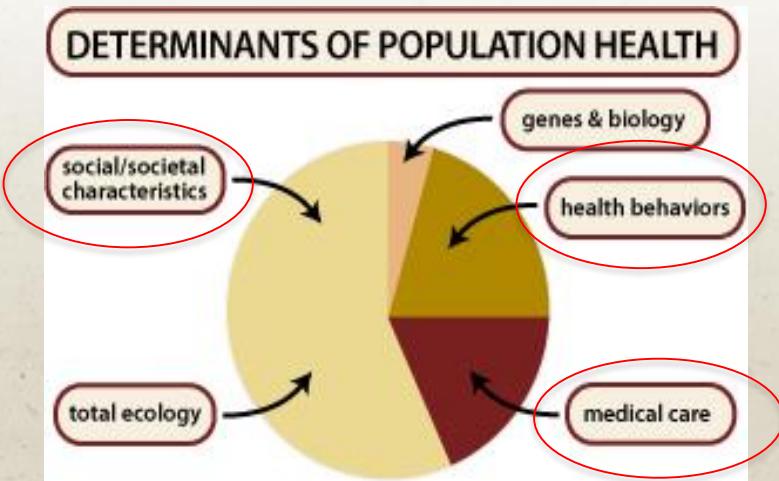
- Explore options to connect patients with Chronic Care Management and Transitional Care Management in communities, including how to bill for these services
- Learn about evidence behind the Behavioral Health Integration models targeted to the rural community and options for billing
- Learn about resources for rural communities to get started with population health programs



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# What is care coordination?

- Services to improve patient well being through connecting with resources and empowering patients
- Many models:
  - Community Paramedicine
  - Nursing
  - Community Health Worker



Tarlov, A.R., Public Policy Frameworks for Improving Population Health. Annals of the New York Academy of Sciences, 1999. 896(SOCIOECONOMIC STATUS AND HEALTH IN INDUSTRIAL NATIONS: SOCIAL, PSYCHOLOGICAL, AND BIOLOGICAL PATHWAYS): p. 281-293



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## Polling Question: How far are you in developing a care coordination strategy?

1. We haven't started
2. We are gathering data to plan
3. We have a vision but, no specific plan
4. We have a plan with specific targets and action items
5. We are already enacting our plan



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# Why implement a care coordination strategy?



Value Based Purchasing (MIPS/ QPP)



Accountable Care Organization Preparation

- Care Coordination is a key piece of population health strategy
  - Key to controlling costs
  - Important driver of performance in 2018 under Quality Payment Program Merit-based Incentive Payment System or Alternative Payment Model
  - It's financially sustainable
  - It improves health outcomes & quality metrics

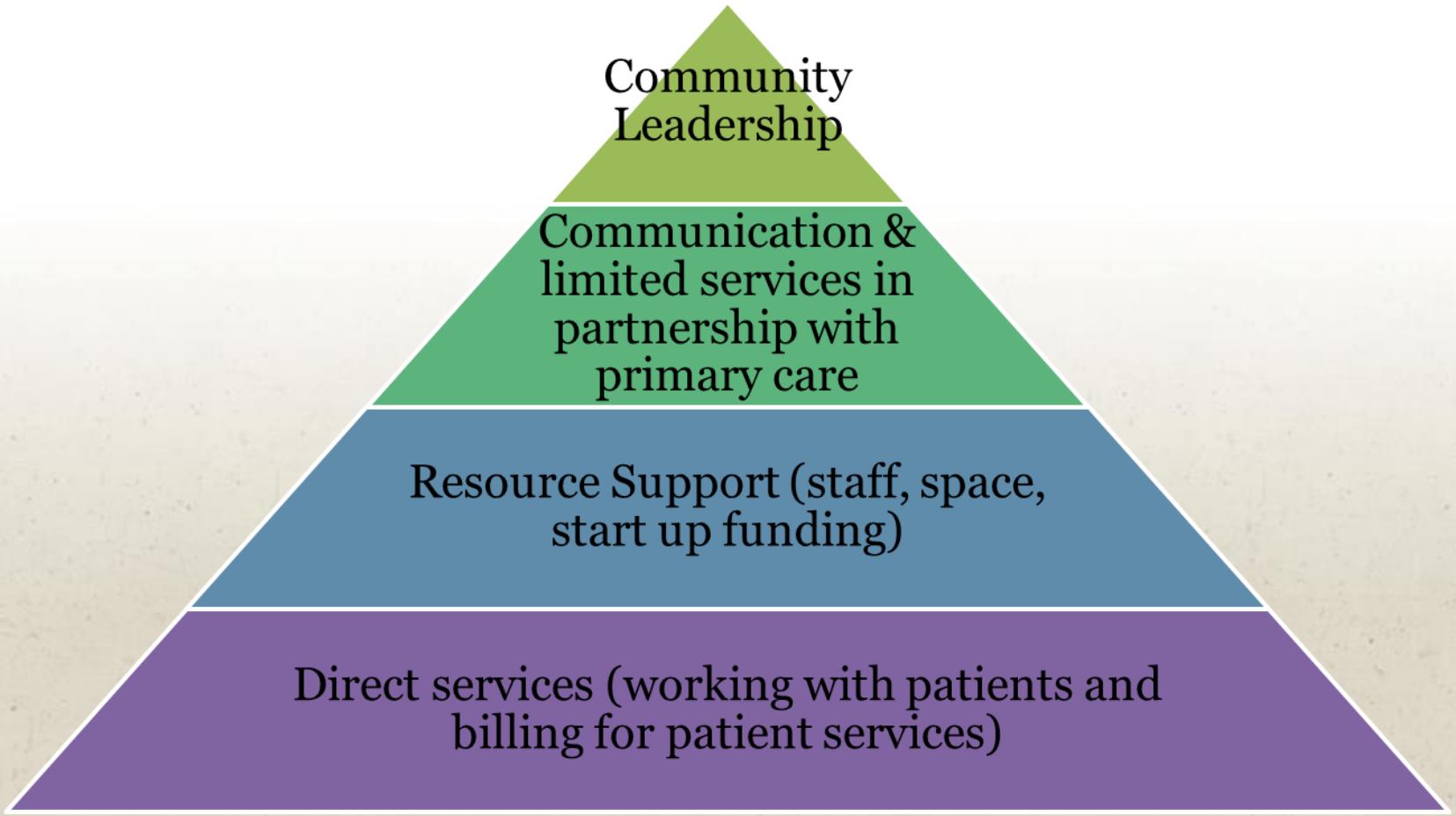


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# What are your goals for care coordination?

- Improve provider engagement & retention
- Do well in MIPS
- Streamline operations
- Relieve overcrowding in ED
- Reduce readmissions
- Generate additional revenue
- Improve health outcomes
- Prepare for an Alternative Payment Model (ACO, Bundled Payment, CPC+)
- Increase market share

# How involved should a hospital be?



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# What does the spectrum of involvement look like?

