RHC Checklist and Performance Benchmarks

Kentucky Office of Rural Health
September 18, 2020

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2019 Kentucky RHCs

RHC Counts

Total RHCs

241

84 **35%**

Provider-Based

157 **65%**

Independent

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Primary Care Options in Rural Healthcare

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Overview

- With uncertainty around a majority of significant provisions, such as payment, insurance, and delivery-system reforms, the healthcare industry must address future market changes
- An effective hospital primary care strategy is an essential component to address those market changes; especially in rural healthcare
  - The patients served, clinic location, and provider productivity must all be considered when developing a primary care strategy
- Since the hospital and clinic designation type can impact reimbursements and other opportunities received by the clinic, hospitals should evaluate each of the following clinic designation types to ensure an appropriate strategy:
  - Federally Qualified Healthcare Center (FQHC)
  - Provider-Based Clinic (PBC)
  - Rural Health Clinic (RHC)
    - Includes Provider-Based Rural Health Clinic (PB-RHC)
  - Free-Standing Health Clinic (FSHC)

2019 OPPS Final Rule

- The Bipartisan Budget Act (BBA) of 2015 clearly identified excepted provider-based items and services as those permitted to bill for items and services under OPPS after January 1, 2017, as the following:
  1. By a dedicated emergency department;
  2. By an off-campus PBD that was billing for covered OPD services furnished prior to November 2, 2015, that has not impermissibly relocated or changed ownership; or
  3. In a PBD that is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital.
- CMS removed #2 above for clinic visits which is the most common service billed under the OPPS, and CMS estimates this change will save the Medicare program and beneficiaries a combined $380m in 2019
  - Under the final rule, CMS is making payments for clinic visits site-neutral by reducing the payment rate for hospital outpatient clinic visits provided at off-campus provider-based departments by 60% with a two-year phase-in of this policy in 2019 and 2020

Primary Care Clinic Designation Types

- As seen, each of the four clinic types evaluated encompass different reimbursement methodologies that greatly impact reimbursements received from Medicare and Medicaid
  - The table below highlights those differences

Reimbursement Options	FQHC	CAH	<50 Beds	FSHC
		PBC	PB-RHC	
330 Grant	Yes	No	No	No
340B Pharmacy	Yes	Yes	Yes*	No
Un-Capped Technical Charge	No	Yes	Yes	No
Method II Billing	No	Yes	No	No
Tort Reform - Malpractice Savings	Yes	No	No	No
Enhanced PPS Reimbursement	Yes	Yes	Yes	No

- For non-CAHs, Hospital needs to meet DSH % to qualify for 340B

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Systems Approach to Revenue Optimization

- With declining reimbursements, all systems need to leverage available reimbursement opportunities to improve financial performance
- The following opportunities are available to hospitals and systems to improve reimbursements when those practices can meet certain eligibility requirements:
    1. Convert eligible practices within a health system or at a hospital to a designation that provides the most advantageous reimbursement opportunity
    2. Realign practices within a health system to leverage reimbursement advantages and additional revenue available to the system
    3. Integrate specialty practices, when possible, with PB-RHCs under a hospital of less than 50 beds to leverage cost-based reimbursement
    4. Acquire independent practices to leverage provider-based reimbursement opportunities and other additional revenue streams available to hospitals
        - This opportunity may not lead to a net positive return; however, will increase in functional, contractual, and governance alignment and increase the attributed lives associated with the hospital / health system

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Definitions and Regulations

Rural and Shortage Area Designations

- Some clinic designation types require the clinic to provide services to a specific group of patients and or operate in a certain location such as the following:
  - **Rural Area Location**
    - The federal government uses both the U.S. Census Bureau and the Office of Management and Budget (OMB) to determine “rural” areas
      - The Census Bureau does not actually define “rural”; however, rural encompasses all population, housing, and territory not included within an urbanized area
    - The Census Bureau defines urban as the following:
      - Urbanized Areas (UAs) of 50,000 or more people
      - Urban Clusters (UCs) of at least 2,500 and less than 50,000 people
    - OMB defines urban areas as the following:
      - Metropolitan contains an urban area of 50,000 or more population
        - OMB considers all counties that are not part of a metropolitan area as rural

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Rural and Shortage Area Designations

- **Rural Area Designations**
  - The following map presents the Urban Areas in Kentucky
    - The blue-shaded areas are considered Urban Areas

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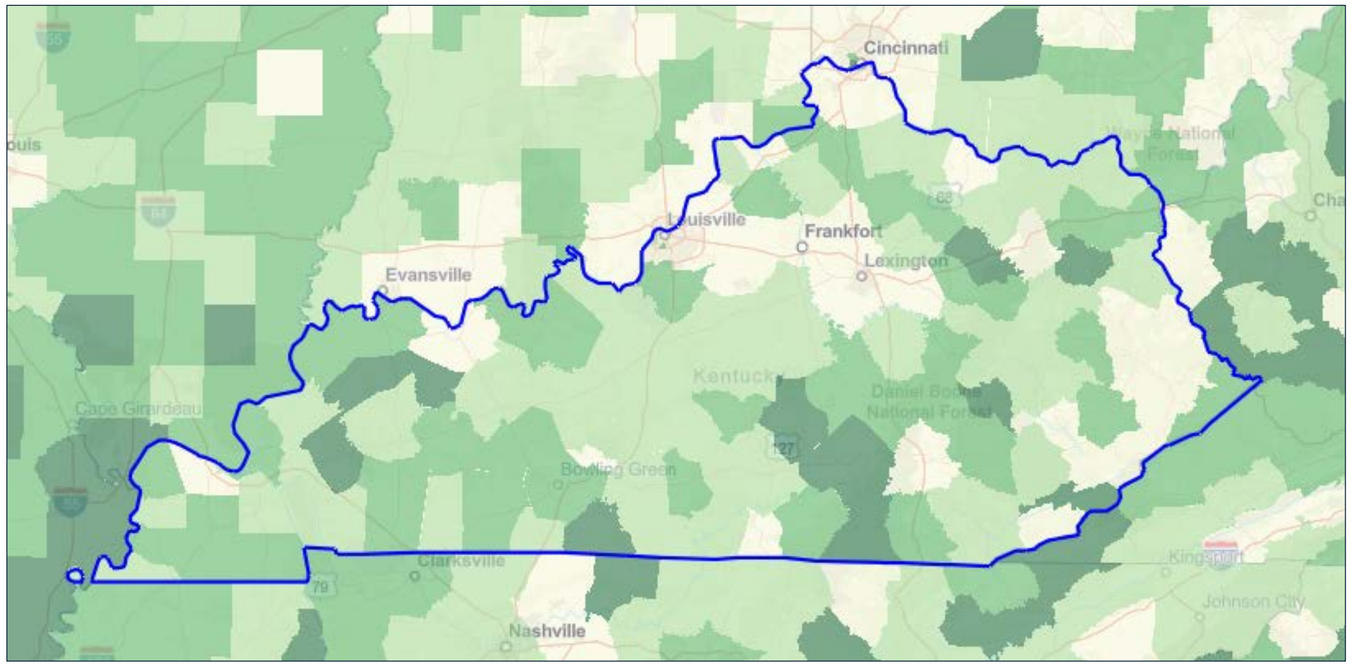
Rural and Shortage Area Designations

