

# **Michigan Critical Access Hospital Quality Network Orientation Manual**

Purpose: This MICAH QN Orientation Manual serves as a resource to new organizational representatives of the Michigan Critical Access Hospital Quality Network. It will be used as a framework for peer-to-peer site visits for all new MICAH QN members.

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## **Section 1: Overview of Critical Access Hospitals**

The Medicare Rural Hospital Flexibility Program (Flex Program), created by Congress in 1997, allows small hospitals to be licensed as Critical Access Hospitals (CAHs) and offers grants to States to help implement initiatives to strengthen the rural health care infrastructure. The Michigan Center for Rural Health coordinates this grant, with the following individuals as the main contact:

- Crystal Barter  
Director of Performance Improvement (Flex Coordinator)  
[crystal.barter@hc.msu.edu](mailto:crystal.barter@hc.msu.edu)  
517-432-0006
- John Barnas  
Executive Director  
[john.barnas@hc.msu.edu](mailto:john.barnas@hc.msu.edu)  
517-432-9216

To participate in the Flex Program, States are required to develop a rural health care plan that provides for the creation of one or more rural health networks, promotes regionalization of rural health services in the State, and improves the quality of and access to hospital and other health services for rural residents of the State. Consistent with their rural health care plans, states may designate eligible rural hospitals as CAHs.

CAHs must be located in a rural area or an area treated as rural; be more than 35 miles (or 15 miles in areas with mountainous terrain or only secondary roads available) from another hospital, or be certified before January 1, 2006 by the State as being a necessary provider of health care services. CAHs are required to make available 24-hour emergency care services that a State determines are necessary. CAHs may have a maximum of 25 acute care and swing beds, and must maintain an annual average length of stay of 96 hours or less for their acute care patients. CAHs are reimbursed by Medicare on a cost basis (i.e., for the reasonable costs of providing inpatient, outpatient, and swing bed services). To see the full CAH Conditions of Participation, [click here](#).

The legislative authority for the Flex Program and cost-based reimbursement for CAHs are described in the Social Security Act, Title XVIII, Sections 1814 and 1820. [Click here to view details of this Act](#).

There are 36 CAHs in Michigan. Click here for a [listing](#), and here for a [map](#).

## **Section 2: Overview of Michigan Critical Access Hospital Quality Network**

Mission Statement: As a premier system of quality, the Michigan Critical Access Hospital Quality Network (MICAH QN) will be a model in developing processes that demonstrate the

high quality service provided by CAHs. MICAH QN will identify opportunities for change that lead to continued improvement in the health status of the population we serve.

Vision Statement: MICAH QN will be known as the statewide and national leader in the measurement of healthcare quality for Critical Access Hospitals (CAHs).

Purpose:

- Improve the health of our communities by working together to expand our professional and financial resources.
- Develop a process to measure quality standards.
- Establish a common database for benchmarking by collecting data and identifying best practices that each CAH can use in their individual process improvement plan.
- Demonstrate the value of CAHs to our communities.
- Demonstrate commitment and unification as a collaborative body to regulatory agencies and political concerns regarding health care quality in Michigan CAHs

MICAH QN Strategies:

In 2015 the MICAH QN underwent a strategic planning process to align their priorities with the National Quality Strategy. The following three strategies were adopted:

**Strategy Group # 1** - Making care safer by reducing harm caused in the delivery of care

**Strategy Group #2** - Promoting Effective Communication and Coordination of Care to Improve Patient Safety as Evidenced by Increasing MBQIP Bundle Compliance from 60% to 90% Congregate Score.

**Strategy Group #3** – Working with Communities to Promote Wide Use of Best Practices to Enable Healthy Living

Brief Timeline of Events:

- The initial meeting of the MICAH QN took place in March 2001, with subsequent meetings taking place on a quarterly basis.
- The first core metric to be benchmarked was Pneumonia – time to treatment. This decision took place on June 2001, with all CAHs agreeing to have a quality improvement process in place to address pneumonia in October 2011.
- In March 2003, the MICAH QN determined the Flex funding would support \$15,000 per hospital to work with networking hospitals on specific diagnosis, or JCAHCO standards.
- June 2003 – A strategic planning session was held outlining the committee structure
- January 2004 – Partnership with the Michigan Peer Review Organization to incorporate CAHs into the Governor’s Award.
- April 2004 – MICAH QN memorandum of agreement was distributed to all CAHs.
- June 2004 – The following goals were adopted by the network: 1.) Help members improve the quality of their organization; 2.) Ensure Sustainability of MICAH Quality Network; 3.) Promote the value of CAHs in the continuum of care. Coordinating teams and chairs were developed.

- May 2005 – All MI CAHs (17) receive the Governor’s Award for Excellence.
- February 2006 – All MI CAHs participating in Core Options, and MHA Core Options Member was added to the network
- May 2006 – CAH representative added to MHA Keystone Project
- August 2006 – First DBA for MICAHA QN approved by Ingham County Clerk
- February 2007 – Articles of Incorporation filed for MICAHA QN
- August 2007 - Affiliate Organizations (non-CAH) are permitted to become MICAHA QN members
- August 2007 - BCBS PG5 P4P Advisory Committee created, and Ed Gamache was appointed.
- May 2008 – CMS outpatient measures AMI and CP, and MICAHA transfer measures approved as core measures.
- November 2008- 24 CAHs received Governor’s Award of Excellence
- August 2009 – Strategic planning was conducted, and new strategy group announced:
  - New Strategy Groups
    - **Strategy 1:** Help members Improve the quality of their Organizations
    - **Strategy 2:** Advocacy for Critical Access Hospitals
    - **Strategy 3:** Education, Resources, Information & Performance Improvement Support
    - **Strategy 4:** P4P-Clinical/Outpatient- National
- October 2009 - BCBS P4P for PG5 hospitals was implemented
- October 2009 – 34 CAHs were 2009 Michigan Rural Health Quality Improvement Award Recipients – Emergency Room Transfer Quality Improvement and Inpatient Clinical Quality Improvement
- October 2010 - 32 CAHs were awarded the 2010 Michigan Rural Health Quality Improvement Award.
- February 2011 – CAH Best Practice Booklet was published
- November 2011 – BCBS P4P tied to MICAHA QN meeting attendance
- September 2011- Phase I of MBQIP is implemented. All MI CAHs agree to participate in all three phases of MBQIP.
- September 2012 - Phase II of MBQIP is implemented
- February 2013 - Strategic planning was conducted, and new strategy group announced:
  - New Strategy Groups
    - **Strategy 1:** Quality Measures
    - **Strategy 2:** Promote the Value of CAHs
    - **Strategy 3:** Support P4P Programs
    - **Strategy 4:** Support EMR – Smart Sharing- Develop Leadership
- February 2013: \$100.00 MICAHA QN Due Structure established
- September 2013 - Phase III of MBQIP is implemented
- May 2014 – 16 CAHs were awarded the 2014 Michigan Rural Health Quality Improvement Award.
- May 2014 – Trended data reports will be provided from Josh Salander
- May 2015 - Strategic planning was conducted, and new strategy group announced:
  - **Strategy Group # 1** - Making care safer by reducing harm caused in the delivery of care

- **Strategy Group #2** - Promoting Effective Communication and Coordination of Care to Improve Patient Safety as Evidenced by Increasing MBQIP Bundle Compliance from 60% to 90% Congregate Score.
- **Strategy Group #3** – Working with Communities to Promote Wide Use of Best Practices to Enable Healthy Living
- [Current progress of the strategy groups can be found here.](#)
- November 2015 – Barb Cote, MICAQ QN President, appointed to National Rural Quality Advisory Council

[A compilation of August 2014 – August 2015 MICAQ QN meeting minutes can be found here.](#)

[A compilation of November 2015 – November 2016 MICAQ QN meeting minutes can be found here.](#)

#### Quarterly Meeting Details:

- Regular Meeting Dates: The meeting dates are set for the upcoming year at the Annual MICAQ QN Meeting that takes place in November in conjunction with the MI CAH Conference. Typically, meetings take place on the third Friday of the month (February, May, and August).
- Annual Meeting Date: The Annual (November) meeting date is determined by the MI CAH Conference.
- Meeting Times: Typically MICAQ QN meetings run from 8:00-12:00 p.m. Lunch is served.
- Location: [Kalkaska Memorial Health Center](#), 419 South Coral Street, Kalkaska, MI 49646. The meetings take place in the William Kitti Education Center, commonly known as the Stone House. A campus map can be found [here](#). The Annual Meeting takes place at the location of the CAH Conference. In the 2015 year, the meeting will take place at the [Shanty Creek Resort](#) in Bellaire, MI.
- Lodging: A room block is reserved at the [All Seasons Resort](#) in Kalkaska, Michigan. Lodging information is found on the meeting registration forms. Lodging for the Annual Meeting is sent out with the MI CAH Conference information.
- Support: The Michigan Center for Rural Health will support mileage (.43/mile) to and from the MICAQ QN meetings, and will support lodging costs at the All Seasons Resort and the Annual Meeting.
- The 2017 MICAQ QN Calendar can be found [here](#).

