

## **RHCs, Quality Reporting, and Delivery System Reform**

Rural Health Clinic Technical Assistance Series Call

Wednesday, March 11, 2015, 2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time, all participants are on a listen only mode. During the Question and Answer session, please press Star 1. Today's conference is being recorded. If you have any objections, you may disconnect at this time. Now I'd like to turn the meeting over to (Bill Finerfrock). Thank you, you may begin.

(Bill Finerfrock): Thanks Operator, and thanks everybody for listening in and participating in today's call. We appreciate you taking the time to be with us. As the Operator said, my name is (Bill Finerfrock) and I'm the Executive Director of the National Association of Rural Health Clinics and I'm the moderator for today's call.

Today's topic is on delivery system reform and this is, "Changes and Opportunities for Rural Health Clinics". This particular series of telephone conference calls is funded by the Health Resources and Services Administrations Office of Federal Office of Rural Health Policy and is done in conjunction with the National Organization of State Offices of Rural health and the National Association of Rural Health Clinics.

The purpose of the series is to provide RHC staff with valuable technical assistance in RHC specific information. Today's call is a 63rd in the series which began in late 2004. During that time we've had over 15,000 participants. As you know, there's no charge to participate in the series and we encourage you to refer others who might benefit from this information to sign up and receive announcements.

For information, you can go to the Office of Rural Health Policy's website which is <http://www.hrsa.gov/ruralhealth/policy/confcall/index.html>. We will have a Q and A period during today's call and we'll ask that folks identify those by their name, city and state that you're calling from.

If you have ideas or suggestions or questions you'd like to pose that you wanted to do via email, you can send them to [info@narch.org](mailto:info@narch.org) and put RHC TA question or RHC TA topic in the subject line. Today we have (Paul Moore) with the Federal Office of Rural Health Policy. (Paul)'s going to start us off today. He's going to provide some - an overview of what the department is looking at in the way of

delivery system reform kind of some of the overall global concepts and ideas that play here.

I'll talk a little bit about what NARHC is doing and the role for Rural Health Clinics and then (John Gale) who's with the University of Southern Maine Muskie School of Public Health. We'll talk to you about what they're doing in terms of data collection that will be feeding into this whole initiative and how you as rural health clinics can help participate and help be involved in this process.

So without further ado, I'd like to introduce (Paul Moore) with the Federal Office of Rural Health Policy. Paul comes from a rural background. We were just chatting. He's from rural Oklahoma. His professional credential is he was a pharmacist. Continues to be involved with community pharmacy in Oklahoma but has been with the ORHP for the last few years.

Prior to that, he was very active with the National Rural Health Association. (Paul), we appreciate you taking the time to be with us here today and look forward to what you have to say. It's yours.

(Paul Moore): Thank you so much (Bill). I appreciate the opportunity to spend this time with the RHC community and friends on the call today. To get right into it, on January 26th, Secretary Burwell announced a major new initiative focused on healthcare delivery system reform. The announcement included measurable goals in a timeline to move the Medicare program and the health system at large for paying providers based on the quality rather than the quantity of care they give patients.

Now this initiative will have important implications for all healthcare providers and the patient's they serve including rural. So the Federal Office of Rural Health Policy wants to hear from the folks on the phone today to ensure that rural providers can leverage the opportunities to align with the goals laid out by the secretary.

These are the kind of things I want you asking yourself if you're listening today. What are the implications of the unique payment classifications for rural health clinics? The implications for engaging fully in these new directions that the rest of the system is going? And how can we ensure that the goals are attainable for rural providers?

So to achieve better care, smarter spending and healthier people, HHS is focusing on three key areas. First -- improving the way providers are paid. Secondly -- improving and coordinating care delivery. And third -- sharing information more

broadly to providers, consumers, and others to support better decisions while maintaining the privacy.

So when it comes to improving the way providers are paid, the idea is to reward value and care coordination rather than volume and care duplication. In other words, to promote value based systems that pay providers for what works. And it this - this is including linking Medicaid, Medicare fee-for-service and other payments to value.

These and other models are being tested as important approaches for improving care and lowering cost and seeing - they're seeing some faster results in some of the initiatives that are going on. To improve care delivery, models are moving providers to find new ways to coordinate and integrate clinical services. There's also a focus on improving the health of our communities with a priority on prevention and wellness.

As we look to improve the way information is distributed, HHS is working to create more transparency on the cost and quality of care. Working to bring electronic health information to inform care and to bring the most recent scientific evidence to the point of care to bolster clinical decision making. Now as you look at the second slide from my handout that's entitled, "Goals and Focus Areas", you will note that this slides a lot the same as the first slide you were looking at but with a couple of important additions -- goals and timelines.