- **Health Professional Shortage Area (HPSA)**
  - Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary care, dental care, and/or mental health providers within a specific geographic area, population, or facility
    - Primary care HPSAs are based on a physician-to-population ratio of 1:3,500
      - The formula used to designate primary care HPSAs does not consider the availability of additional primary care services provided by Nurse Practitioners and Physician Assistants in the area



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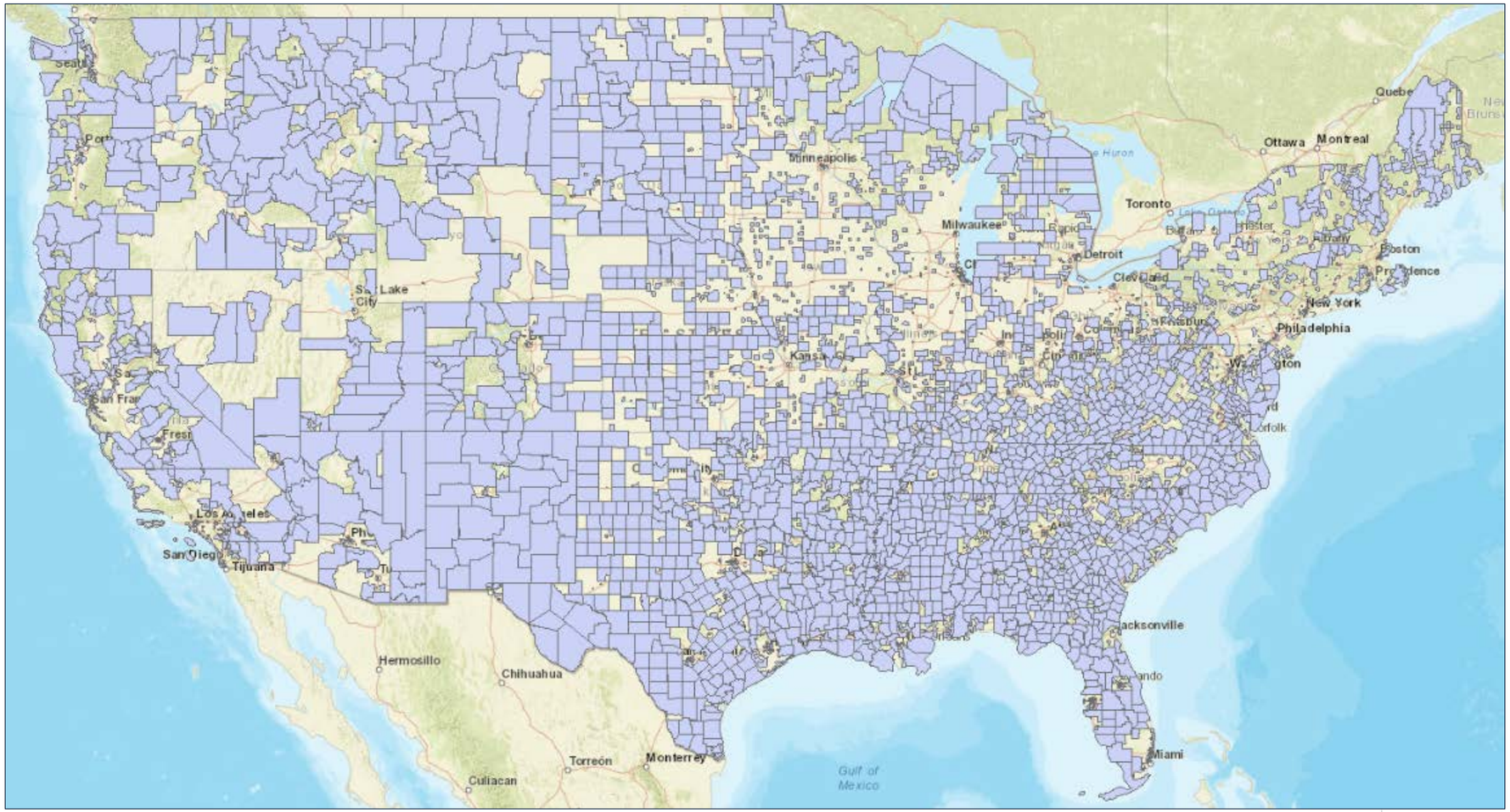
Rural and Shortage Area Designations

- **Medically Underserved Area (MUA)**
  - MUAs have a shortage of primary care health services within a geographic area such as:
    - a whole county;
    - a group of neighboring counties;
    - a group of urban census tracts; or
    - a group of county or civil divisions
  - To qualify as an MUA, the clinic must operate in an area with an Index of Medical Underservice (IMU) rating of 62.0 or less on a scale from 0 to 100
    - Public Law 99-280 states that a population group that does not have an IMU less than 62.0 can still obtain designation if “unusual local conditions exist which are a barrier to access to or the availability of personal health services”

Rural and Shortage Area Designations

- **Medically Underserved Areas and Populations**



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Rural and Shortage Area Designations

- **Governor-Designated Shortage Areas**
  - Governors may designate areas of their state as shortage areas specifically for the purpose of Rural Health Clinic (RHC) certification. These areas must meet specific criteria
    - State-created and HRSA-certified plans outline how to identify areas that need RHC services, but do not otherwise qualify for HPSA or MUA/P designation
  - States wishing to acquire a Governor's Designated Shortage Area for an RHC must submit:
    - A signed letter from the governor requesting the designation; and,
    - A state-specific Shortage Area Plan detailing, at minimum state's rational service area criteria and component guidelines for HRSA's approval
  - Kentucky does not currently have any Governor-Designated and Secretary-Certified Shortage Areas

Case Studies

Case Study 1: Overview / Objectives

- Carroll County Memorial Hospital (CCMH) is a 25-bed Critical Access Hospital (CAH) providing acute care and ancillary services to the residents of Carroll County, Kentucky and the surrounding communities

- CCMH currently operates three provider-based Rural Health Clinics to leverage cost-based reimbursement and improve access to care throughout the region at the following locations:
  - Carroll County Rural Health Clinic (CCRHC), located at 309 11th St., Carrollton, KY 41008
  - Bedford Family Practice (Bedford), located at 470 Highway 421 North, Bedford, KY 40006
  - Warsaw Family Practice (Warsaw), located at 202 Franklin St., Warsaw, KY 41095

- Carroll County has a number of specialty providers in the region and CCMH would like to evaluate the net financial impact of integrating the following provider-based clinic (PBC) into one of the established PB-RHCs:
  - CCMH Surgical Practice (Surgical), located at 309 11th St., Carrollton, KY 41008 and specialized in general surgery

Case Study 1: RHC Requirements

- **Advanced Practice Provider (APP) Requirement**
  - RHCs must employ an APP, which includes a physician assistant (PA), certified nurse midwife (CNM), and/or nurse practitioner (NP), for at least 50% of the time that the practice is open to see patients

Practice	Provider	Credential	Specialty	Hours of Operation	Productive Hours / Week	FTE	APP Coverage / Week	Meet APP Requirement
Surgical	Minzer	MD	General Surgery	M-W: 8:00a - 4:00p F: 8:00a - Noon	28.00	0.40	-	NO