#### MICAQ QN listserv:

All communication regarding the MICAQ QN takes place via the MICAQ QN listserv; [cahcdq@list.msu.edu](mailto:cahcdq@list.msu.edu). To be placed on the listserv, let Crystal Barter know.

[MICAQ Bylaws](#): See appendix A.

[MICAQ QN Organizational Chart](#): See appendix G for full organizational chart.

MICAQ QN Executive Committee

The MICAH QN Executive Committee shall be composed of the officers of the network, the three strategy group leaders, and up to five additional Member Representatives elected by the network membership. In addition, the Executive Committee shall have one member who serves in an advisory position who advises on the larger healthcare environment including national and state quality policy. This committee will be responsible for developing an annual work plan, set the quarterly agenda, and liaison with external member groups.

Members of the Executive Committee shall be authorized to sign documents as may be required for the ongoing functions of the Network and shall perform other duties as may be prescribed by the Member Representatives from time to time.

Current Members of the Executive Committee include:

- President: Barb Cote, Spectrum Health Reed City and Big Rapids
- Vice President: Chris Wilhelm, Munson Charlevoix Area Hospital
- Secretary: Christine Trisch, Caro Community Hospital
- Treasurer: Mariah Hesse, Sparrow Clinton Hospital
- Strategy Group Leader: Jen Anderson, Sparrow Ionia Hospital
- Strategy Group Leader: Barb Wainright, Spectrum Health Gerber
- Strategy Group Leader: Anne Holmes, Paul Oliver Memorial Hospital
- Member: Christi Salo, Munising Memorial Hospital
- Member: Christine Bissonette, Kalkaska Memorial Hospital
- Member: Deb Han, Aspirus Iron River Hospital
- Advisory Member: Vacant

Nominations for the Executive Committee take place at the MICAH QN Annual Meeting held every fall.

### **Section 3: Quality Reporting as a Critical Access Hospital**

Although Critical Access Hospitals do participate in a variety of private-sector, state, and federal quality measurement and improvement efforts, many Centers for Medicare & Medicaid Services (CMS) quality initiatives systematically exclude CAHs and clinicians from participation because they are paid differently than other providers (cost based vs prospective payment system). Examples include exemptions from the Inpatient and Outpatient Quality Reporting System, in which data is reported to the public via Hospital Compare. Other examples include exceptions from Value-Based Purchasing Program, and the Hospital Readmissions Reduction Program.

While not mandated to report on federal quality reporting initiatives, at this time, the MICAH QN has recognized for years that quality reporting is integral to sustainability of CAHs. This commitment and progressive vision is showcased by 100% of MI CAHs publicly reporting to Hospital Compare, and 100% of MI CAHs benchmarking on a core set of quality metrics, known as the MICAH QN Core Measures. In the recent years, the MI CAHs have developed a relationship with the Michigan Health and Hospital Association and Blue Cross Blue Shield Pay for Performance Division as well. Finally, since 2012, the Federal Office of Rural Health Policy, a department of Health and Human Services has unrolled an initiative to

collect Critical Access Hospital quality data across the nation to showcase the quality of care they provide. This initiative is called the Medicare Beneficiary Quality Improvement Project.

The following paragraphs will discuss the relationship between the following initiatives

- MICAH QN Core Measures
- Medicare Beneficiary Quality Improvement Project (MBQIP)
- Blue Cross Peer Group Five Pay for Performance (BCBS PG5 P4P)
- MHA Keystone Metrics

#### MICAH QN Core Measures

The MICAH QN Core Measures are selected by the MICAH QN and reported out on a quarterly basis. These Core Measures can be found in Appendix B.

The MICAH QN core metrics are gathered from the CAHs through a data sharing agreement with the reporting vendors; most of the MI CAHs are utilizing Quantros. Once the data sharing agreement is implemented between the vendor and the Michigan Center for Rural Health (MCRH), MCRH will work with a consultant, Josh Salander, to generate reports for each individual CAH. An example of these reports can be found in Appendix C. At each quarterly MICAH QN meeting, Josh Salander presents the data in an aggregate control chart format. These reports are utilized in peer-education decision making.

#### Medicare Beneficiary Quality Improvement Project (MBQIP)

The Medicare Beneficiary Quality Improvement Project (MBQIP) is a quality improvement activity under the Medicare Rural Hospital Flexibility (Flex) grant program, established by the Office of Rural Health Policy. The goal of MBQIP is to improve the quality of care provided in small, rural Critical Access Hospitals (CAHs). This is being done by increasing the voluntary quality data reporting by CAHs, and then driving quality improvement activities based on the data. This project provides an opportunity for individual hospitals to look at their own data, measure their outcomes against other CAHs and partner with other hospitals in the state around quality improvement initiatives to improve outcomes and provide the highest quality care to each and every one of their patients.

As with all activities related to quality improvement in MI CAHs, the MICAH QN has driven the MBQIP effort. The MICAH QN has decided to fully participate in the first cycle (Phases 1-3) of MBQIP which includes reporting on the following metrics:

- Pneumonia: Hospital Compare CMS Core Measure (participate in all sub-measures)
- Congestive Heart Failure: Hospital Compare CMS Core Measure (participate in all sub-measures)
- Outpatient 1-7: Hospital Compare CMS Measure (all sub-measures that apply)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- Pharmacist computerized provider order entry (CPOE)/Verification of Medication Orders Within 24 Hours
- Outpatient Emergency Department Transfer Communication
  - EDTC-1: Administrative Communication (2 data elements)
  - EDTC-2: Patient Information (6 data elements)

- EDTC-3: Vital Signs (6 data elements)
- EDTC-4: Medication Information (3 data elements)
- EDTC-5: Physician or practitioner generated information (2 data elements)
- EDTC-6: Nurse generated information (6 data elements)
- EDTC-7: Procedures and Tests (2 data elements)

The first cycle of MBQIP ended on September 30<sup>th</sup>, 2015.

The second cycle of MBQIP started on October 1, 2016 and includes the following metrics:

- HCP / OP-27: Influenza vaccination coverage among healthcare personnel.
- Imm-2: Influenza Immunization
- OP-1: Median time to Fibrinolysis
- OP-2: Fibrinolytic Therapy Received within 30 minutes
- OP-3: Median Time to Transfer to another Facility for Acute Coronary Intervention
- OP-5: Median time to ECG
- OP-20: Door to diagnostic evaluation by a qualified medical professional
- OP-21: Median time to pain management for long bone fracture
- OP-22: Patient left without being seen
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- Outpatient Emergency Department Transfer Communication
  - EDTC-1: Administrative Communication (2 data elements)
  - EDTC-2: Patient Information (6 data elements)
  - EDTC-3: Vital Signs (6 data elements)
  - EDTC-4: Medication Information (3 data elements)
  - EDTC-5: Physician or practitioner generated information (2 data elements)
  - EDTC-6: Nurse generated information (6 data elements)
  - EDTC-7: Procedures and Tests (2 data elements)

The Federal Office of Rural Health Policy has notified all Flex Coordinators (Crystal Barter, Michigan Center for Rural Health), that Flex support will be tied to reporting of these metrics. For Michigan, historically, Flex funds have supported the following:

- mileage and lodging for the MICAH QN meetings
- mileage and lodging for the MI CAH Conference (three representatives per CAH)
- consultant support from Josh Salander providing the benchmarking graphs to the MICAH QN
- consultant support from Ed Gamache providing facilitation and leadership to the MICAH QN
- mileage and lodging for the CAH CFO meetings
- support for CAH financial benchmarking via the Baird Group and Quality Health Indicators
- quality benchmarking for certified CAH associated Rural Health Clinics via Quality Health Indicators
- mileage support for certified CAH associated RHCs to the RHC Quality Network
- lean analysis and implementation in CAH departments and CAH associated RHCs
- network development
- service-line analysis



- Board of Directors Training
- Etc.