And as you look at that, you'll notice a couple of things. First of all, that the goals and timelines are aggressive. And secondly, if you're at all familiar with the rural percentage of the total Medicare spend and you look at the goals both for 2016 and out for 2018, you'll realize that you could actually leave rural providers including rural health clinics out of the mix and still potentially reach the goals.

So we want you to be thinking about this in terms of what delivery system reform means or how it applies to your practice, your patient population in your community. Now under the topic of incentives, you'll also note the first section refers to alternative payment models. And it refers to such initiatives as ACOs and medical home models, bundling payments and other demonstration projects that are out there.

Now I just want to pause for a moment and acknowledge that the concept of bundle payments is not new to the folks on the call today. It's not new to RHCs and just to point out that just a few models that perhaps could also have bearing on your practices in the future. The first I'll mention is the Patient Centered Medical

Home model. In the innovation centers PCMH home model, care coordinators oversee all of the patient care.

And then there's also medical homes typically offered patients access to conditions 24/7 and including some extended office hours. A second one that may have bearing on your practice would be the comprehensive primary care initiative and for this innovation center initiative, CMS works with commercial and state insurance plans and I believe its seven U.S. regions to offer population based care management fees and shared savings opportunities.

Another model would be the CMS is planning to test provider payments for care coordination's and patients with chronic conditions. And in addition to testing and expanding alternative payment models, Medicare is promoting value based payment systems by increasing the linkage of Medicare fee-for-service payments to value.

Once that example of that is the physician value based modifier where the physician value based modifier links a portion of the positions Medicare fee schedule to performance on both quality and cost measures. Now, I know and I expect a number of you on the call today are already familiar with the initiative steps I'm talking about, but the Federal Office of Rural Health Policy would be interested in hearing you're thinking about how these programs could work for rural providers and particularly for rural health clinics.

Because while the patients center medical home and accountable practice though is attainable nationally, it could also be reached without any rural participation. I'll just point out, as you know, that PCMH offers a chance for rural providers to align with the incentive on coordinated care. Now, clinicians in some rural FQHCs are participating in a PCMH like Medicare demonstration and we're encouraging them to become PCMHs.

However, RHCs do not have that opportunity or that Federal support to help them attain that. And neither RHCs nor the FQHCs are subject to the value based modifier or report to PQRS or some of the meaningful use although they may be eligible for Medicaid meaningful use. So, once again, those incentives aren't out there to move you in a particular direction.

CMS has indicated that rural health clinics are able to participate in the transforming clinical practice initiative but, again, you don't currently participate in PQRS and that's the way that they're reporting the quality that they're tying the incentives too there and the - and even the technical assistance to it. So, once again, you might ask, "Where are the RHC incentives to do so." That RHCs are

excluded from most quality reporting efforts is why the Federal Office has initiated the HRC specific voluntary reporting pilot that (John) is going to share with you great - in much greater detail later about in the call.

And I'll just tell you right now, we at the office want to encourage you to consider participating in this pilot project as a way to test reporting and benchmarking performance compared to other RHCs -- not compared to practices that have nothing to do with the kind of practice you are. So as we continue on, regarding the other care areas under care delivery there's the portion on improving population health.

Now the CMS innovation center has what we call, "The State Innovation Models" or the "SIMS" and some of them are offering ideas for bringing rural providers and populations into delivery system reform. There's at least a couple that I'm aware of in Mississippi and in Washington State that include rural projects.

And in the coming months, the innovation center will announce an initiative to address population health issues which hopefully will include meaningful rural participation. So the question for you is, "How can you encourage your state to consider innovative thinking about rural projects that make sense for your practice within their State Innovation Model approaches?"

Under the area of patient engagement, CMS meaningful use program criteria include requirements for engaging patients in their care both in the clinic and outside of the clinic. Now, rural providers that I have heard from have indicated that there are some significant challenges getting patients engaged through the portals once they leave the clinic. And so, the question would be, "How can HHS assist rural health clinics in engaging patients more fully in their care?" Now, if you're thinking to yourself, "There doesn't seem to be many resources to directly support rural health clinics in transitioning from this volume to value basis." Well, I just want to mention one resource to you that the Federal Office here funds and that is a project called, "Rural Health Value".

And the project looks at existing delivery system reforms and develops resources to assist rural healthcare providers in order to understand and participate in them. This includes short informational briefs, some profiles of rural innovators who have implemented some innovations, then it also provides some tools and resources to help other rural providers to do so. Now, I'll give you the website for that project. It's <http://www.ruralhealthvalue.org>.

So, before I hand this over to (Bill), there's just one more thing I want to say and that is one purpose of my being on the call today in addition to giving you kind of

a high-level look at delivery system reform, is to stimulate your thinking on how you might want to strategically act. Some questions I have, "Are you aware of value based payment initiatives in your community or in the market that you serve? How would you respond if you're approached by a forming ACO or another type of potential strategic partner? Are you planning to continue involvement in or seek to be part of a coordinated care effort in your area?"