Leadership in Planning & Convening	Communication	Resource Support	Direct Services <i>(if providing Primary Care)</i>
<ul style="list-style-type: none"><li>• Lessens burden on clinic staff</li><li>• Align Care Coordinator Program with CHNA</li><li>• Develop stronger relationships with providers</li></ul>	<ul style="list-style-type: none"><li>• Send ED &amp; Discharge reports</li><li>• Establish direct messaging</li><li>• Reduces readmissions</li><li>• Improve ACI score in MIPS</li><li>• Improve cost score in MIPS</li></ul>	<ul style="list-style-type: none"><li>• Provider staff to serve as care coordinator</li><li>• Participate in 24/7 telephone access</li><li>• Maintain community resource directory</li><li>• Assist in setting up EHR to run CC program</li><li>• In some cases, hospital bill clinics for these resources</li></ul>	<ul style="list-style-type: none"><li>• Provide CCM, TCM, BHI, CoCM</li><li>• Generate revenue</li></ul>



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## Polling Question: Is your hospital affiliated with primary care?

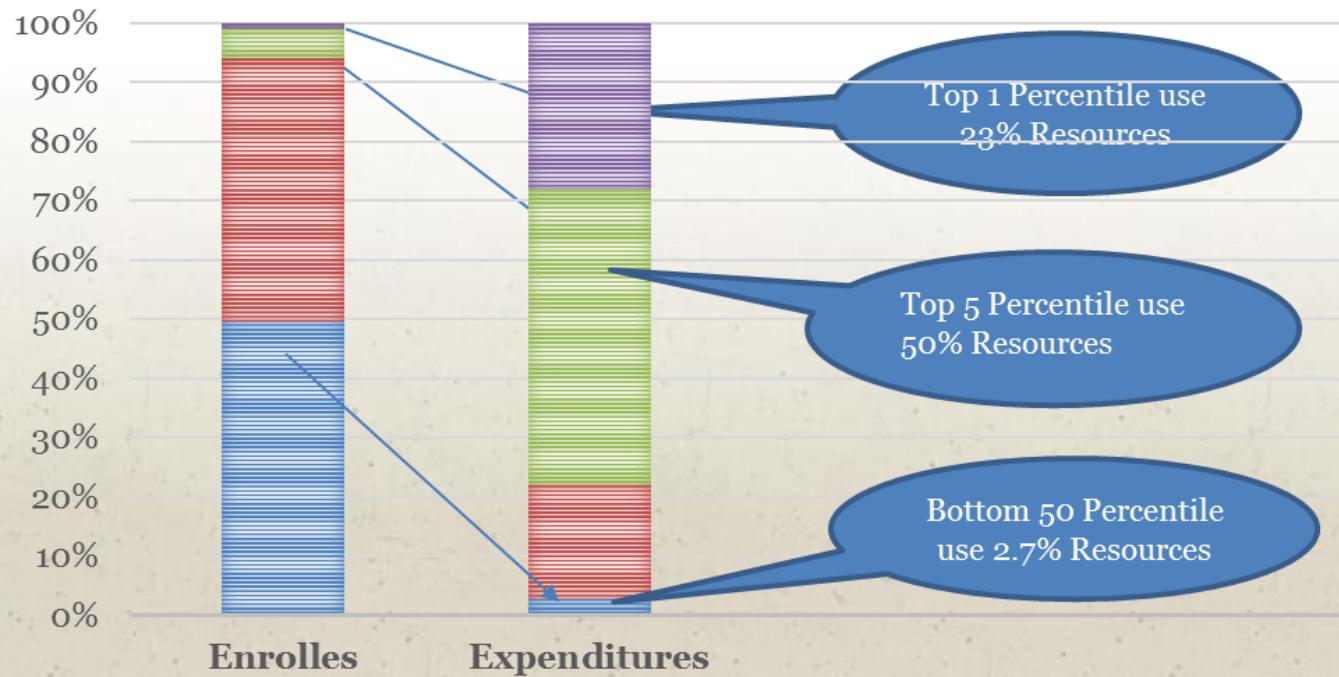
1. No
2. Yes, we have at least one provider based clinic
3. Yes, we own other clinics



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# How do we pick a strategy for care coordination?