In addition, the Federal Office of Rural Health Policy has noted that Small Hospital Improvement Grant Funds will be tied to the reporting of the MBQIP metrics. Typically, this is \$9,000 per CAH to work on projects associated with value-based purchasing.

So, while not mandatory for CAHs, participating in MQBIP is strongly suggested. MI CAHs have historically been national leaders in quality reporting and improvement, and it is the vision of the MICAH QN to stay at the forefront.

For specific details on the MQBIP metrics, [see appendix D](#).

#### Blue Cross Blue Shield Pay-for-Performance

Blue Cross Blue Shield of Michigan (BCBSM) designates small, rural acute care facilities that provide access to care in areas where no other care is available as peer group 5 facilities (PG 5). Additionally, many of these hospitals are also classified as Critical Access Hospitals (CAH) by Medicare. The BCBSM PG5 Hospital Pay-for-Performance (P4P) program provides these hospitals with an opportunity to demonstrate value to their communities and customers by meeting expectations for access, effectiveness and quality of care. The PG 5 Hospital P4P program described in this document is effective April 1st, 2017 through March 31st, 2018. Performance in the program determines up to six percentage points of a rural hospital's payment rate, effective October 1st, 2018. For the April 2016-March 2017 program year requirements, [click here](#).

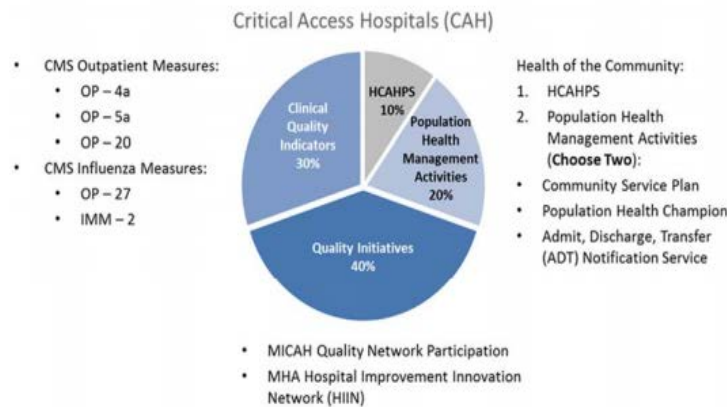
Program structure is guided by a PG5 P-4-P Advisory Committee, of which the following MICAH QN members are current participants:

- Chris Wilhelm, COO, Charlevoix Area Hospital
- Barb Cote, Total Quality Management, Spectrum Health Reed City and Big Rapids
- Tiffany Friar, Director of Quality and Outcomes, Hayes Green Beach Memorial Hospital
- Lee Gascho, Scheurer Healthcare Network
- Brenda Bolsby, QA Risk Management, Marlette Regional Hospital
- Carolyn Vanwert, Case Management and Quality Analyst, Mid-Michigan Gladwin

The program is represented at every MICAH QN meeting with updates from BCBS contacts Kristen Frey and Lauren Rossi, and reminders on upcoming deadlines.

A snapshot of the Program Structure is below.

## 2017-2018 P4P Program Structure



As the diagram shows, MICAH QN participation is a component of the overall P-4-P score.

BCBSM will communicate P4P payment rates to hospitals by July 31st, 2018 with rates becoming effective October 1st, 2018. The BCBSM Peer Group 5 P4P program, established by the BCBSM Participating Hospital Agreement for Peer Group 5 facilities, determines up to six percentage points of a participating hospital's inpatient and outpatient payment rate. Regardless of a hospital's fiscal year end, the P4P payment rate is effective for a twelve month period beginning on October 1st.

Pay-for-Performance payment rates are calculated by multiplying a facility's final P4P score by the 6 percent maximum payment rate that each peer group 5 hospital is eligible to receive. For those hospitals earning a P4P score less than 100%, the difference between the corresponding P4P payment rate and six percent maximum is subtracted from your overall reimbursement rate. If applicable, any rate adjustments made for the 2016-2017 P4P program year will be added back at this time. In October, hospital's earning less than the full six percentage points attributed to P4P performance can expect to receive a revised rate sheet from BCBSM's Facility Reimbursement department.

For more details on the BCBS Pay-for-Performance Program, please see [Appendix E](#).

### MHA Keystone Initiatives

As noted in the BCBS P4P Program Structure, MHA Keystone initiatives are part of the overall P4P score; for the 2017-2018 year this is the MHA Keystone Hospital Improvement and Innovation Network requirement.

[See appendix E\(a\) for each scoring guide.](#)

As with BCBS, MHA is represented at every meeting providing updates on program deadlines and items that need to be completed by the CAHs.

#### MICAH QN Quality Reporting Matrix:

While the above paragraphs do not encompass all the quality reporting initiatives, they do focus on those most relevant to the MICAH QN. To further support and track reporting requirements, the MICAH QN has developed a MICAH QN Quality Reporting Matrix. [See Appendix F.](#)

#### **Section 4: MICAH QN Annual Survey**

Every summer, the MICAH QN develops an annual survey in which each MI CAH completes. This is submitted via Survey Monkey or a paper version. This provides the MICAH QN with data that supports advocacy, and helps the MICAH QN tell the story of the impact that CAHs make across the State of Michigan. It is also an avenue to connect similar CAHs.

Information about the MICAH QN Annual Survey will be distributed via the listserv. Results of the survey are distributed at the annual meeting in an infographic format. [See appendix H for the 2014 infographic.](#)

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## Appendices:

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**BYLAWS**  
**OF**  
**MICHIGAN CRITICAL ACCESS HOSPITAL QUALITY NETWORK**

**ARTICLE I**

**Corporation**

**NAME.** The name of the Corporation is Michigan Critical Access Hospital Quality Network (MICAHA QN).

**OFFICE:** The Corporation shall have its principal place of business in East Lansing, Michigan, Ingham County. The corporation may have such other offices, within the State of Michigan as the Executive Committee may determine or as the affairs of the corporation may require from time to time.

**ARTICLE II**

**Membership**

**SECTION 1. Membership Categories.**

- A. Network Member: The Network shall be an incorporated group of eligible entities or organizations, which shall serve as Network Members. Eligible entities are limited to each federally designated Michigan Critical Access Hospitals. Each Michigan Critical Access Hospital shall be considered one Network Member, irrespective of ownership or other network affiliation.
- B. Special Member: Michigan Center for Rural Health (MCRH) will provide on-going consultation, management and advisory support for the Michigan Critical Access Hospital Quality Network. The MICAHA QN Executive Committee shall determine additional special members to provide support to the MICAHA QN as needed. Special Membership will be reviewed on an annual basis by the Executive Committee.
- C. Advisory Member: Designated entities who serve as consultants but have no voting rights or meeting requirements. These members would be invited to attend regular meetings and be a part of projects as requested by the 'full membership'.
- D. Affiliate Member: Eligible entities are limited to Rural and Non Rural hospitals that have a demonstrated purpose to participate in and are committed to the MICAHA quality process, supporting collection and

sharing of quality data, development and testing of relevant rural healthcare measures, and are willing to share in best practice exchanges. Affiliate Members are not eligible to hold officer positions or vote.

SECTION 2. Admission of Subsequent Members. Members may be admitted to the Network upon a determination by the existing membership that such Member's admission will enhance the purpose of the network and upon the vote of a majority of the existing membership.

SECTION 3. Removal of Members. Removal of any Member may be done only for cause, and upon an 80% vote of the membership exclusive of the vote of the Member who is the subject of the vote. The membership shall establish the basis for cause for removal of a Member, which shall include, but not limited to, failure to conform to any policies or procedures adopted by the membership.

### **ARTICLE III**

#### **Member Representation**

SECTION 1. Member Representation. Each Member shall appoint one representative who shall be authorized to exercise the voting rights of that Member. Such representative shall be entitled to one vote on each matter submitted to a vote of the membership of the Network. Subject to the membership's right to remove a Member pursuant to Section 3 of Article II, the term of office of a Member Representative shall be at the discretion of the Member appointing its representative.

SECTION 2. Removal of Member Representative. The Member appointing such representative may remove a Member Representative, with or without cause. In addition, the Network Membership may, by 80% vote, remove any Member Representative whose actions are found by the membership to be disruptive to the ongoing functions of the Network. The Member who originally appointed the Member Representative shall appoint a replacement. In order to remaining in good standing, each member is expected to participate in one strategy group.