  - CCMH would have to add an APP to Surgical or integrate that practice within a practice that employs an APP to meet this requirement
    - Surgical anticipates integrating the specialty practices within an established PB-RHCs which already meet this requirement

- **Primary Care Requirement**
  - RHCs must be “primarily engaged,” that is, at least 51 percent of the services provided, in primary medical care

Practice	Provider	Credential	Specialty	Hours of Operation	Productive Hours / Week	Primary Care Hours/Week	Meet Primary Care Requirement
Surgical	Minzer	MD	General Surgery	M-W: 8:00a - 4:00p F: 8:00a - Noon	28	0	NO

  - The Surgical practice does not meet the 51 percent primary care requirement to operate as a stand-alone RHC and would have to be integrated within one of the other RHCs to qualify for the RHC benefit

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Case Study 1: PB-RHC Assessment

- **PB-RHC Impact**
  - The following presents the net financial impact on CCMH **if** the Surgical practice were integrated within one of the RHCs and CCMH consolidated the cost reports

Summary	Specialty as PBC			Specialty Integrated in PB-RHC		
Payor Data	Payment / Visit	Visits	Revenue	Payment / Visit	Visits	Revenue
Practice Impact						
Medicare	$ 156.95	5,531	868,093	$ 174.93	5,531	$ 967,559
Medicaid	156.77	12,163	1,906,796	174.93	12,163	2,127,720
Average	$ 156.83	17,694	$ 2,774,890	$ 174.93	17,694	$ 3,095,279
					Specialty Reimbursement Variance:	**$ 320,389**
Hospital Impact						
CAH Impact			$ -			$ (44,803)
Variance With Current State				**$**		**275,586**

  - Analysis shows CCMH would realize an increase in reimbursements of $276K by integrating the Surgical practice into an established RHC and consolidating the RHC cost reports
    - The $276K increase in reimbursements as a PB-RHC offset the $45K reduction in reimbursements CCMH will experience from other cost-based programs as a CAH
    - The average Medicare and Medicaid reimbursement would increase from $156.83 to $174.93

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Case Study 2: Overview / Objectives

- A five-hospital system with more than 1,000 physicians and other clinicians
  - Hospitals include:
    - A 400-bed, short-term acute facility
    - A 320-bed, short-term acute facility
    - A 60-bed, short-term acute facility
    - A 25-bed Critical Access Hospital (CAH)
    - HMC, an 80-bed, short-term acute facility
- HMC operates five provider-based clinic (PBC)
  - 4 practices are off-campus and would be impacted by site neutrality
- In 2019, HMC engaged Stroudwater to compare the net impact on reimbursements under the following scenarios:
  - Scenario #1: Reimbursements received as PB-RHC under HMC with more than 50 beds
  - Scenario #2: Reimbursements received as PB-RHC under HMC with fewer than 50 beds

Case Study 2: Benefit

- **PB-RHC Impact**
  - The following table shows an average rate and reimbursements received from Medicare and Medicaid under each scenario:

Summary Data	Base Case	Scenario #1 PB-RHC >50 Beds	Scenario #2 PB-RHC <50 Beds
Medicare / Medicaid Average	$ 143.17	$ 84.70	$ 183.42
Annual Visits	27,338	27,338	27,338
Reimbursements Received	$ 3,913,934	$ 2,315,529	$ 5,014,296
340B Benefit	n/a	n/a	n/a
Variance w/ PBC		$ (1,598,405)	$ 1,100,362

- **Study Outcomes:**
  - Analysis shows HMH would realize an increase in reimbursements of $1.1M by reducing beds to fewer than 50 and designating the practices as PB-RHCs
    - The average Medicare and Medicaid reimbursement would increase from $143.17 to $183.42
    - The reimbursements received in Scenario 1 would be the same if the practice was an independent RHC

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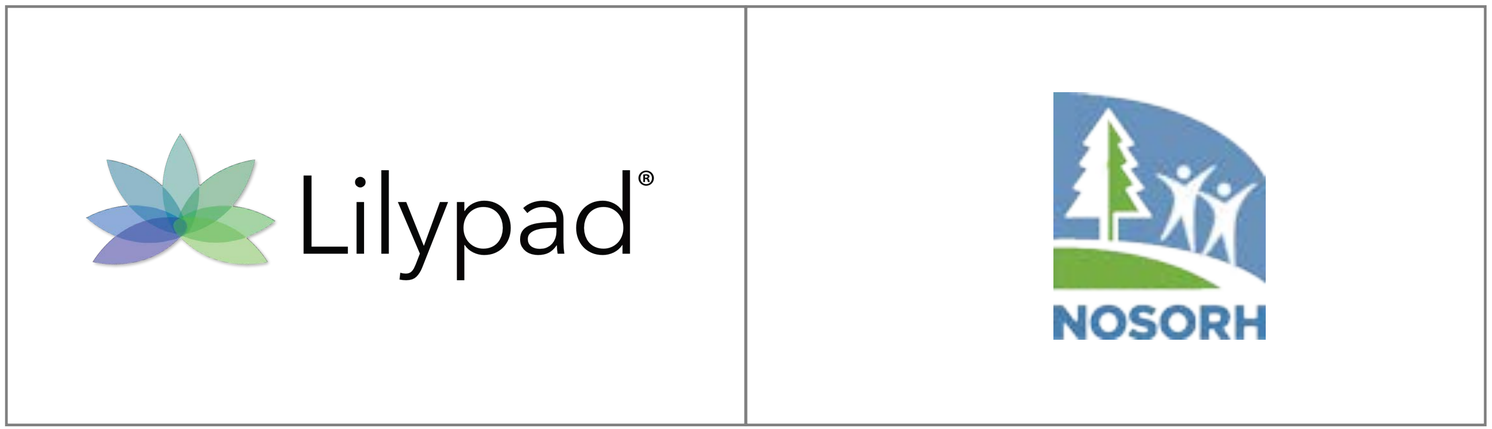
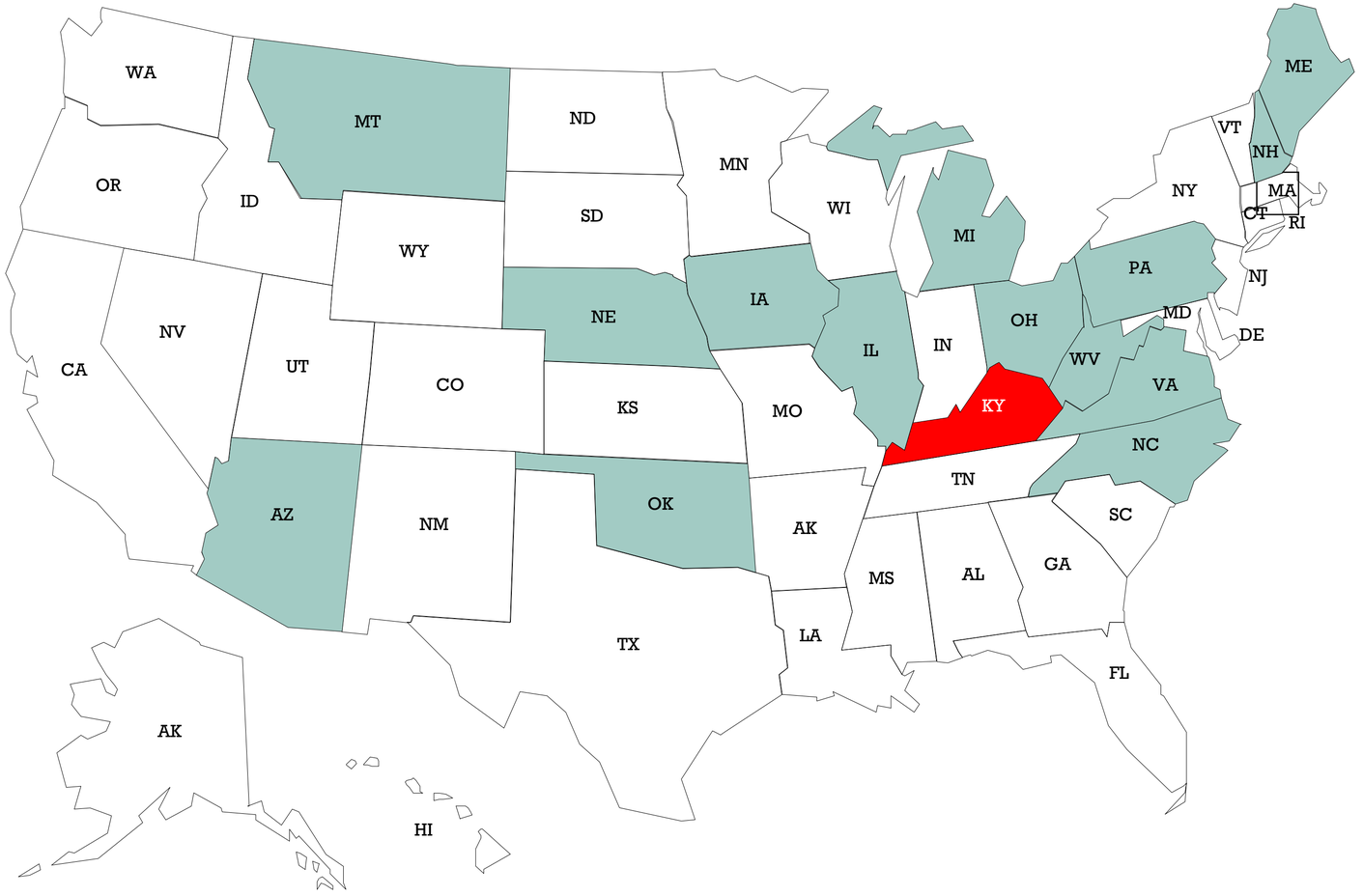
Performance Checklist and Benchmarks