2016 Medicare Data Source: AHRQ

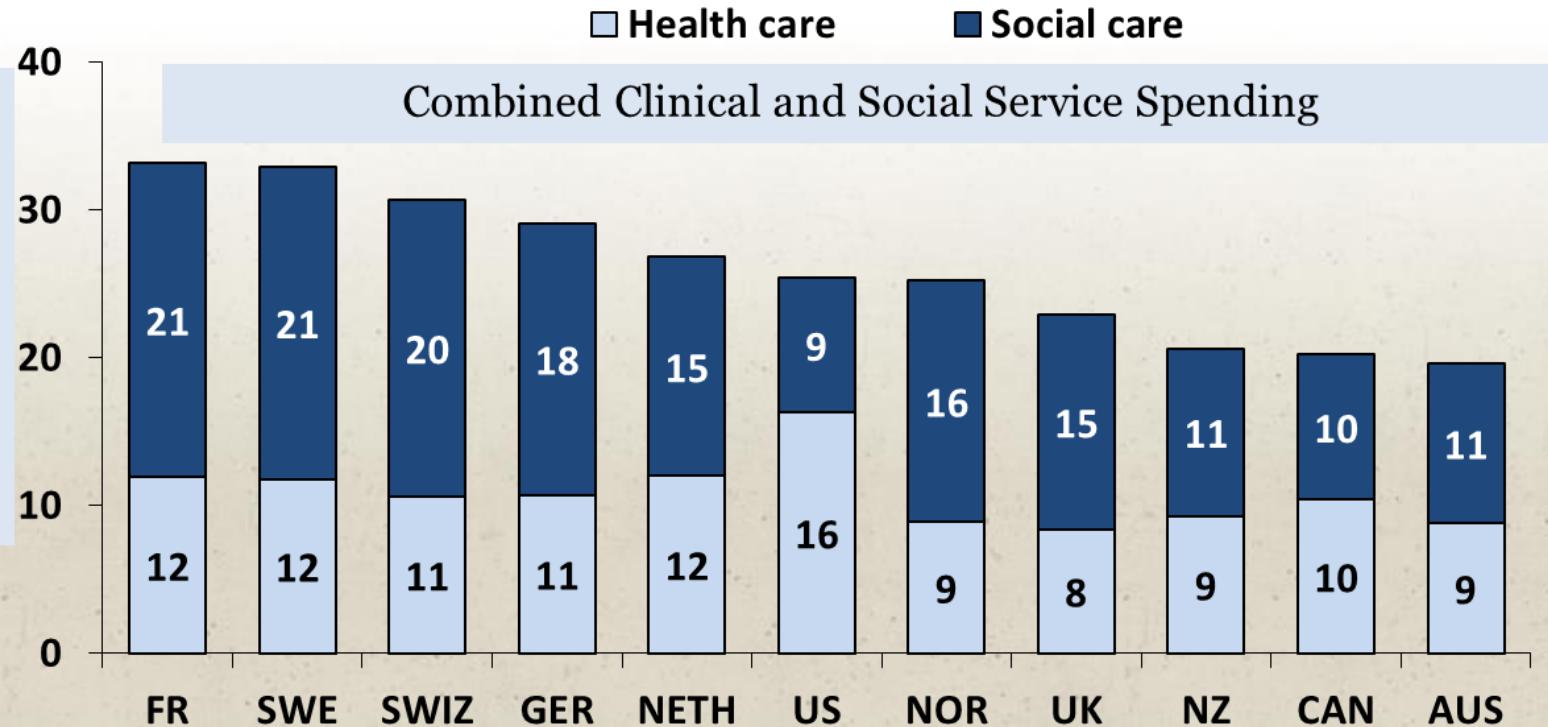


Source: AHRQ, 2014 MEPS #455



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# The US Spends on Health Care



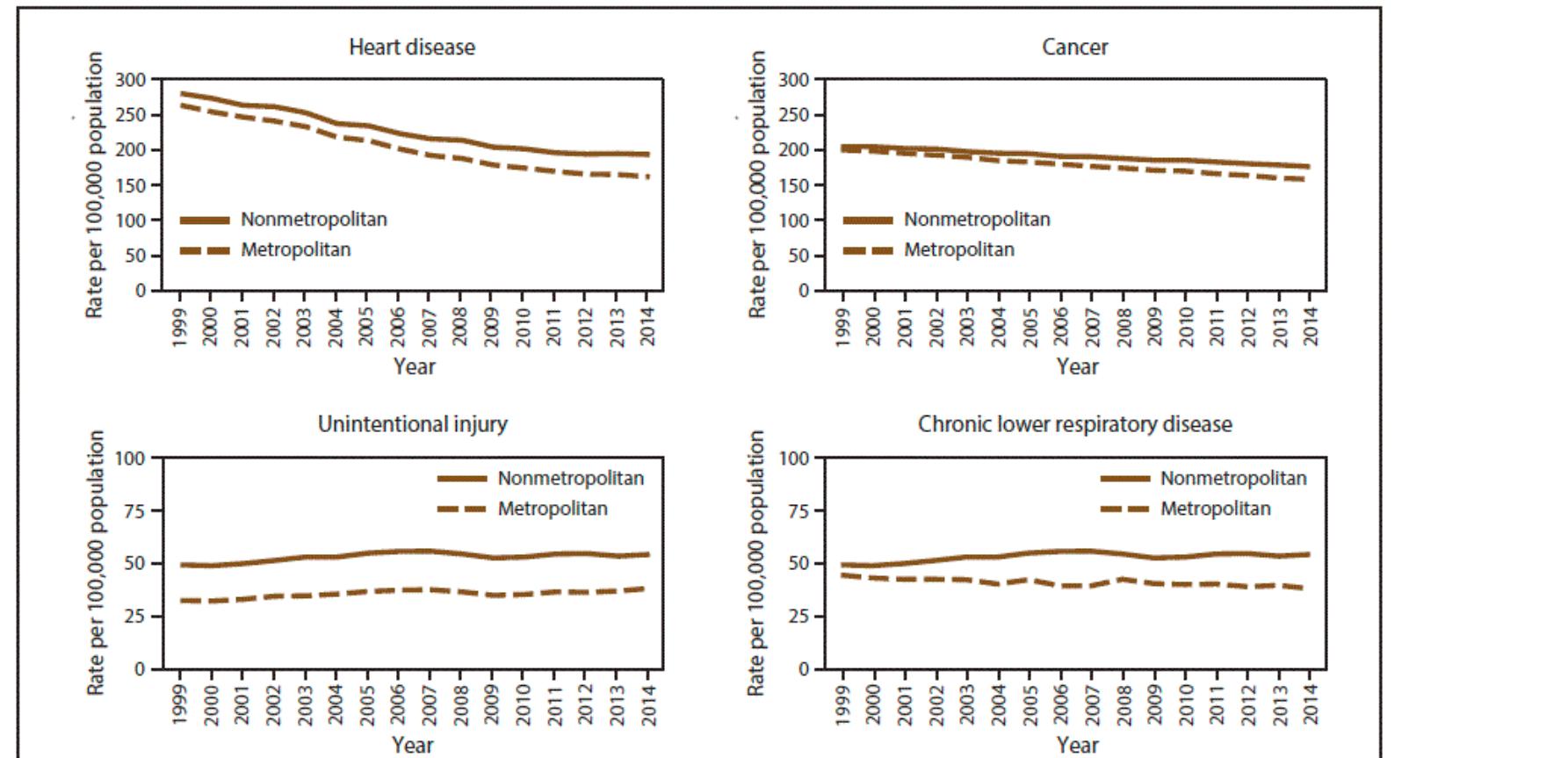
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.



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# Widening Rural/ Urban Disparities

FIGURE 2. Age-adjusted death rates among persons of all ages for five leading causes of death in nonmetropolitan and metropolitan areas,\* by year – National Vital Statistics System, United States, 1999–2014



Moy E, Garcia MC, Bastian B, et al. Leading Causes of Death in Nonmetropolitan and Metropolitan Areas — United States, 1999–2014. MMWR Surveill Summ 2017;66(No. SS-1):1–8. DOI: <http://dx.doi.org/10.15585/mmwr.ss6601a1>.



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# Chronic Conditions Are a Challenge

- Three in four Americans 65+ have multiple chronic conditions.
- Many risks come with multiple chronic conditions:
  - Hospitalization
  - Poor day-to-day functioning
  - Conflicting advice from different providers.
  - High out-of-pocket costs
- Among Medicare FFS beneficiaries, people with multiple chronic conditions account for 93% of total Medicare spending.
- Controlling chronic conditions is essential to good patient care and controlling costs.

