2023 Kentucky RHC Conference

RHC Performance Improvement

Context

The typical Rural Health Clinic is challenged by its lack of resources, broad scope of practice, chronic staff turnover and poor financial performance relative to other provider organizations.

Yet RHCs often represent the key strategic and operational assets in most rural healthcare delivery systems.

If They Are So Important...

On the one hand, the public reporting exemptions enjoyed by RHCs have reduced administrative burden which is **good**

... however ...

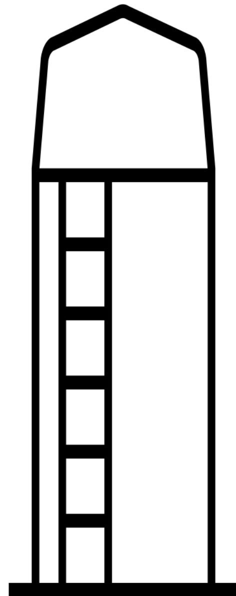
On the other hand, the exemptions leave us with minimal data related to RHC performance nor value which is **bad**

What Does the Future Hold?

CMS Innovation Center's Strategic Objectives

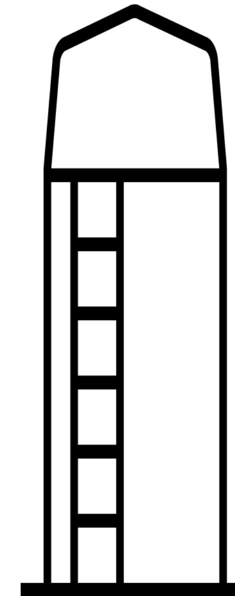
Healthcare Provider Silos

Quality



"I'm not a finance person…"

Finance



"I don't provide patient care…"

- Payer Contracting
- Expense Management
- Cost Reporting
- CCM, TCM, BHI, ACO
- Revenue Cycle
- EMR and Technology

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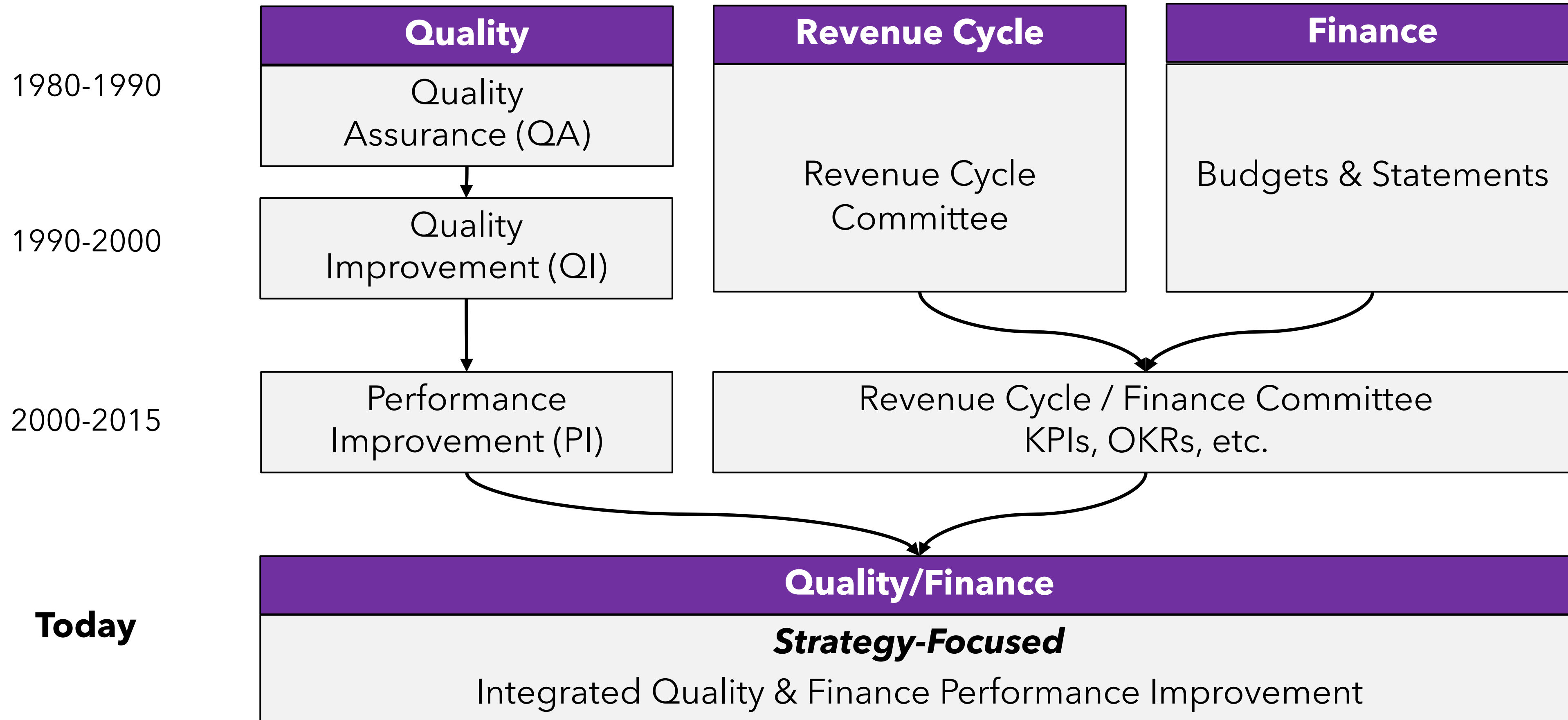
Evolution of Performance Models