Practice Operations National Database®



Developed by Lilypad, POND® is the only analytics and benchmarking system dedicated specifically to rural primary care practices

Our Current States



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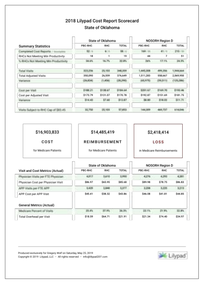
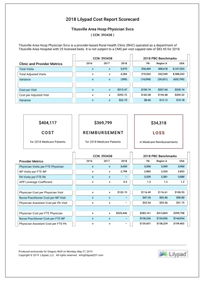
How Does It Work?

Cost Report Scorecards

State Scorecards

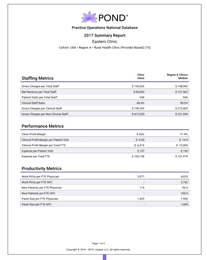


Clinic Scorecards

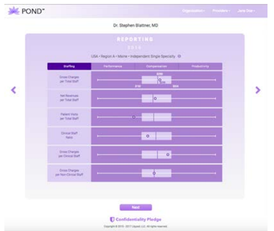


POND Analytics

Clinic Scorecard



Interactive Tools



To gain access to these reports and tools the required data must be entered into the POND web application

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RHC Performance Checklist

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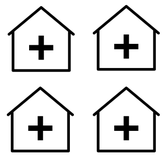
10-Point Checkup

- Cost Report Consolidation
- Productivity Standards
- Optimal Hospital Linkage
- 340B Optimization
- Specialty Care Integration
- Patient Panel Development
- HCC Education and Monitoring
- CCM, TCM and BHI Implementation
- Contracts and Compliance
- Quality Measurement/Benchmarks

Cost Report Consolidation

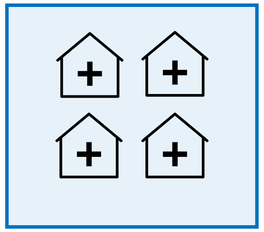
Hospitals have an option to “consolidate” statistics for rural health clinics on their Medicare cost report submissions.

Sample A
4 clinics, **NO** consolidation



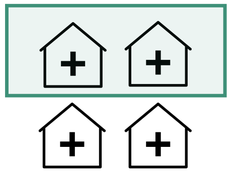
4 Schedule M

Sample B
4 clinics, **FULL** consolidation



1 Schedule M

Sample C
4 clinics, **PARTIAL** consolidation



2 Schedule M

Note: Hospitals need to indicate they will consolidate clinics prior to the start of the cost report year
Note: Consolidation of clinics makes financial sense approximately 90% of the time
Note: Hospitals can elect to consolidate all, some or none of their rural health clinics

Consolidation Case Study

	Clinic A	Clinic B	Combined	Consolidated	Variance
Costs	$1,440,287	$910,724	$2,351,011	$2,351,011	--
Visits	8,644	4,788	13,432	11,031	(2,401)
Adjusted Cost/Visit	$166.62	$190.21	$169.14	$231.13	$43.99
Medicare Visits	2,919	349	3,268	3,268	--
Reimbursement	**$486,372**	**$66,383**	**$522,755**	**$696,501**	**$143,746**

Productivity Standards

CMS defines a minimum expected number of patient visits for physicians and advanced practice providers (i.e. Nurse Practitioners and Physician Assistants)

The goal is always to maximize visit volumes

4,200	2,100
Physicians	APPs

Note: Only employed providers are subject to the Minimum Productivity standards
Note: Contracted physician volumes are not included in the calculation
Note: If clinics do not meet productivity standards, the clinic does not get cost-based reimbursement

2019 Kentucky RHCs

Meeting Productivity Standards

Total RHC Cost Reports

210

Provider-Based

Cost Reports **85**

Meeting Standard **56** **66%**

Independent

125 Cost Reports

70% **85** Meeting Standard

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Annual Work RVUs

Physicians (n=561)	3,276 RVUs
APPs (n=564)	2,338 RVUs

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Optimal Hospital Linkage

PB-RHC and hospital should maintain operational, financial and quality alignment

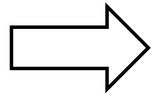
RHC	Hospital	Opportunity
☐	☐	Quality Improvement Program
☐	☐	ER Re-Direct Program
☐	☐	Overhead Allocation
☐	☐	Electronic Health Record
☐	☐	Financial and Reporting Systems
☐	☐	Budgeting
☐	☐	System-wide Clinic Alignment
☐	☐	CCM, TCM, BHI