SECTION 3. Vote. Each Network Member shall be entitled to one (1) vote. If unable to attend any meeting of the Network (annual, regular or special), a Member Representative may send in his or her place another individual to represent the Member at such meeting and may give such individual his or her written or email proxy to vote on any and all matters at such meeting. A member may also vote by e-mail or by giving written proxy to another member representative for presentation.

### **ARTICLE IV**

#### **Meetings**

SECTION 1. Network Meetings:

- A. Annual Meeting. The annual meeting of the Network Membership shall be in any one of the months of October, November, or December of each year. The annual meeting will be for election of officers, annual review of Bylaws and agenda items to include any strategic planning needs that might have been identified during the last year along with a Network Financial report.
- B. Regular Meetings. Regular meetings of the Member Representatives shall be held on a schedule determined by the Member Representatives, no less than three (3) times each calendar year. In the unlikely event that a regular meeting is cancelled, the Executive Committee will determine if a make-up meeting is needed.
- C. Special Meetings. Special meetings of the Network Members may be called by or at the request of the President of the Executive Committee or a majority of the Member Representatives. Special meetings must be preceded with notice in advance by as much as possible of the date, time and place of the meeting.

SECTION 2. Attendance. One hundred percent attendance is strongly encouraged by a Network Member to meetings of the Network (annual, regular, or special) is required to maintain Network membership. Greater than 50% attendance to assigned Network committee meetings is also required to maintain good standing. Member Representatives can participate in a regular or special meeting, or conduct the meeting through the use of any means of communication by which all Member Representatives participating may simultaneously hear each other during the meeting. A Member Representative participating in a meeting by this means is deemed to be present in person at the meeting.

SECTION 3. Quorum. A quorum of the Member Representatives consists of a majority defined as 50% plus one of the Member Representatives immediately before the meeting begins. The meeting can be held without quorum but no votes will be taken.

SECTION 4. Manner of Acting. While the Network always seeks to obtain a consensus prior to taking action, a majority vote of the members present is considered binding on all members except in situations specifically described elsewhere in these Bylaws.

SECTION 5. Action Without A Meeting. Action may be taken without a meeting if all Member Representatives participate in the action. Requests for action without a meeting must be done in writing and approved by the Executive Committee. Voting may be conducted orally (i.e. telephone), through electronic mail, or in written form (i.e. letter, fax) with a record of action taken filed with the Network records. Action taken under this section is effective when the last Member Representative votes, unless a different effective date is specified.

## **ARTICLE V**

### **Compensation**

In no event shall the Network pay any compensation or other remuneration to any Member or Member Representative. Funds procured on behalf of and for the benefit of the Network will be managed by the Executive Committee and expenses approved by the Executive Committee.

## ARTICLE VI

### Officers

SECTION 1. Officers. Officers of the Network will be a President, Vice President, Secretary, and Treasurer, voted in by a majority of the membership at the Annual Meeting. Terms will be two-years. Elections will be held at the Annual Meeting every two years.

SECTION 2. Duties of Officers:

- A. President: The President shall preside at all meetings of the Network and Executive Committee and all other meetings including the Annual Meeting; shall perform all duties normally incident to the office; shall ensure the Network has adequate information needed to fulfill its role and responsibilities; and shall report to the members concerning the affairs of the Network at the Annual Meeting.
- B. Vice-President: The Vice President shall, in the absence or disability of the president, perform all acts pertaining to the Office of President and shall perform all other duties normally incident to the office. Upon expiration of the original term, the Vice President shall assume the office of President.
- C. Secretary: The Secretary, in conjunction with the Michigan Center for Rural Health member, shall be the custodian of the books and records of the Network; shall be responsible for the giving of all notices of meetings in accordance with the bylaws; shall keep minutes of all meetings of the Board and the Executive Committee; and shall perform all other duties normally incident to the office.
- D. Treasurer: The Treasurer shall be the financial officer of the Network; shall have charge and custody of, and be responsible for, all funds of the Network, and the books and records relating to the same, shall supervise the deposit of all such funds in the name of the Network in depositories selected by the Network; shall render to the President and Membership an account at each regular meeting of all transactions and of the financial condition of the Network; shall, if required to do so by the Network, furnish bond in such form and amount and to cover such risks as the Executive Committee may determine; and shall perform all other duties incident to the office. At the Annual Meeting of members, the Treasurer shall report to the members about the state of the Network's finances.



## **ARTICLE VII**

### **Committees**

SECTION 1. Executive Committee. The Network shall have an Executive Committee, which shall be composed of the officers of the network, strategy group leaders, and up to five additional Member Representatives elected by the network membership. In addition, the Executive Committee shall have one member who serves in an advisory position who advises on the larger healthcare environment including national and state quality policy. This committee will be responsible for developing an annual work plan.

Members of the Executive Committee shall be authorized to sign documents as may be required for the ongoing functions of the Network and shall perform other duties as may be prescribed by the Member Representatives from time to time.

SECTION 2. Other Committees. The Member Representatives may create one or more committees in addition to the Executive Committee and may appoint individuals to serve on them. Each committee shall have two (2) or more Members who serve at the pleasure of the Member Representatives.

Any committee, including the Executive Committee, may not adopt, amend, or repeal these Bylaws or any other policies or procedures approved by the Member Representatives. Provisions of these Bylaws governing meetings, action without meetings, notice and waiver of notice, quorum and voting requirements of the membership and resignation and removal of Members or the Member Representatives, apply to all committees of the Network and their Members as well.

## **ARTICLE VIII**

### **Notice of Annual Meeting and By-Law Changes**

30 days' notice of annual meeting and by-laws may be oral or written. Notice may be communicated in person, by telephone, electronic mail, or other form of wire or wireless communication; or by mail or private carrier.

Written notice, if in a comprehensible form, is effective at the earliest of the following:

- (1) When received,
- (2) Five (5) days after its deposit in the United States mail, as evidenced by the postmark, if mailed correctly addressed and with first-class postage affixed;
- (3) On the date shown on the return receipt, if sent by registered or certified mail, return receipt required, and the receipt is signed by or on behalf of the addressee;

- (4) Thirty (30) days after its deposit in the United States mail, as evidenced by the postmark, if mailed correctly addressed and with other than first-class, registered or certified postage affixed;
- (5) Five (5) days after it is transmitted via electronic mail, as evidenced by records of the sending communications server, if mailed correctly addressed to a tested electronic address;
- (6) On the date and time shown on the return receipt of electronic mail, if sent by return receipt requested, and is evidenced by the records of the sending communications server.

Written notice is correctly addressed, either US Mail or electronic, to a Member if addressed to the Member's address shown in the Network's current list of the Members. Oral notice is effective when communicated if communicated in a comprehensible manner. Oral notices shall be documented, including response to notice, and filed with Network records.

## **ARTICLE IX**

### **Waiver of Notice, Assent to Actions**

SECTION 1. Receipt of Waiver. A Member or a Member Representative may waive any notice required by these Bylaws, before or after the date and time stated in the notice. Except as provided below, the waiver must be in writing, be signed by the Member Representative and delivered to the Executive Committee for inclusion in the minutes or filing with the Network records.

SECTION 2. A Member Representative's attendance at or participation in a meeting waives any required notice to him of the meeting unless the Member Representative at the beginning of the meeting (or promptly upon his arrival) objects to holding the meeting or transacting business at the meeting and does not thereafter vote for or assent to action taken at the meeting.

Section 3. An individual who is present at a meeting of the Member Representatives or a committee of the Network when action is taken is deemed to have assented to the action taken unless: (1) he/she objects at the beginning of the meeting, or promptly upon his/her arrival, to holding it or transacting business at the meeting; (2) his/her dissent or abstention from the action taken is entered in the minutes of the meeting; or (3) he/she delivers written notice of his/her dissent or abstention to the presiding officer of the meeting before its adjournment or to the Executive Committee immediately after adjournment of the meeting. The right of dissent or abstention shall not be available to a Member Representative who votes in favor of the action taken.

## **ARTICLE XI**

### **Program Year**

The Program year of the Network shall begin on the 1<sup>st</sup> day of January and end on the 31<sup>st</sup> day of December in each year.

## **ARTICLE XII**

### **Amendments**

These Bylaws may be altered, amended or repealed, and new Bylaws may be adopted by action after notification and majority vote of the Member Representatives.