<https://www.cdc.gov/chronicdisease/about/multiple-chronic.htm>

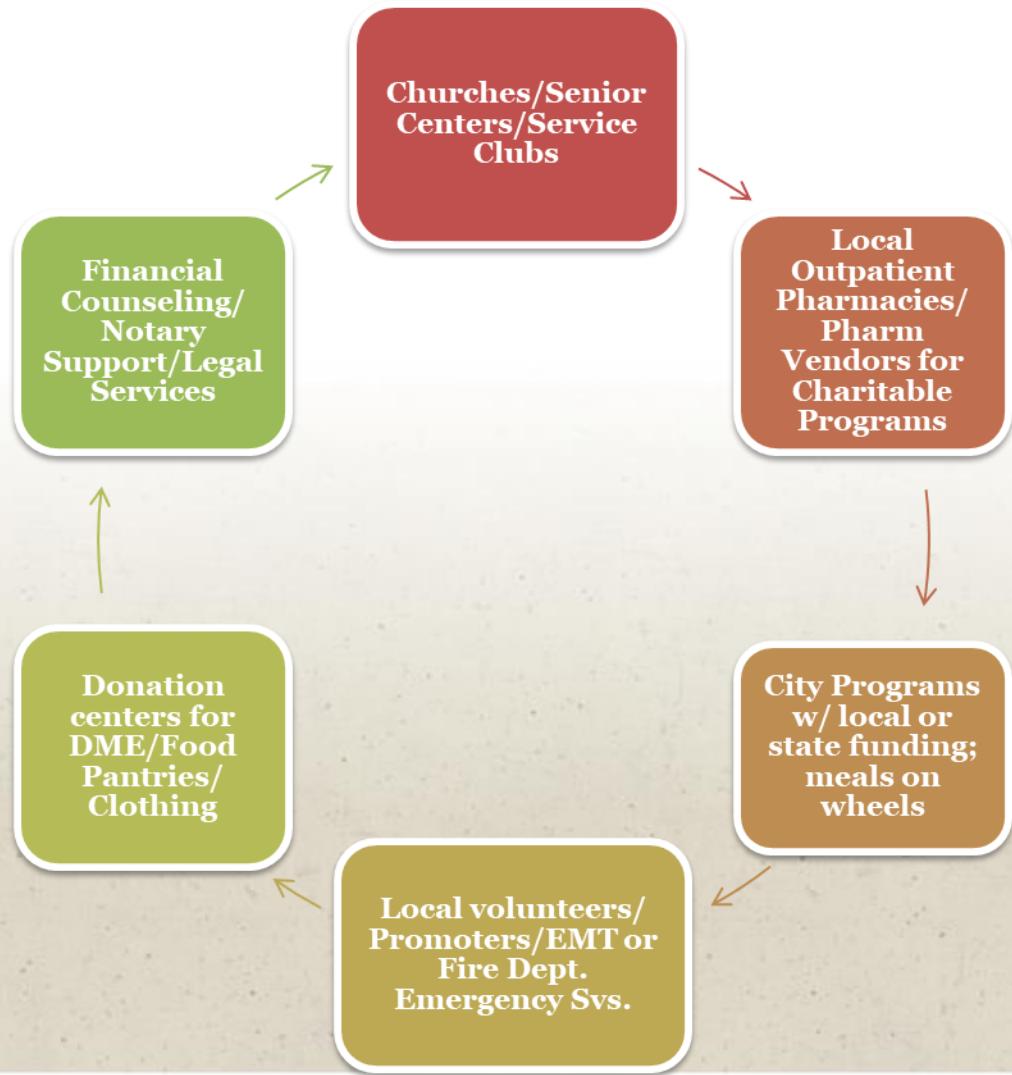
# Psychosocial Needs Can Be Addressed

- 70% of health outcomes are attributable to the social and environmental factors that patients face.
- Different issues have different non-medical solutions. CCM provides a way to do this work.
  - Food insecurity → local food banks and meals-on-wheels style organizations
  - Housing Instability → community, government resources and legal aid societies
  - Utility needs → utility companies customer assistance programs and tenants' rights groups
  - Financial resource strain → job programs and community groups
  - Transportation → community and government resources
  - Exposure to violence → shelters and police



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# Types of Community Resources You Need



# It Takes Access to Community Resources

- Effective relationships with community resources is essential for providing patients in need of access the opportunity for achieving optimal health
- **To Do:** Develop and maintain a list of appropriate community resources for your Care Management team to be able to provide patient/family access to handle environmental, functional, and social challenges (**Hint: Ask Community Hospital Case Management Team for their list**)
- Keep it up-to-date and accessible to all Care Team members in the practice

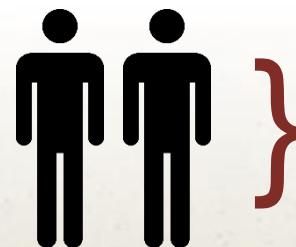
# Focus and Strategy

Average Spend:

Top 1% = \$97,956

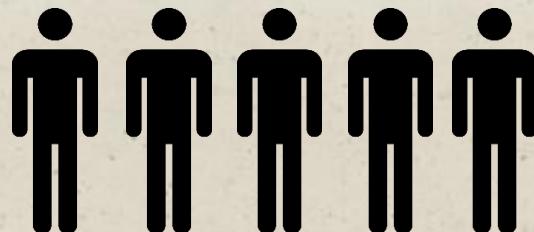
Top 5% = \$43,058

Top 10% = \$28,468



Care Coordination

Bottom 50% = \$8384



Wellness Promotion

Source: AHRQ, 2014 MEPS #455



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# What are opportunities for a hospital in Care Coordination?

- See the sickest patients
  - “crisis points” can be a place of intervention
- Care transitions can greatly impact outcomes and patient safety
- Communication among providers
- Greatest resources in the community to promote health
  - Many hospital finance ACO participation for primary care providers
  - Support population health EHR functions
- Run care coordination programs
- Convene community health needs assessments & social services councils to plan for care coordination

## Billable Options to Support Care Coordination

CMS wants to pay to coordinate care!



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# What are the billable options?

- Chronic Care Management
- Transitional Care Management
- General BHI
- Psychiatric Collaborative Care Management



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# Polling Question: Which of these services are you already involved in?

*Select all that apply*

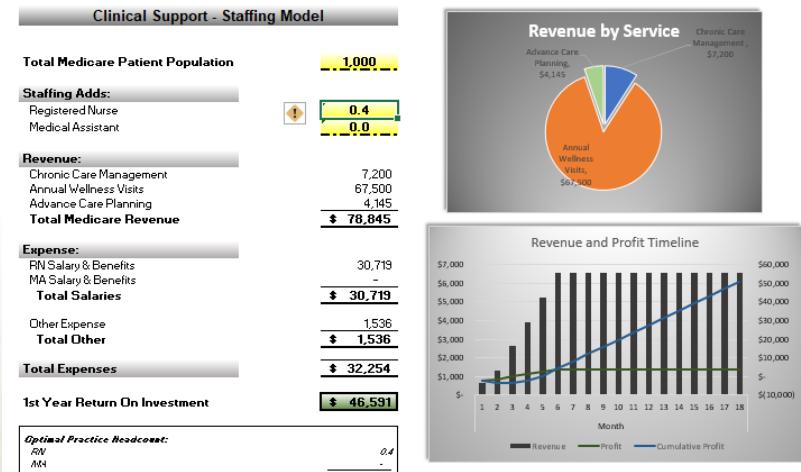
- CCM
- TCM
- General BHI
- Psychiatric Collaborative Care
- Convening a community resources council
- Unbilled care coordination services



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# Evaluate Your Return on Investment

- Starting a care coordination program requires an investment
- Tool at right calculates time to ROI based on staffing and Medicare population



- This model does NOT include payments from shared savings, or MIPS bonuses from improving outcomes



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# Chronic Care Management

Supporting patients in the community with multiple chronic conditions



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# Definition: Chronic Care Management

- Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
  - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline
  - Comprehensive care plan established, implemented, revised, or monitored
- CCM services are typically provided outside of face-to-face patient visits, and focus on characteristics of advanced primary care such as a continuous relationship with a designated member of the care team; patient support for chronic diseases to achieve health goals; 24/7 patient access to care and health information; receipt of preventive care; patient and caregiver engagement; and timely sharing and use of health information.