340B Optimization

Federal government program that requires drug manufacturers to provide outpatient drugs to eligible health care organizations at significantly reduced prices

For every 10,000 patient visits equals $300-$400k of Net Revenue

20,000
Patient Visits



Up to $800,000
Potential Net Revenue

Note: Practices have to qualify for the 340B Program

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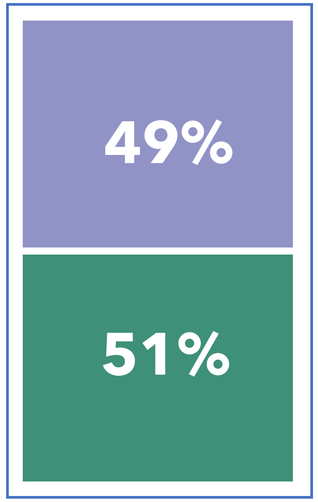
Specialty Care Integration

Rural Health Clinics were designed to increase access to primary care in rural communities but RHCs also can offer access to specialty care

Primary Care
At least 50% of all services rendered in the RHC need to be “primary care services”



Specialty Candidates
- General Surgery
- Orthopedics
- ENT
- GI
- Neurology

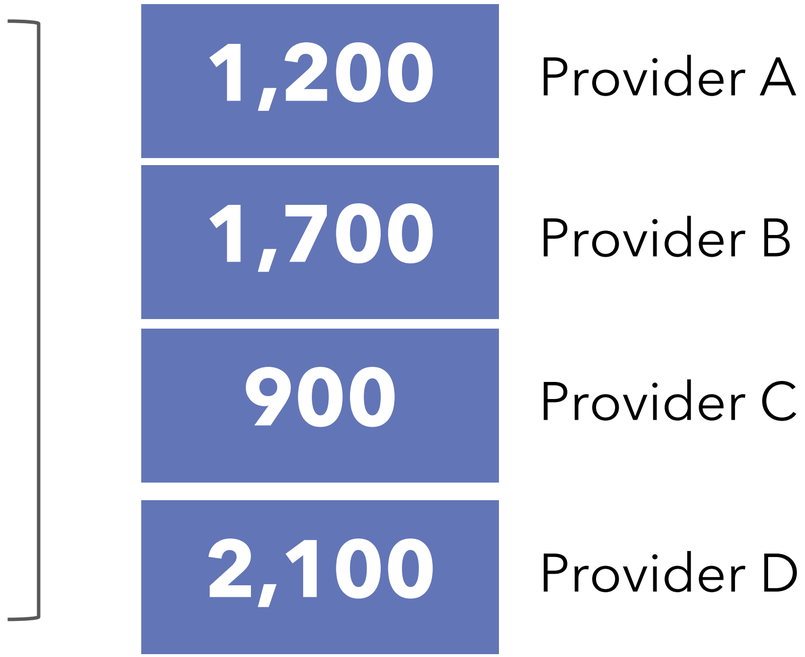
Note: RHCs should prioritize specialties that require clinical time to support surgical volumes

Patient Panel Development

Develop a 1:1 assignment of all RHC patients to a provider to create defined patient “rosters”

Using the EHR, establish a consensus-driven methodology for assigning patients to providers

Create a field in the EHR for primary provider to facilitate future reporting and analysis



Note: Internal Target = Count of annual wellness visits equal to Patient Panel size for each provider

Patient Panel Benchmark

Physicians (n=561)	1,345 patients
APPs (n=564)	1,033 patients

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HCC Education and Monitoring

Hierarchical Condition Category (HCC) coding is a risk-adjustment model driven by ICD-10 coding and originally designed to estimate future health care costs for patients

Patient A

A 68-year-old patient with type 2 diabetes with no complications, hypertension, and a body mass index (BMI) of 37.2

RAF = 0.00

Patient B

A 68-year old patient with type 2 diabetes with diabetic polyneuropathy, hypertension, morbid obesity with a BMI of 37.2, and status post-left below knee amputation (BKA)

RAF = 1.18

Note: HCC scores need to be re-computed every year

CCM, TCM and BHI Implementation

Chronic Care Management services are integral to the mission of Rural Health Clinics

CCM

- CCM services are non-face-to-face care management and coordination services for Medicare beneficiaries with two or more chronic conditions
- CCM services can be billed by adding the general care management G code, G0511, to an RHC claim, either alone or with other payable services
- Payment is the average of the national PFS payment rate for CPT codes 99490, 99487, 99491, and 99484
- CCM or General BHI (HCPCS code G0511) services are paid at the rate of **$67.03** for 2019
- A minimum of 20 minutes of CCM or general BHI services must be furnished within the calendar month

TCM

- TCM services support patient's transition from inpatient, SNF, inpatient rehab, outpatient observation or partial hospitalization settings to home or community settings
- TCM services can be billed by adding CPT code 99495 or 99496 to an RHC claim
- If it is the only medical service provided on that day with an RHC practitioner, it is paid as a stand-alone visit
- If it is furnished on the same day as another visit, only one visit is paid
- For 2019, TCM (CPT code 99495 or 99496) is paid the **same as an RHC Visit**

BHI

- General BHI is a defined model of care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions
- General BHI services can be billed by adding the general care management G code, G0511, to an RHC claim, either alone or with other payable services
- Payment is the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, and 99484
- CCM or General BHI (HCPCS code G0511) services are paid at the rate of **$67.03** for 2019
- A minimum of 20 minutes of CCM or general BHI services must be furnished within the calendar month

Contracts and Compliance

Provider Compensation is critical but mistakes are common

Inconsistency	Contracts, valuation opinions, and payroll are not standardized, documented, or executed consistently.
Reasonableness	Desperation leads to throwing money at recruitment and retention rather than stepping back and determining what makes sense. Often opportunities for non-monetary compensation are overlooked.
Wrong People	Organizations take a top down approach with compensation and do not involve the practice administrator or the physicians.
Benchmarks	Hospitals assume MGMA (or POND) median will protect them from a compliance standpoint – it won't. The OIG has consistently come out saying surveys are not the final word on Fair Market Value.
Monitoring	When compensation requires supervision, minimum clinical hours, or administrative duties, monitoring of scheduling and documentation is critical.