## **ARTICLE XIII**

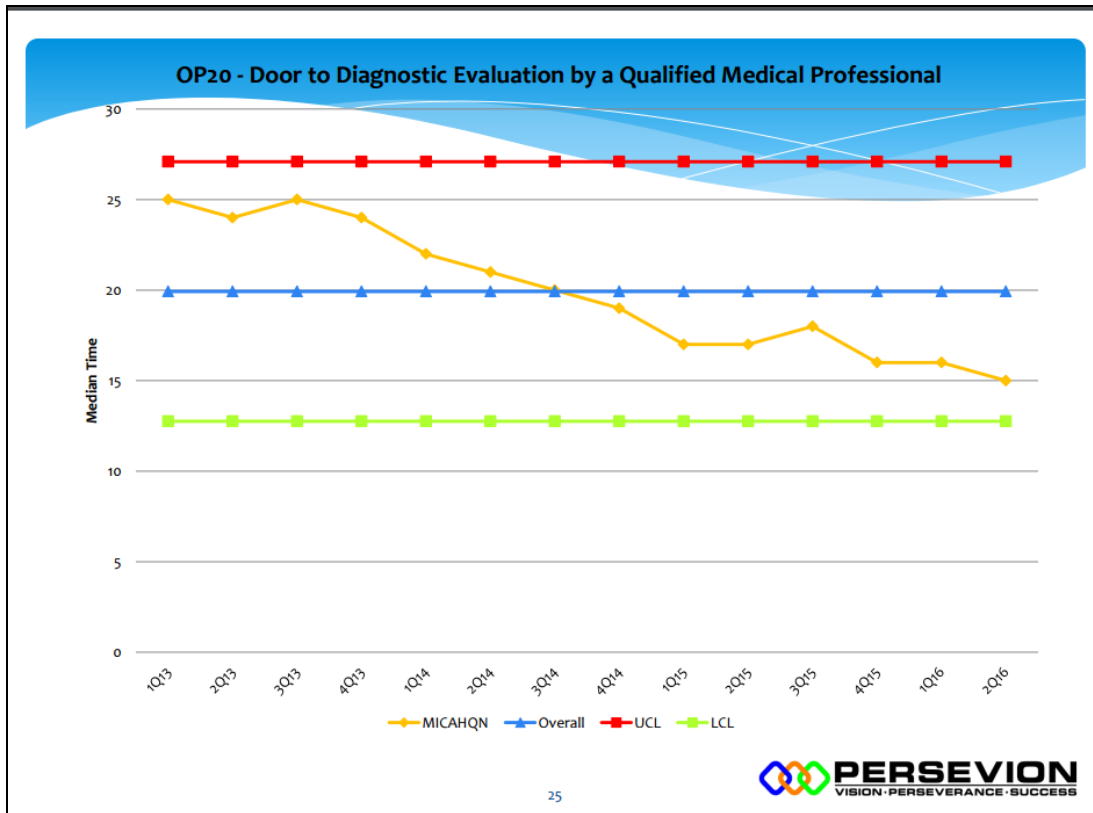
### **Approvals**

These Bylaws shall be approved by the Membership of the Network.

## Appendix B: MICAH QN Core Measures

HF2	Evaluation of LVS Function
HF3	ACEI or ARB for LVSD
PN6	Initial Antibiotic Selection for PN in Immunocompetent Patient
IMM-2	Influenza Immunization – Overall Rate
OP1	Median Time to Fibrinolysis
OP2	Fibrinolytic Therapy Received Within 30 Minutes
OP3a	Median Time to Transfer to Another Facility for Acute Coronary Intervention – Overall
OP3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention – Reporting Measure
OP3c	Median Time to Transfer to Another Facility for Acute Coronary Intervention – QI Measure
OP4a	Aspirin at Arrival – Overall Rate
OP4b	Aspirin at Arrival – AMI
OP4c	Aspirin at Arrival – Chest Pain
OP-5a	Median Time to ECG – Overall Rate
OP-5b	Median Time to ECG – AMI
OP-5c	Median Time to ECG – Chest Pain
OP6	Antibiotic Timing
OP7	Antibiotic Selection
OP18a	Median Time from ED Arrival to ED departure for discharged ED patients – Overall
OP18b	Median Time from ED Arrival to ED departure for discharged ED patients – Reporting Measure
OP18c	Median Time from ED Arrival to ED departure for discharged ED patients – Psychiatric/Mental Health Patients
OP18d	Median Time from ED Arrival to ED departure for discharged ED patients – Transfer Patients
OP20	Door to Diagnostic Evaluation by a Qualified Medical Professional

# Appendix C: Example of MICAHA QN Core Measures Control Chart



Appendix D: Details on MBQIP Metrics

Medicare Beneficiary Quality Improvement Project (MBQIP)

The Medicare Beneficiary Quality Improvement Project (MBQIP) is a quality improvement activity under the Medicare Rural Hospital Flexibility (Flex) grant program. The goal of MBQIP is to improve the quality of care provided in small, rural Critical Access Hospitals (CAHs). This is being done by increasing the voluntary quality data reporting by CAHs, and then driving quality improvement activities based on the data. This project provides an opportunity for individual hospitals to look at their own data, measure their outcomes against other CAHs and partner with other hospitals in the state around quality improvement initiatives to improve outcomes and provide the highest quality care to each and every one of their patients.

As with all activities related to quality improvement in MI CAHs, the MICAH QN has driven the MBQIP effort. The MICAH QN has decided to fully participate in the first cycle (Phases 1-3) of MBQIP which includes reporting on the following metrics:

The second cycle of MBQIP will start October 1, 2016 and includes the following metrics and how the information will be collected/reported to.

<b>Metric</b>	<b>How does the CAH report to the Office of Rural Health Policy?</b>
HCP / OP-27: Influenza vaccination coverage among healthcare personnel	The CAH submits the information to the National Healthcare Safety Network.
Imm-2: Influenza Immunization	The CAH submits the information to Quality Net via a vendor or CART.
OP-1: Median time to Fibrinolysis	The CAH submits the information to Quality Net via a vendor or CART.
OP-2: Fibrinolytic Therapy Received within 30 minutes	The CAH submits the information to Quality Net via a vendor or CART.
OP-3: Median Time to Transfer to another Facility for Acute Coronary Intervention	The CAH submits the information to Quality Net via a vendor or CART.
OP-4: Aspirin at arrival	The CAH submits the information to Quality Net via a vendor or CART.
OP-5: Median time to ECG	The CAH submits the information to Quality Net via a vendor or CART.
OP-18: Median time from ED arrival to ED departure for discharged ED patients	The CAH submits the information to Quality Net via a vendor or CART.
OP-20: Door to diagnostic evaluation by a qualified medical professional	The CAH submits the information to Quality Net via a vendor or CART.
OP-21: Median time to pain management for	The CAH submits the information to

long bone fracture	Quality Net via a vendor or CART.
OP-22: Patient left without being seen Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)	The CAH submits the information to Quality Net via an Online Tool.
Outpatient Emergency Department Transfer Communication EDTC-1: Administrative Communication (2 data elements) EDTC-2: Patient Information (6 data elements) EDTC-3: Vital Signs (6 data elements) EDTC-4: Medication Information (3 data elements) EDTC-5: Physician or practitioner generated information (2 data elements) EDTC-6: Nurse generated information (6 data elements) EDTC-7: Procedures and Tests (2 data elements)	The CAH submits the information to the Flex Coordinator (Crystal Barter) via the Stratis developed Excel- Tool. The Flex Coordinator submits to the Office of Rural Health Policy.
Hospital Consumer Assessments of Healthcare Providers and Systems	The CAH submits the information to Quality Net via a vendor.

MBQIP Resources:

[MBQIP Quick Reference Resource List](#)

[MBQIP Quick Reference Resource List](#)-This list was compiled as a quick one page reference list of the most used and important resources which can be kept in one easy to find location.

[MBQIP Measures Fact Sheets](#)

[MBQIP Data Submission Guidelines](#) – This grid notes each measure, where it is reported to, and the deadlines for submission.

[MBQIP Reporting Guide](#)

[MBQIP Measure Matrix](#) - Measures summary information in an Excel format.

### Submission of Metrics

Most of the metrics are submitted via the CART tool, or a vendor (i.e. Quantros) with the exception of the following:

OP-27 must be submitted via NHSN thus each CAH should be registered with NHSN and able to submit data.