*Source: CMS 2016*



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# Care Coordination Improves Provider Work



- Informed and engaged patient
- Effective team management
- Plan of care adherence
- Improved visit efficiency
- Patient-centered care
- Improved outcomes



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# Care Coordination Improves Quality of Care

Evidence from recent studies show:

- Improved utilization of healthcare services and reduction in E.D. utilization seen with patients who participated in the Chronic Disease Self-Management Program (Whitelaw, et.al., 2013).
- Collaborative goal setting helped patients reach realistic goals in managing their chronic disease with coaching, social support and navigation/care coordination activities (Kangovi, et.al., 2016).
- Improved patient outcomes in LDL control w/ Diabetic patients when disease registry models were implemented in a CCM program (Halladay, et.al., 2014).
- Diabetes Self-Management in primary care helps improve psychosocial and clinical outcomes in Diabetic patients (Stellefson, et.al., 2013) .



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# CCM Eligibility Requirements

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.



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# CMS Requirements for CCM Billing

- Can be billed by physician, and non-physician practitioners (APN, PA, CNS, Nurse Midwife)
- “Clinical staff” may perform under general supervision of the billing practitioner
- Billed under “incident to” rules
- Electronic health record utilization
- 24/7 access
- Must have an “initiating visit” within 12 months prior to start of CCM services
- Acquire verbal patient consent
- Patient-centered electronic care plan
- Comprehensive care management
- Home and community-based care management
- Manage transitions of care
- Face-to-face or non face-to-face time



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# Coding and Billing Opportunities for CCM-FFS

**99490**

- CCM
- At least 20 minutes of “clinical staff” time
- 2 or more chronic conditions
- \$43 month

**99487**

- Complex CCM
- At least 60 minutes of time
- 2 or more complex chronic conditions
- Moderate or high complexity decision making
- \$94 month

**99489**

- Complex CCM add-on code
- Each additional 30 minutes of “clinical staff” time
- Used only with code 99487
- \$47



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# RHC Coding and Billing Opportunities for CCM

- G0511, General Care Management for RHCs and FQHCs
- Based on...
  - CPT 99490—20 minutes or more of CCM services
  - CPT 99487—at least 60 minutes of complex CCM services
- RHCs and FQHCs can bill the new General Care Management code when the requirements for any of these codes are met
- May be billed alone or in addition to other services furnished during the RHC or FQHC visit
- May only be billed once per month per beneficiary
- Cannot be billed if other care management services (such as home health care supervision) are billed for the same time period

# Avoid Duplicate Billing Codes

CCM cannot be billed with overlapping codes or services:

- Transitional Care Management (**CPT 99495 and 99496**)
- Care plan oversight (**CPT 99339,99340, 99374-99380**)
- Home Healthcare Supervision (**HCPCS G0181**)
- Certifications & Recertification (**HCPCS G0180 & G0179**)
- Hospice Care Supervision (**HCPCS G0182**)
- Anticoagulant Management (**CPT 99363-64**)
- Certain End-Stage Renal Disease (ESRD) Services (**CPT 90951-90970**)
- Other codes



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# Transitional Care Management

Supporting patients in transitioning back to the community



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# What is Transitional Care Management?

**Transitional care** refers to overseeing coordination of a patient's care as they move throughout the healthcare continuum.

**Billable TCM** requires certain requirements are met as a patient moves from facility setting back to the community.



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# Key Elements of TCM



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# Differentiation of Facility vs. Practice Scope in TCM

Hospital  
or other  
Facility

Discharge  
Instructions (f/u with  
provider, med list,  
and pt. education  
materials)

Discharge Orders  
(prescriptions, DME,  
additional  
tests/procedures)

Ambulatory  
Provider  
Practice

Securing provider  
scheduled  
appointment prior to  
patient discharge

Calling patient within  
2 days of discharge  
Ensuring patient  
follow-through with  
provider visit  
Contact with patient  
during 30-day cycle



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# Who Can Perform TCM?

- Physicians (any specialty)
- The following non-physician practitioners (NPP) who are legally authorized and qualified to provide the services in the State in which they are furnished:
  - Certified nurse-midwives
  - Clinical nurse specialists
  - Nurse practitioners
  - Physician assistants
- **Face-to-Face Encounter Must be Performed by this Role**



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# Why Effective Care Transitions?

Readmission  
vulnerability 7-11  
days post-discharge

A Referral  
Process for  
CCM



Follow patient for  
30 days (first phone  
call within 2-days of  
discharge)

Ensure provider  
appointment before  
discharge (no later  
than 14 days)



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# Levels of Medical Decision Making

## Moderate Complexity (99495)

- Moderate level of complexity of medical data (i.e. lab tests) to be reviewed
- Moderate risk of significant complications, morbidity or mortality and co-morbidities

## High Complexity (99496)

- Extensive number of possible diagnoses and needed management
- Extensive complex medical data to review
- High-risk for significant complications, morbidity or mortality and co-morbidities

*Note: Medical decision making is defined by the E/M Service Guidelines (AMA CPT, p. 7 & 40)*

# Billing

## **Levels**

- Moderate Complexity = Face-to-Face within 14 days (CPT 99495/average \$160)
- High Complexity = Face-to-Face within 7 days (CPT 99496/average \$230)

## **Key Requirements**

- 20% co-pay applies
- Medication Reconciliation performed no later than date of the face-to-face visit

## **Who Performs?**

- MD's, DO's (regardless of specialty); physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives



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# What about RHCs and FQHCs?

TCM can be billed as a stand-alone visit

“If” it is the only medical service provided on that day

RHC/FQHC provider meets TCM requirements

**\*\*If furnished on the same day as another visit;  
only one visit can be billed**



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# Identify Patients Transitioning between Levels of Care

- Run daily reports of patients transferred to a higher or lower level-of-care.
- Create communication plan with each facility for notification to the practice prior to patient discharge.
- Educate your patients/family/caregivers to alert facility on admission of the provider office contact and need for notification of admission.