Annual Compensation (per FTE)

	Base Salary	Variable
Physicians	$165,000 (n=285)	$75,000 (n=184)
APPs	$85,000 (n=292)	$35,000 (n=143)

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Quality Measurement/Benchmarks

Relevant quality measures for rural primary care practices have been elusive but there is a research-based set of NQF measures that all clinics should track – at the provider level

		Good	Better	Best
NQF 0018	Controlling Blood Pressure	Monitor Something!	Quarterly Clinic-wide Just quality	Monthly Physician Scorecards
NQF 0028	Preventive Care: Tobacco			
NQF 0038	Childhood Immunization			
NQF 0059	Diabetes: Hemoglobin A1c			
NQF 0419	Current Medications			

2020 Lilypad Awards

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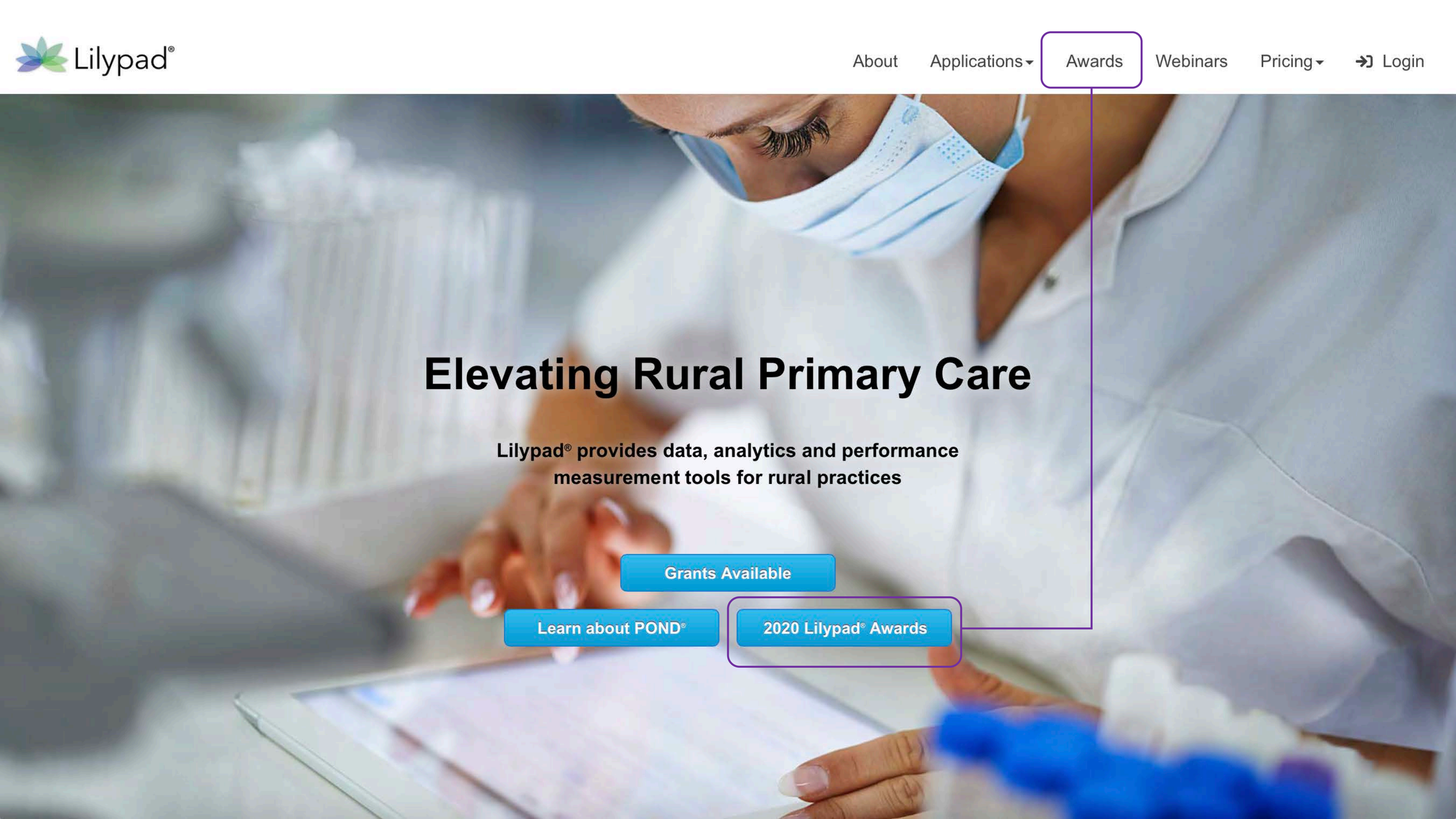
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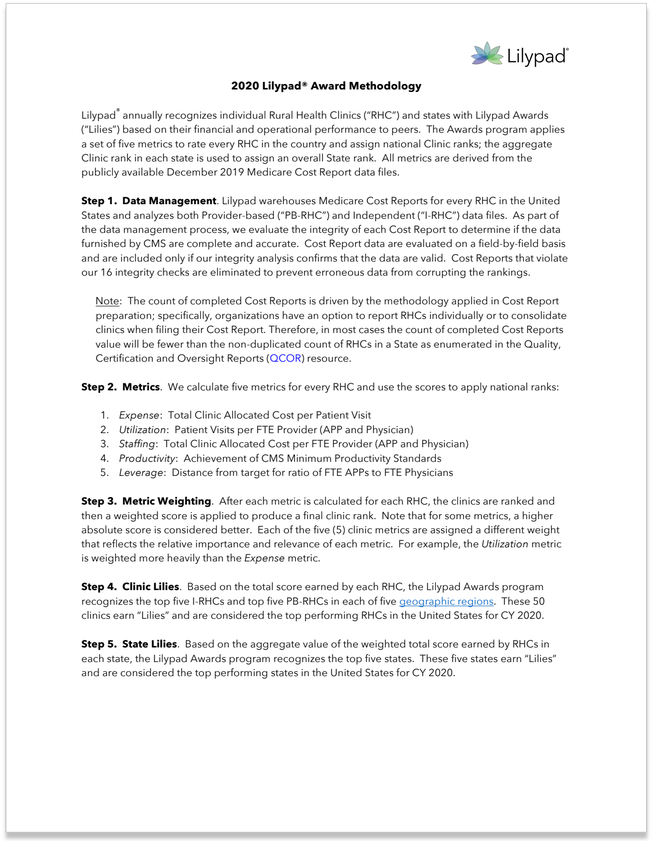
Methodology



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2020 Lilypad® Award Methodology

Lilypad® annually recognizes individual Rural Health Clinics ("RHC") and states with Lilypad Awards ("Lilies") based on their financial and operational performance to peers. The Awards program applies a set of five metrics to rate every RHC in the country and assign national Clinic ranks; the aggregate Clinic rank in each state is used to assign an overall State rank. All metrics are derived from the publicly available December 2019 Medicare Cost Report data files.

Step 1. Data Management. Lilypad warehouses Medicare Cost Reports for every RHC in the United States and analyzes both Provider-based ("PB-RHC") and Independent ("I-RHC") data files. As part of the data management process, we evaluate the integrity of each Cost Report to determine if the data furnished by CMS are complete and accurate. Cost Report data are evaluated on a field-by-field basis and are included only if our integrity analysis confirms that the data are valid. Cost Reports that violate our 16 integrity checks are eliminated to prevent erroneous data from corrupting the rankings.

Note: The count of completed Cost Reports is driven by the methodology applied in Cost Report preparation; specifically, organizations have an option to report RHCs individually or to consolidate clinics when filing their Cost Report. Therefore, in most cases the count of completed Cost Reports value will be fewer than the non-duplicated count of RHCs in a State as enumerated in the Quality, Certification and Oversight Reports (QCOR) resource.