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Performance Improvement Executive Council (PIEC)

- PIEC members typically include the COO/CNO and CFO as co-directors, the CEO, CMO, ED Director, Revenue Cycle Director, QI/PI Director, Board Member, Security/Privacy Officer, and representatives from 2-3 key Departments
  - The Executive Council meets monthly to receive reports from hospital Departments ("Reporting Entities") and Committees
  - The PIEC assumes final responsibility for all Performance Improvement activities, including data collection, reporting, and Action Planning development

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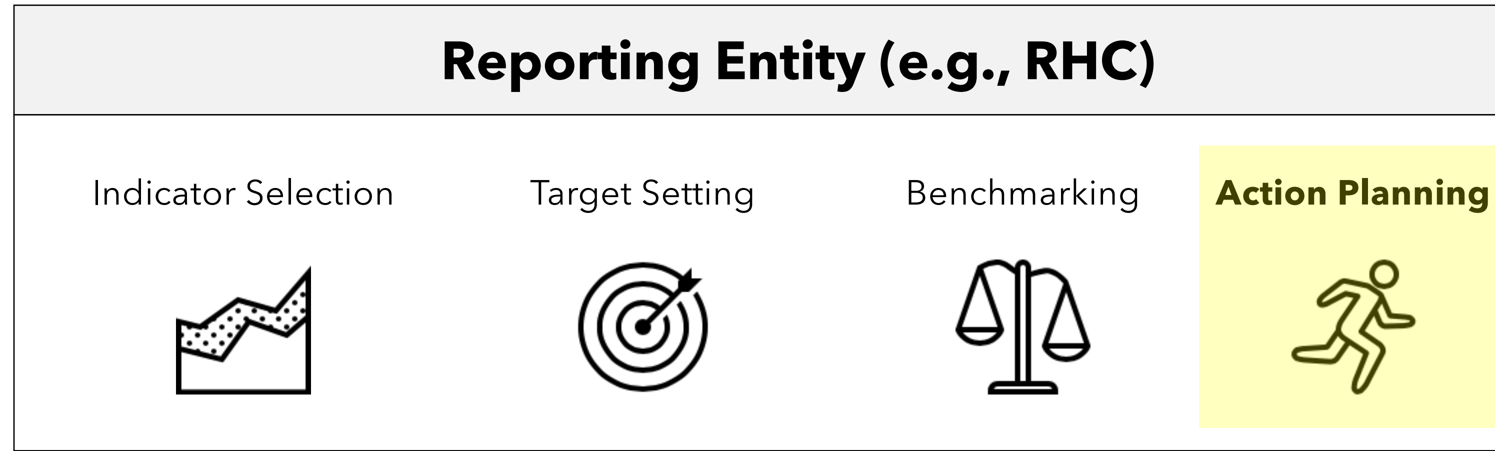
Ideal Information Flow and Accountability



- Clinical and Non-Clinical Departments serve as Reporting Entities
- Reporting Entities are responsible for reporting **to** the PIEC
- Reporting Entities are divided into two categories.
  - **Major** Physician Focus such as RHC, Nursing and Emergency Department
  - **Non-Major** Physician Focus such as Imaging and Rehabilitation

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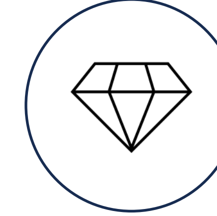
What Should RHCs Do?

Make Hay

RHC should collect, report, benchmark and use data to drive performance

Improve

Focus on provider throughput, scheduling, operations and revenue cycle



Think Value

Demonstrate performance to succeed under new VBP models

RHC Quality Improvement Project

Focus on Action and Change

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Project Goals

The Rural Health Clinic Quality Improvement project helps to **improve patient care** in rural communities, advance the quality measurement agenda and provide training for RHC staff to learn and implement a practice improvement model

- Build and support statewide Rural Health Clinic networks
- Elevate RHCs within Critical Access Hospital Quality Improvement Programs
- Quality Reporting is on the horizon for RHCs

A complementary aim is for RHCs to practice data collection, reporting and improvement around measures that are slated for future public reporting requirements.