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# Follow your Discharged Patients

- Find a process to identify patients discharged from ED, hospital, SNF, rehab and psych facilities.
- Determine who will assess for risk of readmission.
  - How is it measured? Is there a tool in the EHR.
- Determine if patient is eligible for CCM program.
- Conduct a timely post-discharge call to the patient to ensure sure they have discharge instructions, meds and a follow-up appointment.
- Best Practice: Appointment within 7 calendar days of discharge.



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# Schedule Recently Discharged Patients with Their PCP

- Face to face visit: provide medication reconciliation and condition specific guidance for patient.
- Identify eligibility to CCM program
- Practitioner refers to CCM program



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# Admit to Post D/C Patients to CCM Program

- Use discharge to initiate CCM workflows.
- Closely manage transitions of care to avoid decline resulting in ED visit or readmission.
- Coordinate services and referrals to assist with health care needs and psycho-social or economic barriers.
- Schedule for further E/M visits as needed.



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# Behavioral Health Integration

General BHI & Psychiatric Collaborative Care

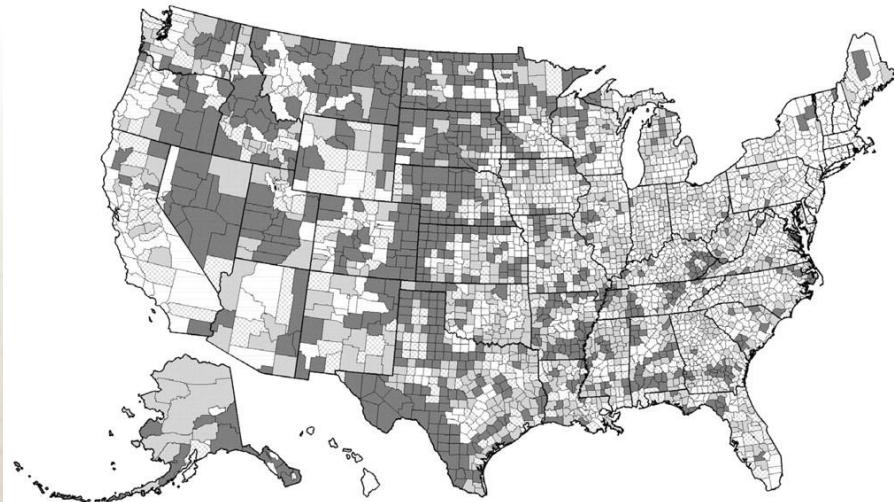


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# There Are a Lot of Under-Served Areas

**Figure 1**

Unmet need for mental health professionals among counties with an overall shortage<sup>a</sup>



<sup>a</sup> Shading (from light to dark, indicating first to fourth quartiles, respectively) is intended to convey an overall pattern of unmet need for prescribers and nonprescribers combined. [For finer detail, this map is available as an online supplement to this article at [ps.psychiatryonline.org](http://ps.psychiatryonline.org).]

- Over three-quarters (77%) of U.S. counties had a severe shortage of mental health prescribers or nonprescribers, with over half their need unmet.

# Improving behavioral health lowers cost and improves quality measures.

- Patients with at least one psychiatric visit were 4.6x more likely to be frequent ED users. (Brennan, 2014)
  - This group visited the ED at a much higher rate ... with both chronic medical and psychiatric conditions.
- Mental health conditions were among the most predictive attributes when describing high ED utilizers. (Ondler, 2014)
  - A typical ED visit costs \$1,220.
- Those with mental health conditions were 32% more likely to have poor glycemic control. (Frayne, 2005)



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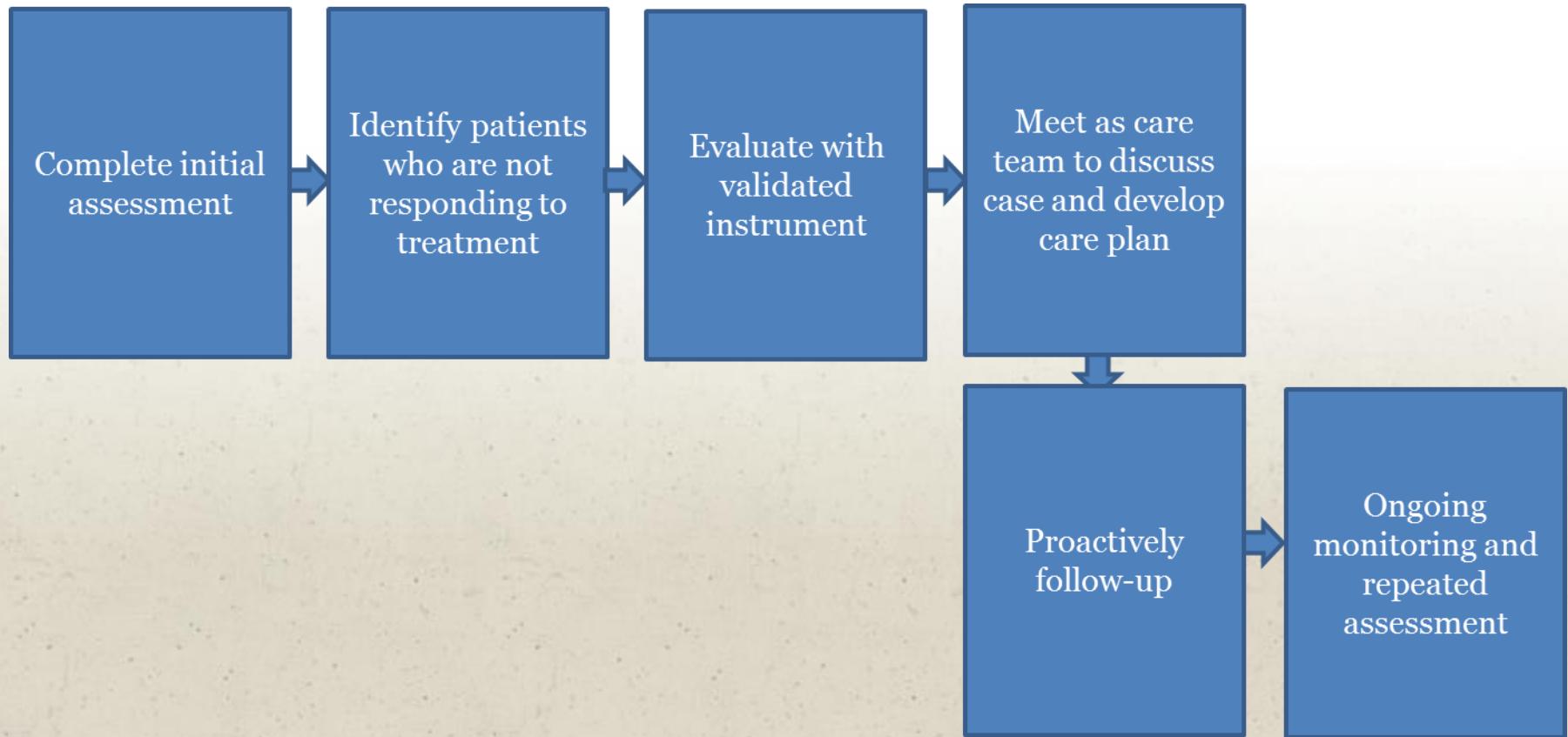
# Two Billable Options to Support BHI