- [Click here](#) for a webinar recording and slides providing an overview of the Healthcare Professional Flu measure (OP-27), including how to sign up for an account through the National Safety Healthcare Network (NHSN), the measure submission process and available quality improvement support. [Click here](#) for a step-by-step webinar recording to showcase how CAHs can obtain NHSN accounts as well as activate the Healthcare Personnel Vaccination Module for successful submission of OP-27. The

webinar will also touch on collaboration opportunities for QIN-QIOs and state Flex Coordinators in order to maximize data submission and quality improvement support for CAHs.

- [Click here](#) for a FAQ document compiled by the Quality Innovation Network

OP-22 must be submitted to QualityNet via secure log-in.

- [Click here](#) for Quality Net Training Videos. This webpage houses videos on the following topics:
  - QualityNet Secure Portal: New User Enrollment Training: The audience for this session is health care providers and support contractors who need to access the QualityNet Secure portal. The training covers preparing for first-time login, logging in for the first time (proofing and credentialing process), logging into the QualityNet Secure Portal and logging out of the QualityNet Secure Portal
  - Hospital Quality Reporting Notice of Participation: This video provides instructions on the Hospital Quality Reporting Notice of Participation (NOP) pledge data entry application. Although it is not necessary for critical access hospitals (CAHs) to complete the inpatient or outpatient notice of participation (NOP) in order to participate in the Medicare Beneficiary Quality Improvement Project (MBQIP), the NOPs must be completed in order for data submitted to QualityNet to appear on Hospital Compare
  - Outpatient Quality Reporting Web- Based Measures: This video demonstrates important features and key steps for submitting outpatient web-based measures via the QualityNet Secure Portal's Web-Based Data Collection Tool. Measures submitted through this tool include MBQIP required measure OP-22 and MBQIP additional measure OP-25. New users will want to watch the beginning of the video which demonstrates where to find the application for reporting outpatient measures. The video provides step-by-step instruction for submitting measure OP-22 starting at the 10:44 mark
- [Click here](#) to access the following resources on the Quality Net Website. Navigate to the section titled Quick Start Guides.
  - Quality Net Account Holders
  - Non- Quality Net Account Holders
  - QualityNet Secure Portal Registration
  - QualityNet Secure Portal User Guide

The EDTC metrics must be submitted to Crystal Barter via fax, or email. Aggregate information for each metric will be generated via the Stratis Health Tool Summary Report Form. For more information on the EDTC metric, [click here](#).

### **Additional Resources Related to MBQIP and Quality Improvement in the CAH Setting**

- [MBQIP Monthly](#) - MBQIP Monthly is a monthly e-newsletter that provides critical access hospitals (CAHs) with information and support for quality reporting and improvement and highlights current information about the Medicare Beneficiary Quality Improvement Project (MBQIP).



- [Quality Improvement Basics: A Collection of Helpful Resources for Rural Health Organizations.](#)
- [Quality Improvement Implementation Guide and Toolkit for Critical Access Hospitals](#)
- This guide and toolkit offers strategies and resources to help critical access hospital (CAH) staff organize and support efforts to implement best practices for quality improvement. It includes:
  - A quality improvement implementation model for small, rural hospital settings
  - A 10-step guide to leading quality improvement efforts
  - Summaries of key national quality initiatives that align with the priorities of the Medicare Beneficiary Quality Improvement Project (MBQIP)
  - Best practices for improvement for current MBQIP measures
  - A simple, Excel-based tool to assist CAHs with tracking and displaying real time data for MBQIP and other quality and patient safety measures to support internal improvement efforts

Please contact Crystal Barter with questions surrounding MBQIP.

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Appendix E: BCBS Pay-for-Performance Details

[Click here for full program details.](#)

Lauren Rossi is the main point of contact for any BCBS related questions.

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## Appendix E(a)

### MHA Keystone Initiatives

As noted in the BCBS P4P Program Structure, the MHA Hospital Improvement and Innovation Network Requirements are part of the the PG5 P4P program.



**A Voluntary Collaborative to Improve Quality and Save Lives**

### MHA Keystone Center Great Lakes Partners for Patients Hospital Improvement Innovation Network (HIIN) Scoring Index

2017-18 BCBSM Peer Group 5 Pay-for-Performance Program  
Critical Access Hospitals (CAH) ONLY

**Table 1: MHA Keystone / Great Lakes Partners for Patients HIIN Requirements**

Component	Weight	Scoring Frequency	Reporting Timeframe
<b>Data submission:</b> Outcome Measures ( <i>Appendix A</i> )	40%	Monthly	April 2017 – March 2018
<b>Performance:</b> Improvement on CAUTI, EDTC-1, and EDTC-4 measures (individual improvement from designated baselines)	25%	Once	Varies by measure (see Table 3)
<b>Person &amp; Family Engagement:</b> Patient & Family Advisory Councils (PFAC)/ inclusion of patient advisors	20%	Twice	1: April 2017 - September 2017 2: October 2017 – March 2018
<b>Antimicrobial Stewardship:</b> Current practices assessment	15%	Once	Due by April 30, 2017

**Table 2: MHA Keystone / Great Lakes Partners for Patients HIIN Scoring Index**

Component Description	Available Points
<b>Data Submission*</b> <ul style="list-style-type: none"> <li>○ At least 90% of outcome data submitted across 12-month period</li> <li>○ 70 – 89% of all outcome data submitted across 12-month period</li> <li>○ Less than 70% of all outcome data submitted across 12-month period</li> </ul>	40 points 25 points 15 points
<b>Performance on outcomes for CAUTI, EDTC-1, and EDTC-4**</b> (see table 3 for additional detail) <ul style="list-style-type: none"> <li>○ Improvement from baseline on 3 of 3 measures</li> <li>○ Improvement from HIIN baseline on 2 of 3 measures</li> <li>○ Improvement from HIIN baseline on 1 of 3 measures</li> </ul>	30 points <b>(5 bonus)</b> 25 points 10 points
<b>Launch of Patient &amp; Family Advisory Council (PFAC) and/or Inclusion of Patient Advisor on Existing Quality Improvement Team***</b> <ul style="list-style-type: none"> <li>○ PFAC / inclusion of patient advisors - Fully implemented</li> <li>○ PFAC / inclusion of patient advisors - Partially implemented</li> <li>○ PFAC / inclusion of patient advisors - Not implemented</li> </ul>	20 points 10 points 5 points
<b>Antimicrobial Stewardship (AMS)****</b> <ul style="list-style-type: none"> <li>○ Completion of AMS assessment by April 30, 2017</li> <li>○ No completion of AMS assessment by April 30, 2017</li> </ul>	15 points 0 points
<b>Total Possible Points</b>	<b>100 points</b>

**Table 3: MHA Keystone / Outcomes Performance**

Measure	Baseline	Performance Period for Mid-year Score	Performance Period – Final Score
<b>CAUTI (Hospital wide):</b> Urinary Catheter Utilization (KDS-HIIN-CAUTI-3a and KDS-HIIN-CAUTI-3b) <b>OR</b> CAUTI Rate (KDS-HIIN-CAUTI-2a (all units))	Q1 2014	Apr. 2017 – Sept. 2017	Apr. 2017 – Mar. 2018
<b>EDTC-1: Administrative Communication</b> Element 1: Healthcare facility to healthcare facility (MBQIP) <b>OR</b> Element 2: Physician to physician communication (MBQIP)	Q1 2016	Apr. 2017 – Sept. 2017	Apr. 2017 – Mar. 2018

<b>EDTC-4: Medication Information</b> Element 1: Medications administered in ED (MBQIP) <b>OR</b> Element 2: Allergies (MBQIP) <b>OR</b> Element 3: Home medications (MBQIP)	Q1 2016	Apr. 2017 – Sept. 2017	Apr. 2017 – Mar. 2018
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*\* Hospitals will only be scored for the submission of outcome data they are eligible to collect. Please reference **Appendix A (HIIN Encyclopedia of Measures)** for a complete list of the required measures.*

<u>General HIIN Participation Requirements</u>
<ul style="list-style-type: none"> <li>• Completion of an enrollment assessment to identify primary contacts including quality and risk leaders, executive, physician and nursing champions, data lead, PFE contact, pharmacy contact and infection prevention lead.</li> </ul>
<ul style="list-style-type: none"> <li>• Participate in HIIN-wide quality improvement activities and/or site-specific activities related to the achieving the aims of the HIIN (20% reduction in all-cause harm and 12% reduction in preventable readmissions over a two-year period).</li> </ul>
<i>In addition to the required components above, hospitals may also be invited to:</i>
<ul style="list-style-type: none"> <li>• Participate in Improvement Action Networks (IANs), Safe Tables, or Site Visits (Maximum requests = 4 per year)</li> </ul>