Are you interested in efforts to promote population health? Are you where you want to be and need to be in respect to the use of electronic health records and in respect to quality reporting? What are your next steps in responding to this reform initiative?" And as you look at my final slide, you'll see that the Federal Office of Rural Health Policy genuinely wants to hear from you to ensure that rural and other rural providers can leverage the opportunities to align with the goals that have been laid out. We want your opinion and perspective on what you think will work and perhaps what needs some tweaking in order to work for rural health clinics.

We want to know where you see the opportunities and any potential adverse consequences and quite honestly, I want to know if you feel like you'd be better off if this just went on and left you alone or if you would feel being left out of where healthcare reform is going and fear maybe becoming irrelevant because of that. So we've set up a mailbox to facilitate that communication. And if you look on that slide you'll see the address is [RuralDSR@hrsa.gov](mailto:RuralDSR@hrsa.gov).

So, let us hear from you. We've already heard from a few, but we also we want to hear from you. So we're asking you to take a thorough look at the information available through the links that are on that last slide. Learn all you can about the initiative. Talk with your colleagues. Talk with your associations. And then provide your feedback on either what you think of it, whether you feel like you need to be participating in it, whether you see the pitfalls or the advantages and then provide us that feedback.

Once again, you can send your comments to the address – [RuralDSR@hrsa.gov](mailto:RuralDSR@hrsa.gov). (Bill), I'm going to toss it back over to you because one part of any reform that we're going to see is going to be tying it to quality and because of where we know the quality reporting is with rural health clinics right now, basically no mechanism or very few places have a mechanism.

I'm really excited to hear what (John) is going to share with us about the initiative that he's been working on. Thank you for the opportunity (Bill).

(Bill Finerfrock): Sure, thanks (Paul), and I wanted to just make a few comments in response to kind of some things that (Paul) said and things that we hear from our colleagues in the rural health clinics community. And I think the first thing that we as RHCs and those who work with RHCs and then work in rural communities have to understand is that change is inevitable.

I don't think that it would be realistic for us to presume that what has existed for the past 40 years in the Rural Health Clinics program is going to be exactly what is going to continue to exist in the years ahead. I think that while it is appropriate to have some concern and possibly even some fear, one of the things that we are trying to do at the National Association of Rural Health Clinics is say, "Okay, let's have this conversation. How do we as (Paul) suggested, you know, incorporate quality into a rural clinic payment model?"

How do we measure quality? How do we assess it? Are there quality measures that are appropriate for rural health clinic and the patient population that rural health clinics serve the same as the quality measures that should exist if it's a practice that's in a large, urbanized area or in a suburban community or are there, in fact, unique characteristics that exist within a Rural Health Clinic, a rural population that need to be counted or measured or included in any kind of a payment system or reform?"

And that will lead into it in a few minutes what (John)'s going to talk about. But the fact of the matter is, that as I said, change is inevitable. One of the things that we've talked about with some of our friends at ORHP and elsewhere is that what's critically important and what will continue to be a driving part of what we try to do as an organization and hopefully you do as rural health clinics is to ensure that whatever changes may come about, that it's done with the perspective that the money that is turned over to the RHCs for the care that they provide is sufficient to cover the cost of that care.

And that may mean a continuation of cost based reimbursement with the ability to not only measure but reward rural health clinics for those who meet the appropriate quality measures. It could mean some modification to cause based reimbursement.

We don't know exactly what it's going to entail, but I think the notion or the suggestion that, you know, we can't either measure quality or somehow figure out how to incorporate that into the rural health clinics payment model is a misnomer and we don't want people to walk away with the impression that rural health clinics aren't interested in trying to improve the quality of care that they provide

and that we are afraid of models that may try to link some aspect of rural health clinic payment to quality.

If we don't do this, if the rural health clinic community does not engage in this conversation, does not provide the data that's necessary in order to try and manage this process, then we run the risk that someone is going to do it for us. And they're going to do it in a way that may not be in the best interest of rural health clinics and more importantly the patients that you serve.

Historically, when changes have been made at the - at - in payment policy at the federal level, the attitude was, "Well, rural is just small urban and so if we make a few tweaks or turns on the edges here, that will fine." And of course we know that there's - that rural is not just simply a small urban area and that there are - there's more than the size of the community at play when we're looking at rural populations.

And so we want to get out of that historical mindset and say, "No, the rural communities do have unique characteristics, do have unique components, and while we are not afraid of change, well, we're not afraid of quality, we want to make sure that we don't lose those unique characteristics, those unique qualities as we try to evolve in this process."