Step 2. Metrics. We calculate five metrics for every RHC and use the scores to apply national ranks:

1. *Expense*: Total Clinic Allocated Cost per Patient Visit
2. *Utilization*: Patient Visits per FTE Provider (APP and Physician)
3. *Staffing*: Total Clinic Allocated Cost per FTE Provider (APP and Physician)
4. *Productivity*: Achievement of CMS Minimum Productivity Standards
5. *Leverage*: Distance from target for ratio of FTE APPs to FTE Physicians

Step 3. Metric Weighting. After each metric is calculated for each RHC, the clinics are ranked and then a weighted score is applied to produce a final clinic rank. Note that for some metrics, a higher absolute score is considered better. Each of the five (5) clinic metrics are assigned a different weight that reflects the relative importance and relevance of each metric. For example, the *Utilization* metric is weighted more heavily than the *Expense* metric.

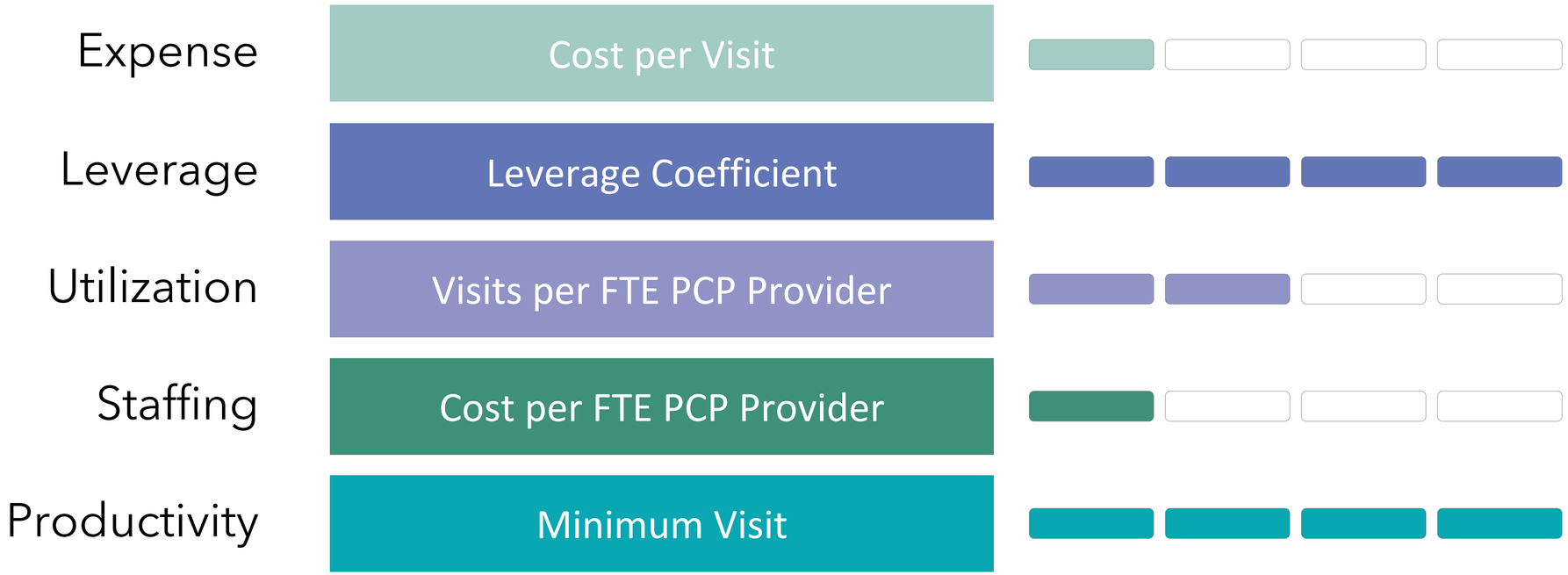
Step 4. Clinic Lilies. Based on the total score earned by each RHC, the Lilypad Awards program recognizes the top five I-RHCs and top five PB-RHCs in each of five geographic regions. These 50 clinics earn "Lilies" and are considered the top performing RHCs in the United States for CY 2020.

Step 5. State Lilies. Based on the aggregate value of the weighted total score earned by RHCs in each state, the Lilypad Awards program recognizes the top five states. These five states earn "Lilies" and are considered the top performing states in the United States for CY 2020.

https://www.lilypad207.com/awards

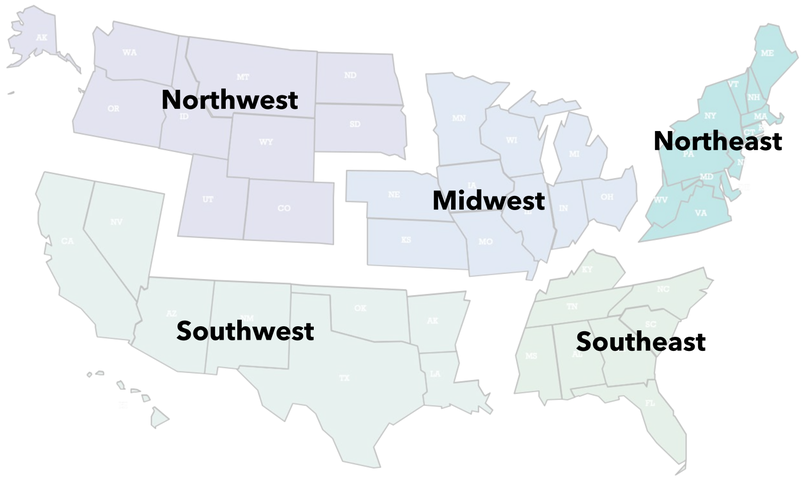
1. Download electronic cost reports
2. Apply data integrity checks (**24** of them!)
3. Eliminate bad data and trim outliers
4. Calculate metrics for every eligible clinic
5. Apply weights across five metrics
6. Rank all eligible clinics and states

2020 Lilypad® Award Metrics



Lilypad®

2020 Lilypad Clinic Awards



Based on each individual clinic's ranking, the top five Provider-Based RHCs and the top five Independent RHCs earn "Lilies"

	25	Top 5 Provider-Based RHCs in 5 Regions
+	**25**	Top 5 Independent RHCs in 5 Regions
	50	**2020 Clinic Lilies**

For a full list of 2020 Lilypad Award RHC Lily winners, visit:

https://www.lilypad207.com/awards

Lilypad®

Kentucky Performance

Southeast Award Winners

Provider-Based RHCs

Clinic	Location
Family Medical Group	Meadville, Mississippi
Hale County Hospital Clinic	Greensboro, Alabama
Healthmark Regional Med Ctr	Defuniak Springs, Florida
South Central Regional Medical Center	Laurel, Mississippi
Sunflower Rural Health Clinic	Ruleville, Mississippi