*\*\* Hospitals will be scored on their own performance over time, and whether they are demonstrating improvement in CAUTI (Urinary Catheter Utilization Ratio **OR** CAUTI Rate), EDTC 1 (Element 1 **OR** Element 2), and EDTC 4 (Element 1 **OR** Element 2 **OR** Element 3) rates from the designated (hospital-specific) baseline to the listed performance period (Table 3). The highest performing metric/element under the designated measure will be selected. Hospitals that maintain rates in the top quartile among all participating CAH hospitals will receive full points for improvement (please see **Appendix A & Appendix B** for measure definition).*

*\*\*\* The goal of this component is to implement a PFAC and/or include patient advisors on existing quality improvement teams by the end of the program year (if not currently implemented). Hospitals would be asked to report on this component minimally twice during the program year, by simply indicating fully implemented, partially implemented, or not implemented in KDS. Please reference the [MHA Community Website – Keystone Center Quality Initiatives – HIIN Foundational Concepts – Person & Family Engagement \(PFE\)](#) folder for additional information on the launch of Patient & Family Advisory Councils and/or inclusion of patient advisors on existing quality improvement committees.*

*\*\*\*\* Completion of the NHSN Patient Safety Annual Survey (which contains AMS questions) during 2017 will meet this requirement if the hospital has conferred rights to MHA Keystone Center. Hospitals who do not submit to NHSN, MHA Keystone Center will provide HIIN infection prevention contacts a link to complete the AMS assessment. Hospitals have designated these contacts upon enrollment in the HIIN.*

As with BCBS, MHA is represented at every meeting providing updates on program deadlines and items that need to be completed by the CAHs. To see full program requirements, [click here](#).

Ewa Panetta is the main contact for all MHA related questions.

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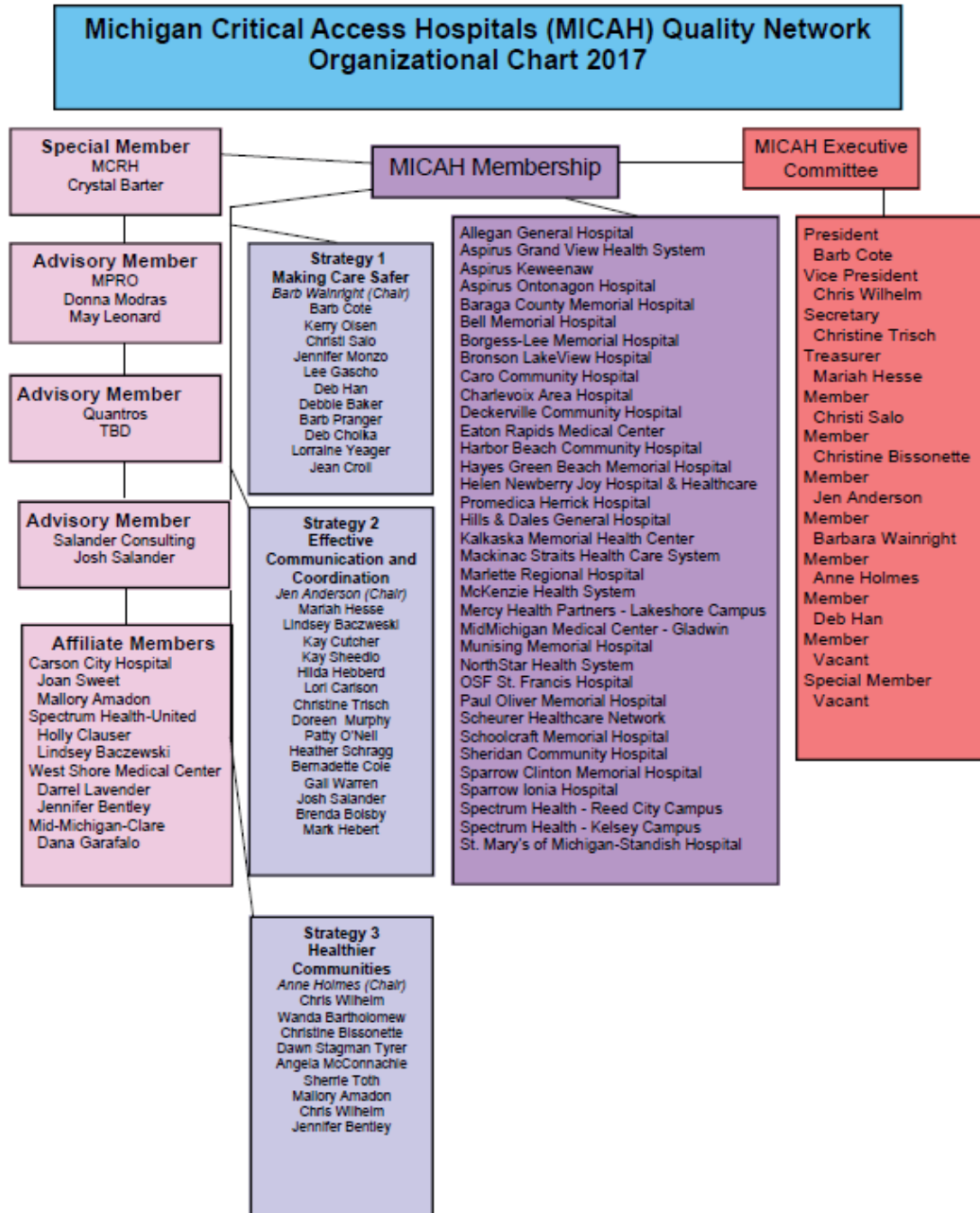
## Appendix F: MICAHA QN Reporting Matrix

The MICAHA QN with support from the Michigan Peer Review Organization compiled a matrix that outlines reporting requirements for the following initiatives:

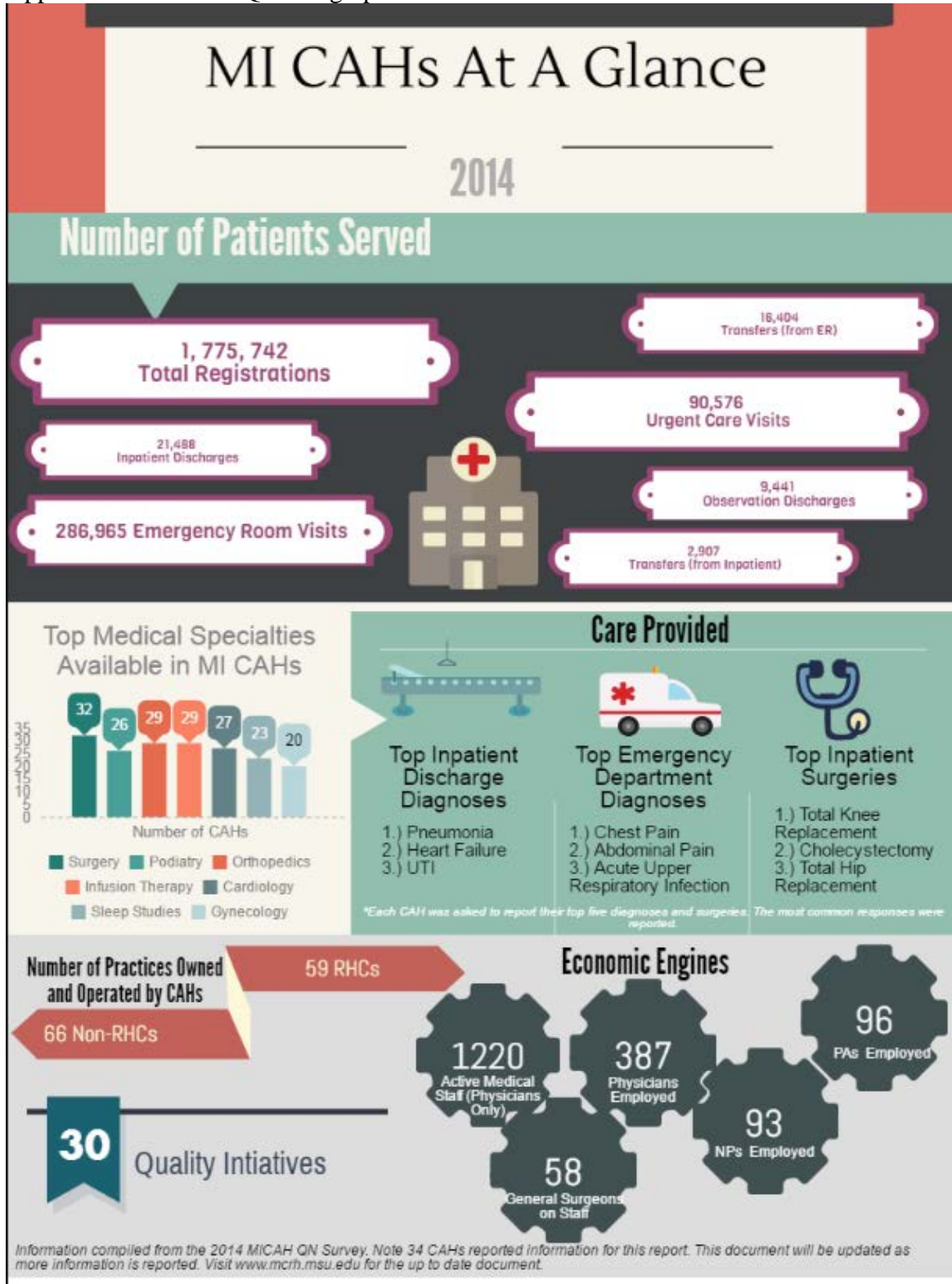
- CMS
- The Joint Commission
- Value Based Purchasing
- Michigan Critical Access Hospital Quality Network (MICAHA QN) Core Measures
- Blue Cross – Critical Access Hospital
- Medicare Beneficiary Quality Improvement Project (MBQIP)