Participating States

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Five National Quality Forum (NQF) Measures

The **National Quality Forum** is responsible for coordinating the development and ratification of clinical quality measures. The following five NQF metrics have been identified via research by John Gale from the Maine Rural Health Research Center as the most rural relevant.

John Gale, Director of Policy Engagement
john.gale@maine.edu

NQF #0018 – Controlling Blood Pressure

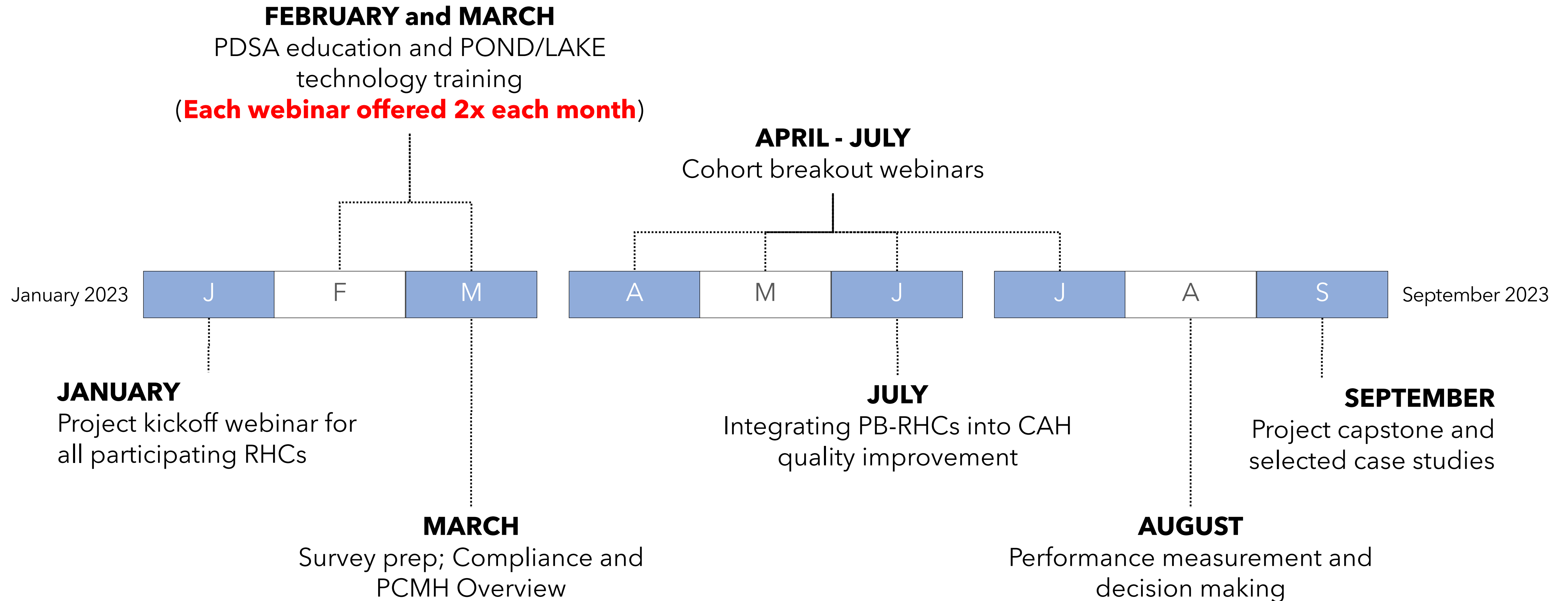
NQF #0028 – Preventive Care: Tobacco

NQF #0038 – Childhood Immunization

NQF #0059 – Diabetes: Hemoglobin A1c Poor Control

NQF #0419 – Current Medications

2023 Webinar Cadence



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Technology and Tools

Learning and Knowledge Exchange

Performance improvement tools for rural primary care practices with a core web application designed to help clinics create and manage PDSA initiatives

Practice Operations National Database

Data collection, reporting and benchmarking of the most rural relevant financial, quality, staffing, productivity and compensation metrics

