RHC Quality Network Meeting
October 19th, 2016

In attendance:
*Lacey Sherlock (Sparrow Carson), Devon Krueger (Sparrow Ionia), Mary Welsh (North Shore Primary Care – Mercy Health), RuAnne Vanderveen (Sheridan Community Clinics), Laura Anderson (Mackinac Straits RHC), Tesia Looper (MPRO), Carrie Sevarns (Helen Newberry Joy), Patrick Frank (Belding Family Medicine, Spectrum Health United) Traci Auernhamer (Hills and Dales General Hospital), Trisha Meinhard (Hills and Dales General Hospital), Melissa Hall (Muninsing Memorial Hospital), Barbara Laux (Sparrow Medical Group Saranac), Marsha Nemeth (Sparrow Medical Group Ionia), Chris Patch (Sheridan Community Clinics), Deb VanDyke (Mackinac Straits Health System), Kay Cutcher (Deckerville Community Hospital), Angela McConnachie (Deckerville Community Hospital), Julee Campbell (MPRO), Andrea Boucher (MPRO), Tesia Looper (MPRO), LeaAnn Haasel (North Shore Primary Care – Hart Family Medical), Linda VanPortfliet (Spectrum Health United and Kelsey) *Contact information can be found at the end of the document.*

Welcome and Introduction
Everyone in attendance introduced themselves including their role within the organization, and how many clinics they represented.

Connecting the MI RHC Community
Time was set aside to discuss best ways to continue to connect the RHC community, and how we can utilize the RHC QN meetings to leverage resources that MCRH and other partners can provide. The discussion was framed around four items:

- The 2016 MI RHC Survey
- Igloo
- Educational Priorities for 2016-2017
- Formalization of the network

<u>2016 MI RHC Survey</u>
Crystal shared a draft of the survey that was used in previous years and discussed the reasoning for the survey.

- Sharing information on the MI RHC landscape – the ability to tell the story of MI RHCs is integral to the continued promotion of MI RHCs as a vital safety net provider. In 2016-17, MCRH will work to develop some more visually appealing graphics showing the RHC landscape – some infographics, maps, etc.
- Advocacy - bi-annually MCRH visits the MI Representatives and Senators. Being able to share statistics surrounding RHCs is important.
- Connection – With the permission of the RHC contact, the survey will be a good avenue to leverage relationships of MI RHCs. For example, if an RHC is thinking of switching EHRs, MCRH could connect that RHC with other RHCs that have that particular EHR.

The group had the following suggestions:

- Add TCPI, Humana, UPHP, PH and BC Star Programs to #23 (question referencing QI incentive program involvement).

- Add a question on the type of patients that RHCs care for.
- Add a question on how far certain specialties are from the RHC, and indicate if there is an extensive wait to get into a particular specialist – ob/gyn, urologists, neurology, endocrinology, mental health, infectious disease.
- Add a question on the number of active patients on the care coordinators panel.
    - Note: Crystal will share some resources on national benchmarks (MiPCT and NRACC, Family Practice Journal Article)

<u>Educational Priorities</u>

The group participated in an activity that outlined the strengths and opportunities for their RHCs. Strengths included:

- Offering diabetic self-management classes (care managers, medical assistants, and community members have taken the training).
- One health system offered an RHC boot camp for their new practice managers focusing on compliance
- Care Management Programs – These programs have really made a difference in patient lives.
- Opportunity for specialists to rent out space in the RHC, or the hospital.

Opportunities included:

- New practice manager boot camp/Quality manager boot camp
- Diabetic Education/Best practices– one attendee noted that they have 40,000 diabetic patients over their four practices.
- One-pager on what RHCs can bill in terms of care management, and other supplemental billing codes. This would include private, state and Medicare (AWV, TCM, CCM, etc).
- Care Coordinator Listserv
- Access to specialists
- Sharing information on the clinics education plan for employees, including unique ways to provide education.
    - One organization does a monthly storyboard, and if employees know what is on the board when asked, they receive a gift card.
    - Education provided at breakfast
    - Knowledge fairs (booths, RHC bingo)
    - Scavenger hunts
- Coding/Billing
    - Targeted education on "new" billing codes (wellness visits, preventative visits)
    - Documentation training
    - Chart Audit best practices
- Bringing new personnel to RHC QN meetings (i.e. care coordinators, finance, billing). The first session could be a quality/coding/billing meeting. MAG or AAPC could assist in facilitation.
- Scribes – not educating not on HER
- Operation of patient portals – including how to educate patients to use them properly.

Formalization of Network

The group discussed how to continue to move the network forward including formalizing membership within the network. The current status of membership is "if you attend meetings, you are a member". The group agreed there needed to be parameters around membership including a goal of quarterly meeting attendance, and submission of the minimum data set.

In addition, the group discussed how to organize the group in terms of a governance structure. Crystal will share a document that details the expectations of the officers (President, Vice-President, Secretary and Treasurer), and work with the group to finalize the document. Once finalized, the group will solicit nominations.

Crystal will also work on an RHC QN member directory – who has attended the meetings in the last year. This will be a starting place for membership.

MI RHC Benchmarking Project

Currently, the MI RHCs focus on collecting three core measures (Controlling High Blood Pressure (NQF #0018), Preventive Care and Screening: Tobacco Use Cessation Intervention (NQF #0028b), and Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up (NQF #0421)).

This work is benchmarked through Quality Health Indicators – a web-based software system out of the Kansas Hospital Association that is used by multiple states (16 thus far). The system allows for clinical, and financial and operational benchmarking on the hospital and clinic side. MCRH has supported RHCs in Michigan using this system for a while now.