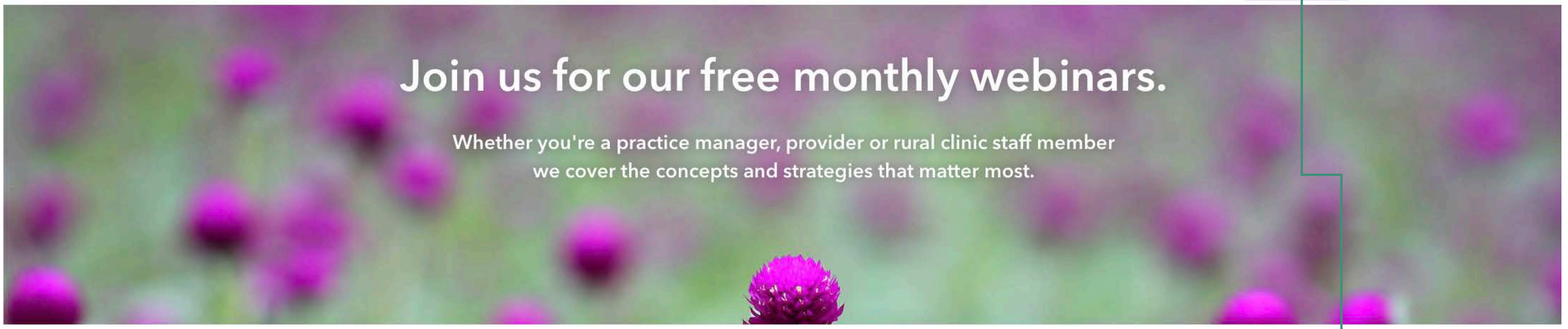
Independent RHCs

Clinic	Location
Candler Medical Group - Metter	Metter, Georgia
EMS Clinic	Greenwood, Mississippi
Family Medical Group PA	Lake Placid, Florida
Holmes County Family Medicine Clinic	Lexington, Mississippi
Monticello Medical Associates	Monticello, Kentucky

Lilypad®

Get Your Clinic's Rank

https://www.lilypad207.com



Lilypad® Webinars Are Free to Register, View or Download

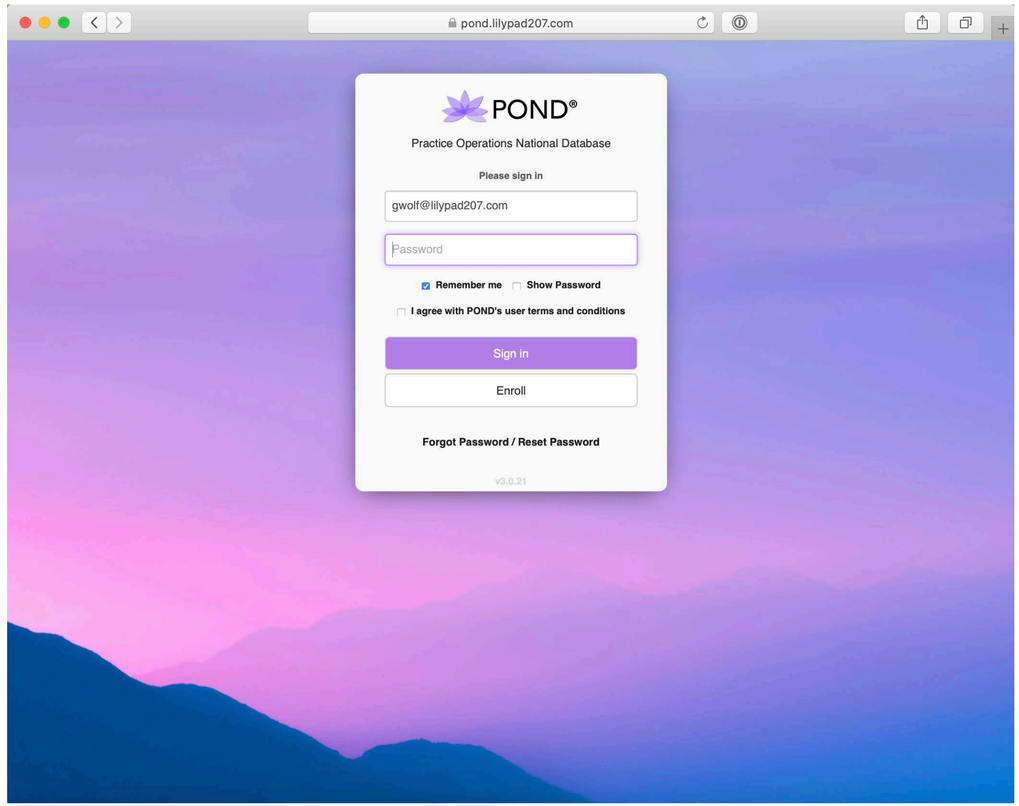
Date	Webinar Topic	Registration	Video	Slides
~~October 16~~	Provider Productivity and Compensation		Watch	Download
~~November 21~~	Clinic Designations and Strategies		Watch	Download
~~December 16~~	Practice Management Best Practices		Watch	Download
~~January 20~~	Practice Alignment - Specialty Care		Watch	Download
~~February 17~~	National and State RHC Rankings		Watch	Download
~~June 22~~	Optimizing Cost Reports for RHCs		Watch	Download
~~July 20~~	Provider Contracting/Compliance		Watch	Download
August 24	340B Drug Program	Register		
September 21	Clinic Spotlight B	Register		
October 19	Process and Outcomes Quality Measurement	Register		

2020 RHC Telemedicine Survey

Lilypad®

RHC Telemedicine Survey

Administered August 1 – September 30



WHAT YOU'LL NEED

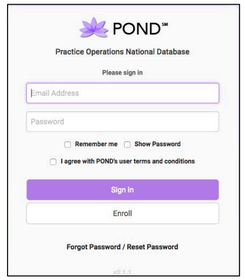
1. 5 minutes
2. Internet connection and Web browser
3. Clinic NPI and CCN

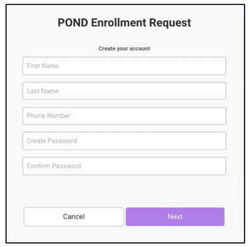
WHAT YOU'LL GET

1. Telemedicine Industry Report
2. Access to dedicated webinar
3. Clinic Lilypad Award® scorecard

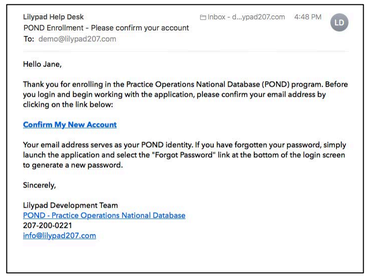
RHC Telemedicine Survey

Step 1: Enroll

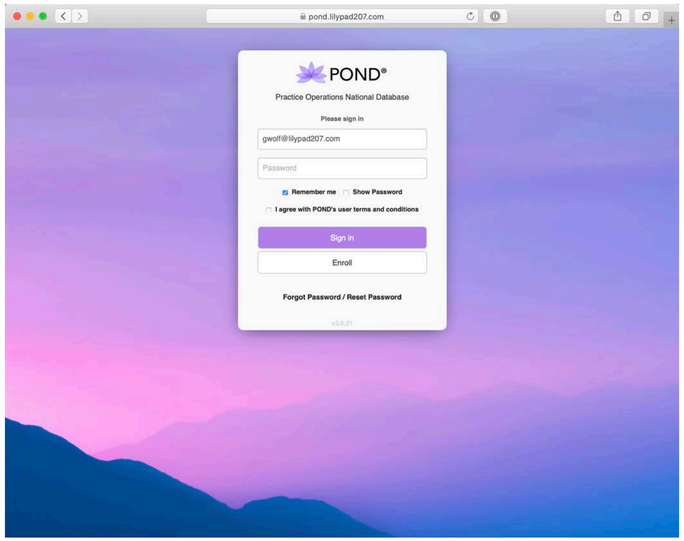




Step 2: Validate



Step 3: Complete Survey



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