PDSA Concepts

Purpose and practical application

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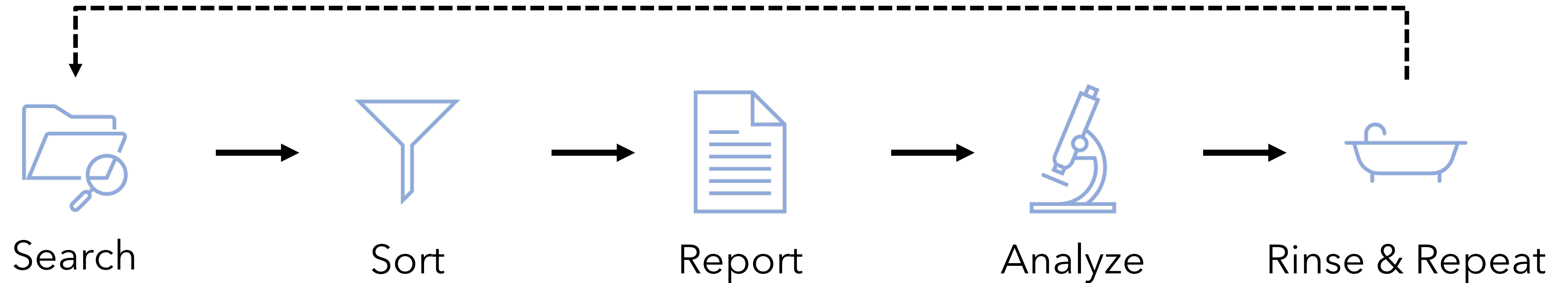
Change how you spend your time

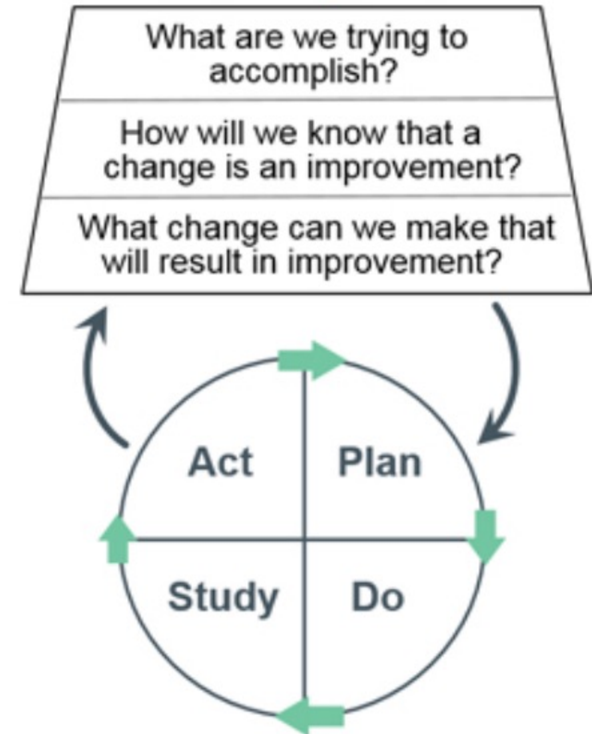


The typical reporting process leaves little time for **actual performance improvement**