There is a national trend in healthcare where consumers are demanding transparency in terms of quality and cost, thus providers need to build the foundation to get used to reporting out on various clinical measures and developing processes to improve those measures. Quality is the name of the game, and with that comes measurement.

It was noted that the MICAH QN group started benchmarking years before their national peers and not only did that allow them to have a voice at the table, but it allowed them to build the foundational concepts within each CAH surrounding data abstracting, reporting, etc. Finally, it allowed them to analyze data to make change. RHCs can follow the same progression.

The group discussed the core measures, and agreed they are still relevant. In addition, they would like to add NQF #0575, which is already in QHi.

Crystal shared the financial and operational metrics, and the group agreed they would like to know this information as well. The group did note that they would not be the person to input this information for some of their organizations.

MACRA Education and Discussion

Crystal shared the following resources on the Quality Payment Program.

Quality Payment Program website – this is a great resource. Very user friendly, visually appealing, and informative. Take the time to use the explore measures options, as you can filter measures by the submission method (EHR, registry, etc.) or specialty (Family practice).

Hall Render provided a webinar on MACRA: The Merit Based Incentive System – What You Need to Know. View the recording here - https://www.youtube.com/watch?v=l-mQHBMie-Q

In addition, if interested, contact Crystal for a presentation from the National Rural Health Association RHC Conference – Merit Based Incentive Programs and Rural Health Clinics.

The final rule came out in Mid-October noting the following "after consideration of the public comments we received, we are finalizing our proposal that services rendered by an eligible clinician under the RHC or FQHC methodology, will not be subject to the MIPS payments adjustments. However, these eligible clinicians have the option to voluntarily report on applicable measures and activities for MIPS, in which the data received, will not be used to assess their performance for the purpose of the MIPS payment adjustment".

Michigan Peer Review Organization Quality Improvement Programs
The MPRO team presented on their *Reducing Disparities in Diabetes Care Initiative* and their *Cancer Control Initiative.*

Diabetic Initiative
The program aims to improve clinical outcomes related to HbA1c, lipids, eye exams, weight, blood pressure control and foot care through the spread of evidence-based practices. In addition, the initiative will increase the number of diabetes trainers and peer educators in the community and increase the number of diabetes self-management education (DSME) classes.

Benefits of participation

- Technical assistance, including:
  - Quality data benchmark reports with suggested opportunities for improvement
  - Electronic health record (EHR) standardization of documentation
  - Quality reporting initiatives, including Physician Quality Reporting System (PQRS) value-based modifier and meaningful use
- Access to best practices
- Patient engagement strategies
- Workflow evaluation and redesign
- Process improvement
- DSME program information
- Access to Learning and Action Networks – a group of health care practitioners, providers, stakeholders and citizens who come together around an action based agenda with a purpose of peer-to-peer learning and solution sharing.

RHCs in attendance spoke to the positive role that the diabetic self-management classes have played in their community. Click here for more information on the program

Michigan Cancer Control
Cancer continues to be the second-leading cause of death in our state. According to the Michigan Cancer Consortium (MCC), "approximately 142 people find out they have cancer and 56 people die from cancer each day in Michigan." This three-part cancer control initiative offers providers the opportunity to enhance the well-being of Michiganders by increasing and improving screening rates for:

Lung cancer and tobacco cessation
Colorectal cancer (CRC)
Breast and cervical cancer

Click here for more information.

Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers

On September 8, 2016 the Federal Register posted the final rule *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers.* The regulation goes into effect on November 16, 2016. Health care providers and suppliers affected by this rule must comply and implement all regulations one year after the effective date, on November 16, 2017.

The purpose is to establish national emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with federal, state, tribal, regional and local emergency preparedness systems.

Rural Health Clinics and Federally Qualified Health Centers are not required to comply with many of the requirements for hospitals (e.g. provide patient information during an evacuation). However, these facilities must, among other requirements, conduct a risk assessment and include policies and procedures in their communication plan to share patient information during an emergency with other local facilities..

Additional resources (all hyperlinked) -

Table outlining requirements for various provider types.
CMS Webpage
Emergency Preparedness Checklist
Core EP Requirements
Final Rule

An audio recording and transcript are available for the October 5 call on Emergency Preparedness Requirements. During this call, CMS discussed the new requirements in the final rule, as well as how to plan for both natural and man-made disasters, while coordinating with other emergency preparedness systems.

Roundtable Discussion

Attendees discussed the following:

- How to filter information from the physician organization meetings to the rest of the staff
- Provider education
- Panic buttons in exam rooms (behavioral health in particular)
- Advanced care plans – time constraints in having the conversation with patients, and getting patients to fill out the form and bring it back (PCMH metric).
- Staff safety (particularly concerning patients seeking narcotics)
    - Look to do a Safety at the Practice level education/presentation
    - Crisisprevention.com was shared as a resource. A few organizations (Hills and Dales) have staff trained in this resource, and are utilizing it as a train the trainer model. All staff will be trained.

Meeting dates for next year.

Proposed RHC QN Schedule			
Meeting Timeframe	Meeting Date/Time	Meeting Location	Notes:
Winter 2017	January 26th, 2017 1:00-3:00 p.m.	Webinar (due to anticipated weather issues).	
Spring 2017	May 5th, 2016 12:00-3:00 p.m.	Soaring Eagle Casino	Directly after MI Rural Health Conference – lunch will be served

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