- **Psychiatric collaborative care (CoCM):** Enhances primary care by adding additional support from a care manager and input from a psychiatrist.<sup>1,4</sup>
  - 99492, 99493 and 99494 will be used to bill for services furnished using the Psychiatric Collaborative Care Model
- **General BHI:** Supports the delivery of services through providers, like MSW's or psychologists, embedded in the primary care location.
  - 99484 (General BHI) will be used to bill services furnished using other BHI models of care



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# BHI Defines a Process of Care



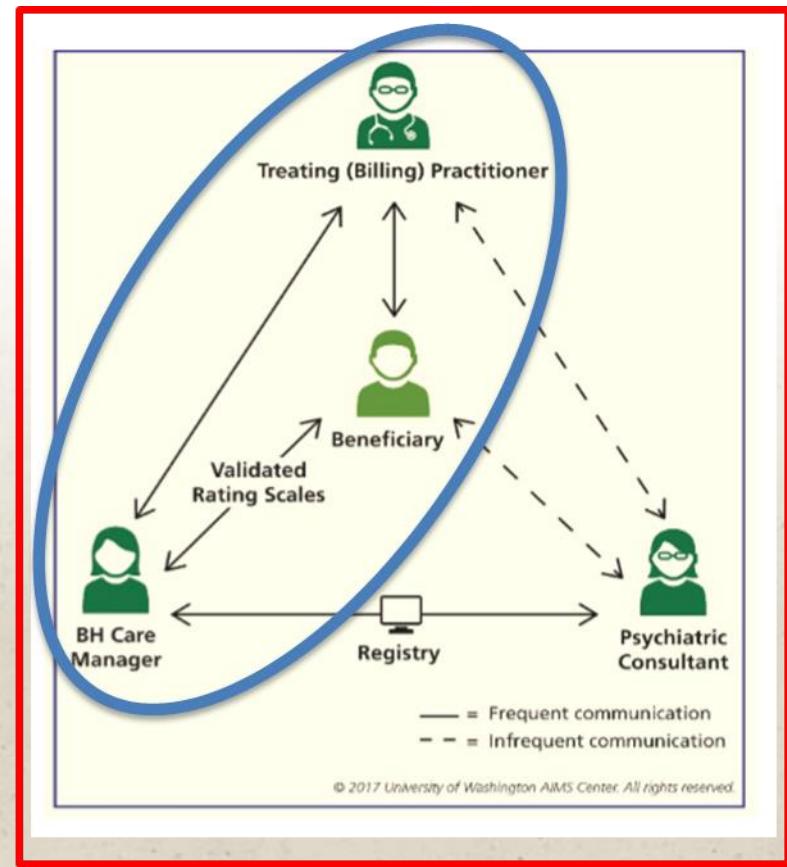
# BHI at the Practice Level

**CoCM:** Patient, Care Manager, Consultant, Billing Practitioner

**General BHI:** Patient, Care Manager, Billing Practitioner



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# Key Elements of CoCM

- This is not telemedicine.
- Licensure in the state is not required. The patient does interact with the psychiatrist.
- The service components include:
  - Initial assessment and administration of validated scale.
  - Care planning by primary care team.
  - Care manager performs proactive and systematic follow-up
  - Regular case review with psychiatric consultant.
- Payment goes to the PCP who bills the service.
- PCP pays psychiatrist direct.
- The psychiatrist does not bill the patient separately.

# FFS Billing for BHI

CPT	Description	Payment * (Non-facility)	Payment* (Hospitals and facilities)
99492	Initial CoCM	\$161.28	\$90.36
99493	Subsequent CoCM	\$128.88	\$81.72
99494	Additional 30 min CoCM	\$66.60	\$43.56
99484	Care Mgmt – General BHI	\$48.60	\$32.76

\*PFS reimbursement rates vary by region



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# RHC & FQHC CoCM: G0512

G0512, Psychiatric Collaborative Care Management (CoCM) for RHCs and FQHCs

- Based on...
  - 99492—70 minutes or more of initial psychiatric CoCM services
  - 99493—60 minutes or more of subsequent psychiatric CoCM services
- RHCs and FQHCs could bill the new psychiatric CoCM code when the requirements for any of these 2 codes (99492 or 99493) are met
- May be billed alone or in addition to other services furnished during the RHC or FQHC visit
- May only be billed once per month per beneficiary
- Cannot be billed if other care management services, including the General Care Management code G0511, are billed for the same time period



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# General Requirements

- Beneficiary must give verbal consent for behavioral health services and must be documented in the medical record.
- Must inform beneficiaries that copay and deductible applies (some supplemental insurers may cover).
- Medicare will require beneficiaries to pay any applicable Part B co-insurance for these billing codes.
- Behavioral health services not provided personally by the billing practitioner can be provided under the direction of the billing practitioner on an “incident to” basis.
- General BHI is subject to applicable state law, licensure and scope of practice requirements.
- An initiating visit is required for new patients not seen within one year prior to commencement of services.



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# Reasons PCPs Love Collaborative Care

*"I practiced for 16 years without it and I will never go back"  
primary care physician, UW Neighborhood Clinic*

1

## Gold Standard of Depression Care

Collaborative Care is the best approach to treating depression, as proven by 79 randomized controlled trials published in a 2012 Cochrane Review. Why practice anything less?

Collaborative Care has been recommended as a primary prevention strategy for fatal and nonfatal cardiovascular events in patients without preexisting heart disease.

2

## Better Medical Care

Collaborative Care has been linked to better medical outcomes for patients with diabetes, cardiovascular disease, cancer, and chronic arthritis pain.

3

## Access to experts

Care managers and psychiatric consultants expand the treatment options available and support the care provided by PCPs. From providing psychotherapy when clinically indicated to supporting pharmacotherapy, these experts support you as the primary clinical decision maker.

4

## Help with Challenging Patients

Many of your most challenging patients likely have un-treated or under-treated mental health conditions. Care managers do the follow-up and behavioral intervention tasks a busy PCP doesn't have time for, tasks that can make a big difference for your patients.