Quality Improvement Model

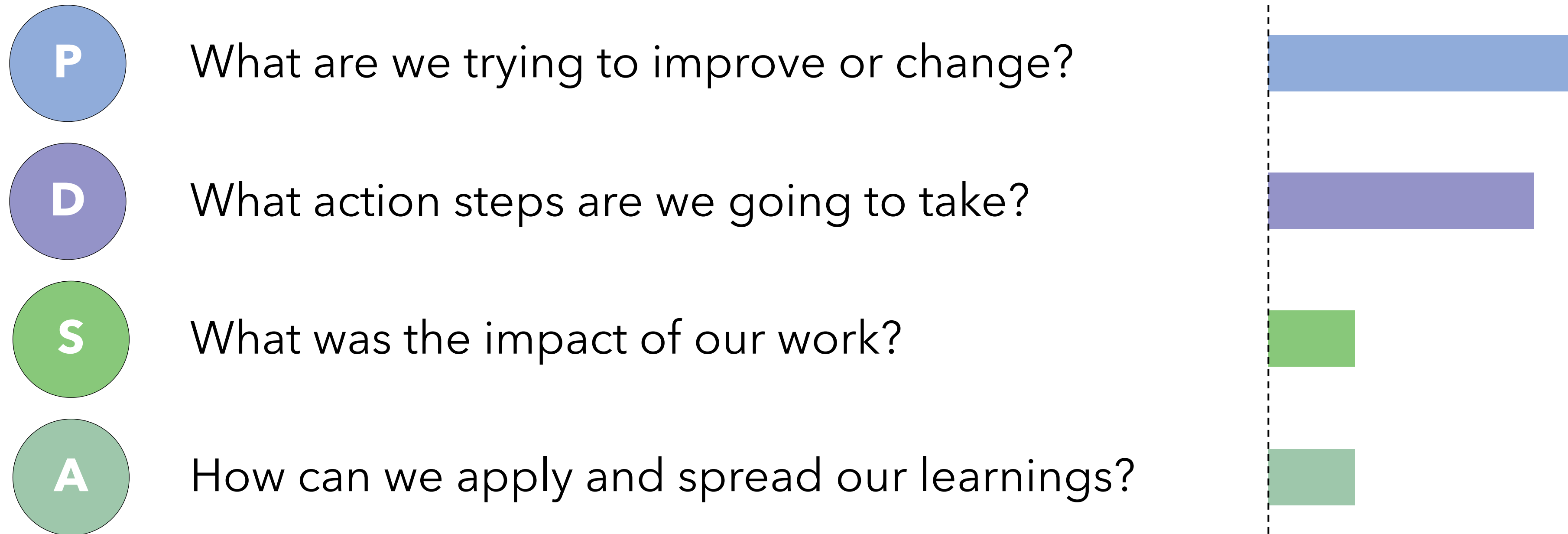
https://www.ihi.org

The Plan-Do-Study-Act (PDSA) cycle tests changes in real work settings. The PDSA cycle guides the test of a change to determine if the change is an improvement.



PDSA for RHCs

The **Plan-Do-Study-Act** Model has been adapted, digitized and simplified for Rural Health Clinics



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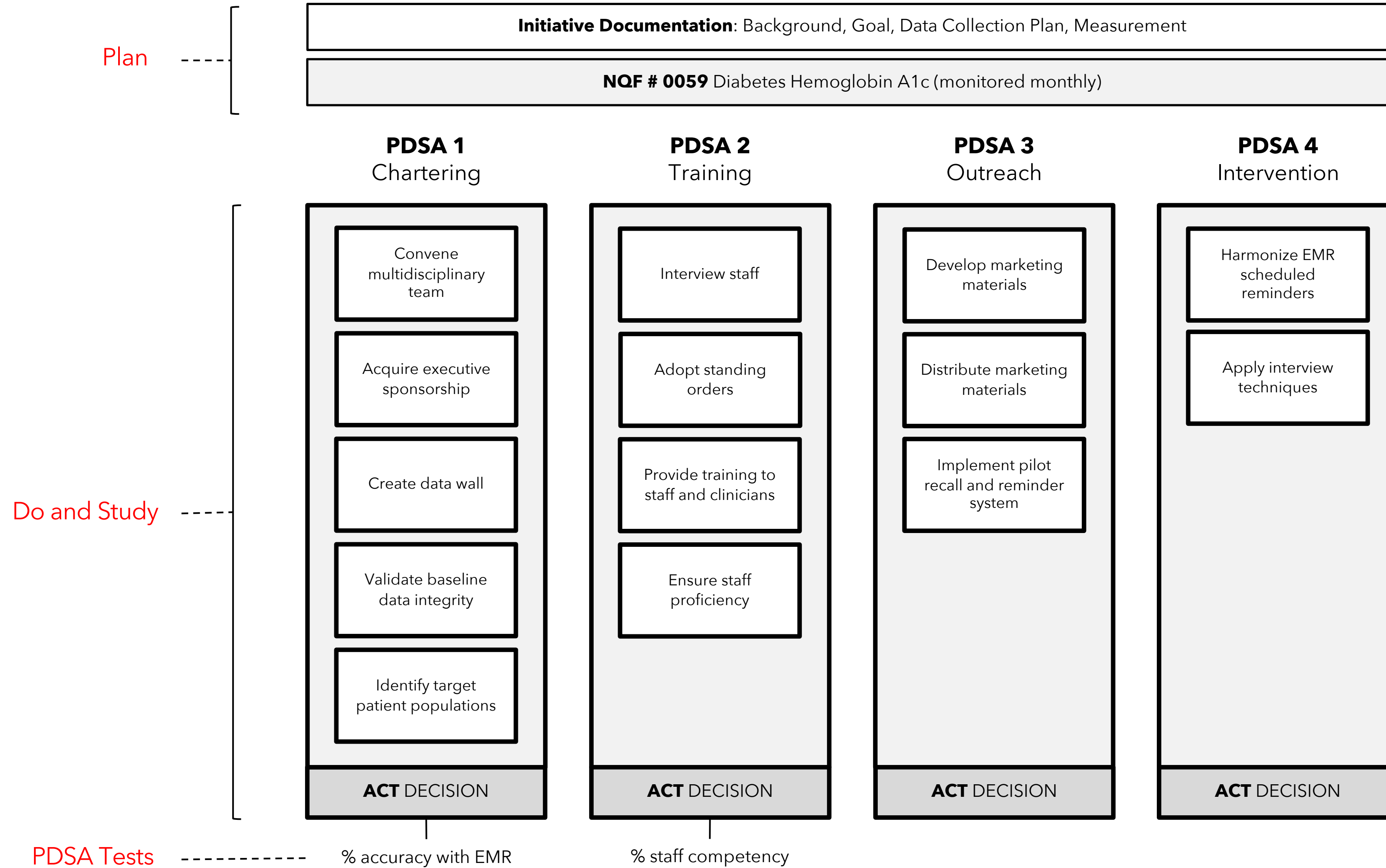
Your Head Start

