

Sole Provider's Transition to APM

Lessons Learned

Performance Challenge

Small, rural practices face challenges making the transitioning to Alternative Payment Model (APM) payment structures. Because APM structures are created with larger systems in mind, it is difficult for small practices to demonstrate success using defined APM metrics. Adding to the challenge is the fact that rural practitioners need to address the needs of their patient population, which is spread over a large geographic area and interacts with many different health systems and providers.

Practice Solution

Define a quality matrix, improve billing and coding, and incorporate quality standards into practice to streamline practice transformation efforts.

Reinvest any revenue increase achievements into service expansion for specialized care or new staff to reach emerging patient populations.

External training programs provide guidance and coaching.

Change Steps

Small, rural practices can introduce concrete changes to their workflows and systems to support progress towards incentive program goals.

- Optimize existing staff and work flows to model income-generating programs like MIPS.
- Redesign systems to ensure billing framework is set up to accurately capture work being done and that quality benchmarks are tracked.
- Add additional staff and services using incentive revenue to meet APM goals.

As small practices fight for sustainability, they must take advantage of existing programs to transform care delivery to meet APM goals.

Firth Medical Center

Firth Medical Center (FMC) is an independently owned and operated primary care health center that serves the small town of Firth, as well as people from across southeastern Idaho, Montana, and Utah. Firth's patient population includes elderly farmers, migrant workers and American Indians. A significant portion of the clinic's patients receive Medicare and Medicaid benefits but many had no established primary care relationships and therefore various untreated chronic conditions.

Katy Searle, a Family Nurse Practitioner (FNP), bought the center when it was near closure to continue to provide care to the diverse, medically underserved population in rural southeast Idaho. The practice struggled during its first year to meet the needs of the rural community while being sustainable.

Challenge: As a rural clinic that was not designated as a Federally Qualified Health Center (FQHC) nor a Rural Health Center (RHC), FMC received no grant funding from the government, nor could it become a RHC because Idaho held that designation for a practices owned by physician providers, not a nurse practitioners. In a fee-for-service model, FMC's sole provider worked 80 hours a week to optimize billable hours. Nonetheless, the infrastructure of the medical center did not support expansion and could not afford to hire another provider.

Actions: FMC identified APMs as the pathway to establish quality and sustainability models. Current systems and workflows were modified to support changes to team roles. The EHR and other documentation methods were evaluated as inadequate to gather quality measures. After joining a statewide Patient Centered Medical Home (PCMH) incentive program, these systems were updated to better capture improvements in health and document services for more accurate billing and coding. Increased reimbursement funds could then be directed toward hiring another FNP for capacity building. FMC identified other incentive programs with which to engage, such as Health Hearts Campaign. They took advantage of practice transformation networks for quality coaching support before finally enrolling in an ACO. With each step along the way, FMC added additional capacity, services, and staffing to meet the greater health and social service needs of the community and expand their care delivery.

Nurse-Led Principles of Care: During the transition to APM, FMC built upon several critical nurse-led care principles to drive performance. Some of these include using FNPs practicing to the top of their licensure, working with care teams with clear roles and fully optimized including Social Workers and Certified Medical Assistants,

Lessons Learned

Change Tactics

Successful practice transformation tactics fall under the priorities of person and family-centered care, continuous quality improvement and sustainable business operations:

- *Enhance teams:* Enhance the care team for efficient and effective coordination to meet the needs of patient and family.
- *Use an organized QI approach:* Use an organized approach to identify and act on improvement opportunities.
- *Use sound business practices:* Use sound business practices, including budget management and calculation of return on investment for all new programs.
- *Streamline work:* Worked with a coding expert to enhance coding and billing accuracy.

Resources

[CMS Quality Payment Program](#) prepares practices

to participate in an APM. Resources are available for technical assistance options to successfully move toward participating in APMs and Advanced APMs.

[Patient-Centered Medical Home](#) guidance to improve quality and the patient experience, and increase staff satisfaction—while reducing health care costs. Practices that earn recognition have made a commitment to continuous quality improvement and a patient-centered approach to care.

[Improving Primary Care’s Team Guide](#) presents practical advice, case studies, and tools from primary care practices that improved care, efficiency, and job satisfaction through team-based care delivery.

[SAN Learning Programs & Learning Labs \(NHRI\)](#) for targeting waste and finding opportunities for improvement. Also offered is a resource to display data and create measures at the practice level.

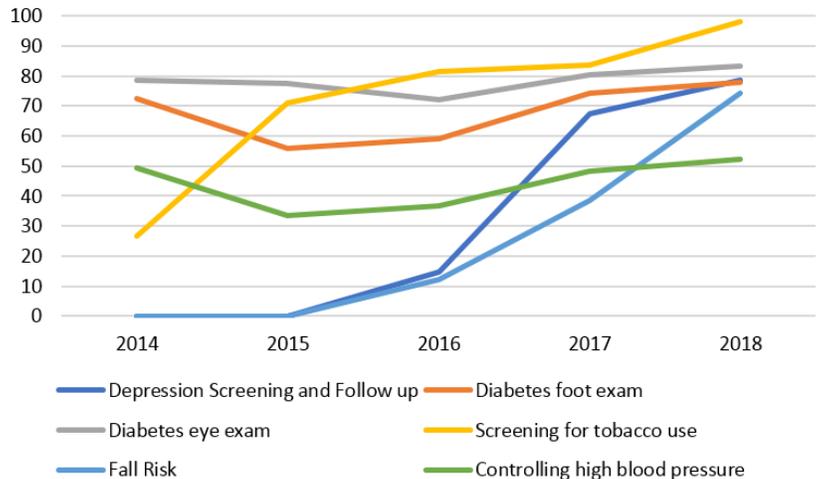
[ACP Practice Advisor®](#) - an interactive online set of modules designed to help practices implement workflow changes to prepare them for value-based payment. Modules include practice biopsies, case studies and multiple resources. Small fee required.

Practice Spotlight

care coordination across the medical neighborhood, and patient-centered, integrated behavioral health and social services.

Results: FMC improved reporting of annual wellness visits, which demonstrated that benchmarks for wellness visits were con-

Figure 1: Practice transformation benefits patients’ care



sistently improving, primary care screenings for quality improvement incentives that previously were completed but not being submitted to payers were coded appropriately due to the newly developed framework for quality measures. FMC received 100% on its first MIPS scores and has been designated a PCMH. They hired additional staff and now employ two other NPs, one bilingual who works with Idaho’s Spanish speaking migrant worker population and one specializing in women’s health, and they distinguish themselves as being one of the few rheumatology specialists in the region. The work with a team-based approach to care, including 3 CMAs who serve as case managers and a part-time social worker. This responsiveness to the community has made Firth Medical Center a successful, sustainable practice that is integral to maintaining the region’s health.

Next Steps: FMC continues to build capacity to meet the growing needs of the communities it serves in a sustainable manner that supports the providers and team.