5

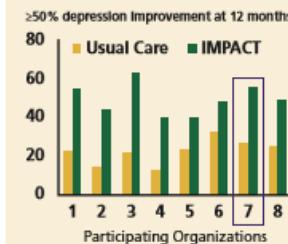
## It Takes a Team

Collaborative Care uses a population-based, treat-to-target approach similar to care for chronic medical conditions. Knowing when a proactive change in care is needed makes sure that none of your patients fall through the cracks.

Only 30-50% of patients have a full response to the first treatment. That means 50-70% of patients need at least one change in treatment. Additional experts can help.

**Don't fool yourself!**  
As few as 20 percent of patients started on antidepressant medications in usual primary care show substantial clinical improvements.

Results of the landmark IMPACT study (1 of the 79 trials in the Cochrane Review) showed that Collaborative Care patients were twice as likely to experience significant improvement even though 70% of usual care patients were prescribed an antidepressant by their PCP.



Think co-locating a behavioral health specialist or handing out referrals is enough? Think again. The organization circled (#7) had Masters-level, co-located behavioral health clinicians practicing within the primary care clinic using a referral model. Collaborative Care still worked twice as well!

**AIMS CENTER**

**W** UNIVERSITY of WASHINGTON  
Psychiatry & Behavioral Sciences



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# BH Quality Measures and APMs

BHI can improve quality scores in alternative payment models like ACO and CPC+.

- Depression Screening & Follow-Up (ACO)
- Adult Weight Screening and Follow-up (ACO)
- Tobacco Use Assessment and Cessation Intervention (ACO)
- Depression Remission at 12 months; This is frequently a difficult measure to close. (ACO/CPC+)
- Dementia Cognitive Assessment (CPC+)
- Initiation and engagement of alcohol and other drug dependence (CPC+)



# Determine the Right Approach

1. Chronic Care Management (CCM) and BHI service can be provided concurrently, except in an RHC
2. BHI and CoCM services cannot be provided at the same time.
3. BHI or CoCM provided for at least 6-12 months.
4. Approach will vary by patient to meet individual needs.
5. Ensure staff are trained in both approaches.
6. Assess your staff resources.
7. Ensure your EHR supports tracking services by time by patient, if not, use the registry to manually track time.



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# RHC & FQHC Care Management

## G0511, General Care Management for RHCs and FQHCs

- Based on...
  - CPT 99490—20 minutes or more of CCM services
  - CPT 99487—at least 60 minutes of complex CCM services
  - CPT 99484—20 minutes or more of BHI services
- RHCs and FQHCs can bill the new General Care Management code when the requirements for any of these 3 codes are met
- May be billed alone or in addition to other services furnished during the RHC or FQHC visit
- May only be billed once per month per beneficiary
- Cannot be billed if other care management services (such as TCM or home health care supervision) are billed for the same time period

## G0512, Psychiatric Collaborative Care Management (CoCM) for RHCs and FQHCs

- Based on...
  - G0502—70 minutes or more of initial psychiatric CoCM services
  - G0503—60 minutes or more of subsequent psychiatric CoCM services
- RHCs and FQHCs could bill the new psychiatric CoCM code when the requirements for any of these 2 codes (G0502 or G0503) are met
- May be billed alone or in addition to other services furnished during the RHC or FQHC visit
- May only be billed once per month per beneficiary
- **Cannot be billed if other care management services, including the General Care Management code G0511, are billed for the same time period**



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# Additional Requirements

	<b>G0511: General Care Management (\$61.37)</b>	<b>G0512: Psychiatric Care Management (\$ 134.58)</b>
<b>Time (per calendar month)</b>	At least 20 minutes	At least 70 minutes in the first month, 60 minutes thereafter
<b>Service Furnished Under the Direction of</b>	RHC or FQHC primary care physician, NP, PA, or CNM	RHC or FQHC primary care practitioner
<b>Service Furnished By</b>	RHC or FQHC practitioner, or clinical personnel under general supervision	RHC or FQHC practitioner or behavioral health care manager under general supervision
<b>Eligible patients</b>	<p>Two or more chronic conditions expected to last at least 12 months which place the patient at significant risk of death or functional decline  <u>OR</u>  Any behavioral health or psychiatric condition being treated by the RHC or FQHC primary care practitioner that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services</p>	Any mental, behavioral health, or psychiatric condition being treated by the RHC or FQHC primary care practitioner that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services
<b>Other Elements</b>	<ul style="list-style-type: none"> <li>Structured recording of patient information using CEHRT; 24/7 access to PCP in the practice; comprehensive care plan; timely access to care plan</li> <li>Behavioral health care planning; coordinating treatment; continuity of care</li> </ul>	<ul style="list-style-type: none"> <li>Care team of PCP, Behavioral Health Care Manager, and Psychiatric Consultant that provide assessment; behavioral health care planning; face-to-face services; availability outside of normal working hours</li> </ul>

## Resources to Get Started

Many organizations offer free assistance to support this work!



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# CMS Care Management Resources

- [CMS Page](#) with information on:
  - TCM
  - BHI
  - CCM
- CMS has a [comprehensive toolkit](#) with resources
- [Connect Care Partner Toolkit](#)



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# Rural Community Health Gateway

- Provides examples of evidence-based and promising practice programs
- <https://www.ruralhealthinfo.org/community-health>



## **Rural Community Health Gateway**

### **Evidence-Based Toolkits for Rural Community Health**

Use these step-by-step guides to develop programs that improve the health of rural communities, based on evidence-based and promising interventions. Toolkits are available on a wide range of health topics and issues of interest to rural communities.

### **Rural Health Models and Innovations**

Find examples of rural health projects other communities have undertaken, including models shown to be effective, as well as new and emerging ideas. For each project, learn about the services provided, audiences served, results, and lessons learned.

### **Supporting Rural Community Health**

Learn about a wide range of programs and tools supported by the Federal Office of Rural Health Policy to help rural communities improve the health of their residents.



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# BHI: University of Washington AIMS Center

- [Comprehensive website](#) with many psychiatric care tools
- Resources for Psychiatric Collaborative Care model
- [Implementation Guide](#)
- [Billing Cheat Sheet](#)



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# Transforming Clinical Practice Initiative

- CMS grant funded program to get practices ready for Alternative Payment Models (APM)
- Transforming Clinical Practice Initiative (TCPI)
- 29 Networks throughout the nation
  - NRACC is a network that works with over 300 practices nationwide
- Offer cost-free assistance for consulting and data software
- PDSA tools, planning services, return on investment tools
- Website shows you how to connect with a PTN in your area



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# Conclusion

1. Assess needs & services currently provided in your community
2. Determine what role your hospital will play
3. Seek out resources
  - All of these services have specific required elements for billing:  
PTNs, RHI, and other centers can help!
  - Connect with others doing the same work
4. Implement your pilot program
5. Evaluate and refine



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# Questions?

Please email Maeve at [mmccllellan@nationalruralaco.com](mailto:mmcclellan@nationalruralaco.com)

Or see <http://www.nationalruralaco.com>



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