We've created PDSA templates for all five (5) measures that include initiative descriptions, tasks and measure suggestions

Activate

Inside LAKE we have created an **Initiative Library** where clinics can review and "go shopping" for PDSA templates. When you find a template that suits your goals, you can activate the template and move it to your account as an active initiative. At that point you can modify, add or delete content and establish deadlines and accountabilities specific to your team

Diabetes Hemoglobin A1c



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Enhanced Diabetes Initiative

CMS Diabetes Prevention Program (DPP)

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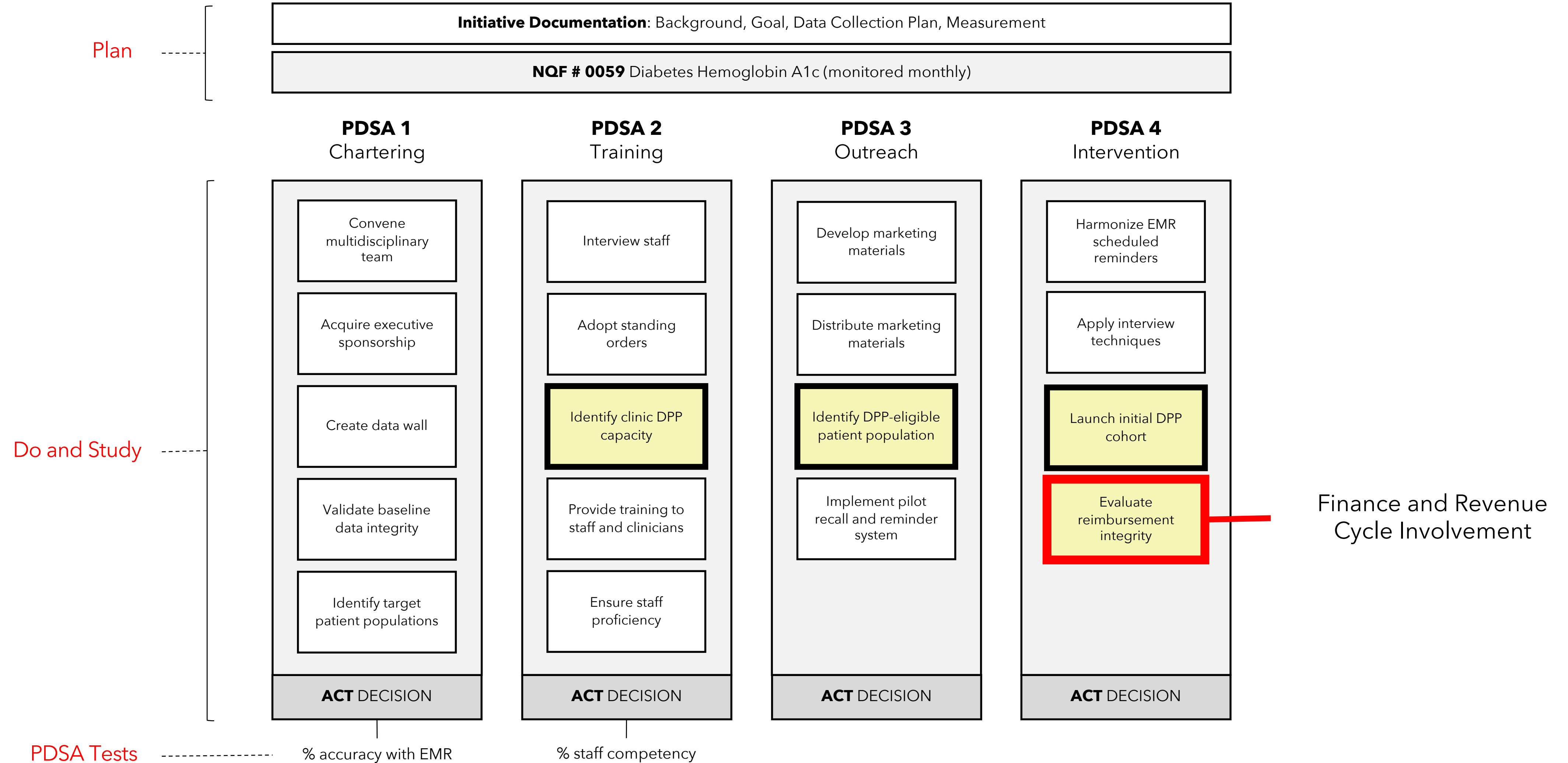
Medicare Diabetes Program