Contact Crystal Barter for an up-to-date version of the reporting matrix.

Appendix G: MICAHA QN Organizational Chart



[Click here for a PDF version.](#)



[Click here for a PDF version.](#)



## Appendix I: MICAHA QN Contact List

### MICAHA QN

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## Appendix K: Healthcare Quality and Rural Health Acronyms

ACA	Affordable Care Act
PPACA	Patient Protection and Affordable Care Act
ADC	Average Daily Census
ACO	Accountable Care Organization
ADE	Adverse Drug Event
AHA	American Hospital Association
AHC	Academic Health Center
AHQA	American Health Quality Association
AHRQ	Agency for Healthcare Research and Quality
ALOS	Average Length of Stay
ALS	Advanced Life Support
AMA	American Medical Association
AMC	Academic Medical Center
ARRA	American Recovery and Reinvestment Act
ASC	Ambulatory Surgical Centers
ATLS	Advanced Trauma Life Support
BBA	Balanced Budget Act
BBRA	Balanced Budget Refinement Act
BFCC	Beneficiary and Family centered Care quality Improvement
Organization (BFCC-QIO)	
BHP	Bureau of Health Professionals
BPHC	Bureau of Primary Health Care
BSC	Balanced Scorecard
CAH	Critical Access Hospital
CAH FIR	Critical Access Hospital Financial Indicator Report (FIR)
CALS	Comprehensive Advanced Life Support
CART	Centers for Medicare and Medicaid Services Abstraction and
Reporting Tool	
CCO	Coordinated Care Organization
CDC	Centers for Disease Control and Prevention
CDE	Clinical Data Exchanged
CDI	<i>Clostridium difficile</i> Infection
CDS	Clinical Decision Support
CFR	Code of Federal Regulations
CHC	Community Health Center
CHNA	Community Health Needs Assessment
CIT	Critical Illness and Trauma Foundation
CLABSI	Central Line-Associated Bloodstream Infection
CMHC	Community Mental Health Center
CMS	Center for Medicare and Medicaid Services
CON	Certificate of Need
CoP	Conditions of Participation
COPD	Chronic Obstructive Pulmonary Disease
CP	Community Paramedic
CPOE	Computerized Provider Order Entry



CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
DHHS	Department of health and Human Services (or HHS)
DPU	Distinct Part Unit
DON	Director of Nursing
DRG	Diagnosis Related Group
DSH	Disproportionate Share Hospital
DUNS	Dun and Bradstreet universal Numbering System
EACH	Essential Access Community Hospital
EDTC	Emergency Department Transfer Communication
eHI	e-Health Initiative
EHB	Electronic Handbook
EHR	Electronic Health Record
EMR	Electronic Medical Record
FFS	Fee for Service
FFR	Federal Financial report
FHSR	Foundation for health Services Research
FI	Fiscal Intermediary
FIR	Financial Indicators Report (CAHFIR)
FMT	Flex Monitoring Team
FOA	Funding Opportunity Announcement
FORHP	Federal Office of Rural health Policy (ORHP)
FQHC	Federally Qualified health Center
FY	Fiscal Year
HAC	Hospital Acquired Condition
HAI	Healthcare Acquired Condition
HCAPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCFA	Health Care Finance Administration (presently known as CMS)
HEN	Hospital Engagement Network
HHS	Department of Health and Human Services (or DHHS)
HIW	Health Information Exchange
HIMSS	Healthcare Information and Management Systems Society
HIPAA	Health Information and Portability and Accountability Act
HIT	Health Information Technology
HITECH	Health Information technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
HSA	Health Savings Account; or Health Systems Agency
ICD-10	International Classification of Diseases- 10 <sup>th</sup> Edition
IHI	Institute for Healthcare Improvement
HIS	Indian Health Services
IOM	Institute of Medicine
IPPS	Inpatient Prospective Payment System
JCAHO	Joint Commission on Accreditation of healthcare Organizations
JCREC	Joint Committee on Rural Emergency Care
LOS	Length of Stay
LTC	Long Term Care

MBQIP	Medicare Beneficiary Quality Improvement Project
MedPAC	Medicare Payment Advisory Commission
MIH	Mobile Integrated Health
MIPAA	Medicare Improvements for Patients and Providers Act
MMA	Medicare Prescription Drug, Improvement and Modernization Act
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MPI	Master Patient Index
MPRO	Michigan Peer Review Organization
MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>
MSA	Metropolitan Statistical Area
MU	Meaningful Use
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NACHC	National Association of Community Health Centers
NACRHHS	National Advisory Committee on Rural Health and Human Services
NARHC	National Association of Rural Health Clinics
NHSN	National Healthcare Safety Network
NOSORH	National Organization of State Offices of Rural Health
NPRM	Notice of Proposed Rulemaking
NRHA	National Rural Health Association
NQF	National Quality Forum
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMH	Office of Minority Health
ONC	Office of the National Coordinator for health Information Technology
OP	Outpatient
OPPS	Outpatient Prospective Payment System
ORHP	Federal Office of Rural Health Policy (FORHP)
P4P	Pay for Performance or Partnership for Patients
PALS	Pediatric Advanced Life Support
PCA	Primary Care Association
PCMH	Patient-Centered Medical Home
PCO	Primary Care Office
PHR	Personal Health Record
PI	Performance Improvement
PIMS	Performance Improvement Measurement System
PIN	Policy Information Notice from Health Resources and Services Administration (HRSA)
POS	Point of Service
PPACA	Patient Protection and Affordable Care Act
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PQRI	Physician Quality Reporting Initiative
QHi	Quality Health Indicators
QI	Quality Improvement

QIN	Quality Innovation Network
QIO	Quality Improvement Organization (QIN-)
QIO	Quality Improvement Organization
RAC	Rural Assistance Center
REC	Regional Extension Center
RHC	Rural Health Clinic
RHPI	Rural Hospital Performance Improvement Project
RHRC	Rural Health Research Center
RPCH	Rural Primary Care Hospital
RTTD	Rural Trauma team Development
RUPRI	Rural Policy Research Institute
SCH	Sole Community Hospital
SCHIP	State Children's health Insurance Program
SHIP	Small Hospital Improvement Program
SMSA	Standard Metropolitan Statistical Area
SNF	Skilled Nursing Facility
SOM	State Operations Manual
SORH	State Office of Rural Health
SRHP	State Rural Health Plan
SSA	Social Security Administration
STEMI	ST-segment Elevation Myocardial Infarction
TASC	Technical Assistance and Services Center
TCD	Time Critical Diagnoses
TeamSTEPPS	Team Strategies and Tools to Enhance Performance and Patient Safety
TQM	Total Quality Management
TRC	Telehealth Resource Center
VBP	Value-Based Purchasing
VTE	Venous Thromboembolism

Appendix L: Matrix showcasing relationship between MCRH, MPRO, MHA, and BCBS.

[Click here.](#)