The Medicare **Diabetes Prevention Program** (DPP) expanded model is a structured intervention with the goal of preventing type 2 diabetes in individuals with an indication of prediabetes. The clinical intervention consists of a minimum of 16 intensive “core” sessions of a Centers for Disease Control and Prevention (CDC) approved curriculum furnished over six months in a group-based, classroom-style setting that provides practical training in long-term dietary change, increased physical activity, and behavior change strategies for weight control.

Diabetes Hemoglobin A1c with DPP



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Resources and Tools

Data Integrity Worksheet

Diabetes

This document outlines a process to improve data integrity for the Plan-Do-Study-Act improvement cycle. The proposed process is flexible for clinics of different sizes, services and staffing models but at the highest level, it centers on a standard chart review process that formalizes and documents how well the clinic staff adhere to data entry and analysis standards.

PROCESS

- Practice manager facilitates 1:1 staff chart reviews one day per week (e.g., Friday mornings)
- Involve all staff who are directly responsible for data entry – the people who "own" the data
  - They use the mouse and keyboard to navigate the EMR
  - They verbalize their observations/feedback
  - Only review 5-10 charts per session
- Establish and broadcast a clinic-wide performance target

MEASUREMENT

- Create a list of critical data elements (specific to your EMR and procedures/standing orders)
- Depending on your EMR and chart review process, quantify the number of inputs, per chart and use that number to calculate the
  - Numerator: How many items evaluated were present in the record and accurate?
  - Denominator: How many opportunities were there? (# of items * # of charts reviewed)

$$\frac{\text{Count of EMR items present and accurate}}{\text{Count of potential EMR items}}$$

- Remember that variation is the enemy, so assess variation by:
  - Staff member or supervising physician
  - Time of day or day of week
  - Clinic sites

SUGGESTIONS/HELPFUL HINTS

- Do not make the process punitive in any manner – it is an opportunity to educate
- Offer financial or non-financial incentives for high performance/compliance with standards
- To promote transparency, involve physicians and share results from the chart reviews
- Develop an Excel-based "Data Integrity Scorecard" scorecard
  - Use the LAKE web application to track performance
- Create and circulate in advance a formal calendar – practice manager should block schedule
- Use results to inform morning huddles and future educational/in-service meetings

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Source materials courtesy of
The Compliance Team

Standing Orders Template

Diabetes

POLICY:
Under this standing order, nursing staff with proper training may provide diabetes panel management for patients who fit these criteria. This protocol applies to all patients with a diagnosis of Type 1 or Type 2 who come into the clinic for any appointment.

PURPOSE:
To attain optimal diabetes control.

PROCEDURE:
1. At every visit, check and document in the medical record:
   a. weight and BMI
   b. blood pressure
   c. medication reconciliation.
2. At every visit, review the chart and identify whether patient is due for the following routine lab tests. If due, complete as soon as convenient for the patient:
   a. Hemoglobin A1c:
   If most recent A1c result is above 7%, repeat A1c every 3 months.
   If most recent A1c result is at or below 7%, repeat A1c every 6 months
   b. Serum Creatinine: Repeat every 12 months.
   c. Lipid Panel: Repeat every 12 months.
   d. Urine Microalbumin Test: Repeat every 12 months
3. At every visit, identify whether patient is due for the following routine procedures:
   a. Retinal eye exam: Repeat every 12 months
      i. Alert patient they are due for their annual exam.
      ii. Refer patient to an eye care provider for DILATED eye exam (for Type 1 – age 10 years or older, begin within 5 years of diabetes diagnosis; for Type 2 – begin at diagnosis).
      iii. If patient says they had an exam in the past 12 months, ask which provider performed exam, document in chart., and request records.
   b. Diabetic Foot Exam: Repeat every 12 months.
      i. Trained medical assistants may perform exam at visit when due.
      ii. Document results in chart.
      iii. If abnormalities exist or comprehensive foot exam not documented in the past year, alert physician/clinician to perform the exam for consideration of referral to podiatry specialist.
      iv. If patient says they had an exam in the past 12 months, ask which provider performed exam, document in chart., and request records.
4. Immunizations
   a. Influenza: repeat once a year.
   a. b. Pneumococcal:
      i. Provide patient with a copy of the most current federal Vaccine Information Statement (VIS).

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Source materials courtesy of
The Compliance Team

Patient Centered Medical Home

The Patient-Centered Medical Home is an approach to primary care that is built around YOU! You are the most important member of your healthcare team! We want to meet your goals and needs. We know that health is not achieved in a clinic; but rather built in our homes, schools, workplaces, and communities. Help us get to know you and your healthcare needs by completing the form below.

What matters most to you?	
Do you have an Advanced Directive? Would you like information on Advanced Directives?	☐ Yes ☐ No ☐ Yes ☐ No

PHYSICAL HEALTH

Do you have any health concerns today?	☐ Yes	☐ No
If yes, please explain:		
Have you been to the ER or hospitalized in the last 12 months?	☐ Yes	☐ No
If yes, please explain:		

Do you need help managing any of the following:

- ☐ Diabetes
- ☐ Blood Pressure
- ☐ Cholesterol
- ☐ Asthma
- ☐ COPD
- ☐ Medications
- ☐ Weight
- ☐ Diet and/or Exercise
- ☐ Quitting Smoking
- ☐ Pain
- ☐ Other-

MY CONCERNS

Select any problems or concerns that you are currently facing as you manage your health:

- ☐ Thinking/memory problems
- ☐ Emotional issues
- ☐ Spiritual support
- ☐ Family Issues
- ☐ Financial Issues
- ☐ Housing
- ☐ Fear for physical safety
- ☐ Find a healthy lifestyle hard/ overwhelming
- ☐ Access to nutritious food
- ☐ Transportation to appointments
- ☐ End of life issues
- ☐ Mobility issues
- ☐ My ability to manage my chronic conditions
- ☐ Other:
- ☐ Social support - friends

MENTAL HEALTH

Do you have any mental health concerns today?	☐ Yes	☐ No
If yes, please explain:		

Do you need help managing any of the following:

- ☐ Depression
- ☐ Anxiety / Social Anxiety
- ☐ Panic Attacks
- ☐ Alcohol consumption
- ☐ Drug Use
- ☐ Prescription medication use
- ☐ Lack of motivation
- ☐ Exhaustion
- ☐ Thoughts of harming yourself
- ☐ Processing a traumatic event/ PTSD/ Unresolved childhood trauma
- ☐ Thoughts of harming others
- ☐ Nightmares/ Night terrors
- ☐ Other:

GOALS

Which of the following health goals would improve your quality of life:

- ☐ Consistent control of blood sugars
- ☐ Weight loss
- ☐ Normal blood pressure
- ☐ Lower cholesterol
- ☐ Heart Health
- ☐ Increased energy
- ☐ Able to manage stress well
- ☐ Minimal symptoms of depression
- ☐ Eliminate anxiety / panic attacks
- ☐ Reach a fitness goal (ex: run a 5K, join a recreational sports team, etc.)
- ☐ Achieve / Maintain sobriety
- ☐ Maintain consistent healthy and clean eating habits
- ☐ Other:

Identify a life goal or reason that motivates you to work towards better health.

Data Integrity Worksheet
Overview of a suggested method for ensuring your clinic can effectively capture the data related to the quality measure.

Standing Orders Template
Sample document outlining the structure and content that may be suitable for standing orders in your clinic related to the specific quality measure.

TCT Needs Assessment
PDF tool that can be used as part of the patient intake process; it was developed for clinics pursuing or maintaining PCMH accreditation.

POND Benchmarking

Comparative Analytics for RHCs

POND Reports

Lilypad's flagship report, the **POND Summary Report** includes RHC-specific financial, staffing, provider compensation, productivity and clinical metrics with customized peer group and national benchmarks.

The **Cost Report Scorecard** includes multi-year trended volume, financial, cost and staffing ratios as well as state, regional and national benchmarks from all US RHCs based on current Medicare Cost Reports.

The **Site Audit** combines data from multiple public sources to provide summary statistics as well as a proprietary Medicare Cost Report integrity analysis and an evaluation of the out-of-pocket obligations for Medicare patients.

The **Lilypad Award Ranking Report** displays your RHC's annual performance in five weighted rural-relevant performance metrics according to the industry's only comprehensive RHC ranking and ratings program.

POND® Technical Assistance

01

Report

Enter data into POND to generate a set of management and benchmark reports

Validate your data

02

Review

30-60 Zoom session with us to review your POND reports and discuss options

Go over your reports

03

Plan

30-60 Zoom session to answer questions and help identify priorities

Discuss opportunities

Lilypad is a Maine-based analytics firm that provides mobile and web-based applications for rural primary care practices. We adhere to a core business principle that accountable physicians/clinical leaders and administrators require sound data and simple, innovative tools to be successful in their roles within the emerging value-based care delivery environment.

Gregory Wolf, President
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