So we at the National Association of Rural Health Clinics are working to educate elected officials, elect federal policymakers not only about rural health clinics in general, but the communities that you serve. And this is where the work that (John) and the University of Southern Maine becomes really critical in terms of our ability to continue to engage in this dialogue.

So with that having been said, (John), if you could at this point start your portion of the presentation and then at the end we'll open the phone lines for some questions. (John)?

(John Gale): Yes, thanks (Bill). And thank you everyone, I appreciate the opportunity to talk to you today and I want to echo a lot of what (Bill) and (Paul) have said in that that our goal in this project is to really capture the issues and needs of rural health clinics. And so that we can have and give the clinics an opportunity to weigh in on the measures and let us know what some of the issues are related to the burden of reporting in some of the challenges, so...

What I'll do today is talk to you a little about our project and the measures that we're using, how we got there and then how you might participate. And so, our goal from the beginning has to work with State Offices of Rural Health, Rural

Health Clinic Associations and the National Association of Rural Health Clinics to recruit clinics to participate in this project. And what we want to do is ask clinics to pilot test, evaluate and refine a set of measures. Focus specifically on quality.

And there's a minimum reporting quality - requirement of five core measures and they're an additional 13 measures system that clinics can participate in. And so the goal in selecting and developing measures was to identify useful and valid measures using some basic criteria. We wanted to look at the prevalence and volume in our rural health clinics. Do the measures capture a commonly provided RHC services? Are they internally important for quality control? Do they measure core services and can clinics actually do something about them? Are they actionable? Is there external importance for public reporting and payment reform?

One of the things that I think is critical for rural health clinics is to have data to show and document the quality of care provided and the importance of the services you provide to rural residents. Are they scientifically sound? Are they feasible? By that, we mean are the data easily collected at a reasonable cost? And how easy are they to pull from patient records?

We sought comparability and consistency with existing national measure sets. At the end of the day, rural health clinics are primary care providers. It is useful to be able to compare HRC's to other primary care providers and I believe they'll compare favorably. To do so, however, we need some consistent measures. And finally again, are they actionable? Can you interpret the results? What can RHCs do with the data?

So we have a set of 18 measures -- five core, and 13 optional. They were developed and identified through a process of using RHC experts and stakeholders from state rural health clinic associations, the National Rural Health Clinic Association quality measurement programs and rural health clinics. And we went through a multi-month process of winnowing down a very large list to 18 measures, all of which are national quality forum measures.

**The Five Core Measures:**

1. NQF # 18 - Controlling High Blood Pressure
2. NQF # 28 - Tobacco Use Assessment and Cessation Intervention
3. NQF # 38 - Childhood Immunization Status
4. NQF # 59 – Diabetes: Hemoglobin. A1c poor control
5. NQF # 419 - Documentation of current medications-adults/geriatric

**The 13 Optional Measures:**

1. NQF # 24 - Body Mass Index - Pediatric

2. NQF # 36 – Asthma – use of appropriate medications
3. NQF # 41 – Influenza Immunization
4. NQF # 43 - Pneumonia vaccines – older adults
5. NQF # 56 – Diabetes: foot exam – adult/geriatric
6. NQF # 57 - Diabetes Hemoglobin A1c testing
7. NQF # 61 – Diabetes: Blood Pressure Management
8. NQF # 62 – Diabetes: Urine protein screening
9. NQF # 63 - Diabetes Lipid profile
10. NQF # 68 - Ischemic Vascular Disease – use of aspirin – adult/geriatric.
11. NQF # 73 - IVD: Blood Pressure Management – adult/geriatric.
12. NQF # 75 - Ischemic Vascular Disease: Complete Lipid Profile and LDL – C  
Control < 100 mg/dL
13. NQF # 421 – BMI screening and follow-up – adults

What we expect from participants is to: 1) select any of the 13 optional measures of value to your clinic (in addition to the five core measures); 2) complete the registration paperwork; 3) register in the QHi portal; and 4) report on the five core measures at minimum and any optional measures you choose through the QHi data portal on a monthly basis. We'll talk about that in a moment. After entering the data, you can use the data for benchmarking and quality improvement within your clinic.

Finally, we ask each participant to participate in some very brief evaluation work that we will conduct on the measures. We are interested in a number of questions. Are they the right measures? Should they be changed? What reporting issues and burdens have you encountered? Are you able to pull the information easily from your electronic health records? Are there additional costs to generating the reports needed for these measures? How are you using the data? This sort of information is very important to understand as we move forward.

As you know -- and I'm only repeating what (Bill) and (Paul) have said -- the expectations and requirements for quality improvement reporting is not going to be an option for rural health clinics or any providers in the future. Although RHCs are not required to do so at the moment, eventually it will be necessary for them to do so. This project will give clinics a vehicle to gain access to useful and proven reporting tools, as well as an opportunity to work with a cohort of RHCs to benchmark performance as well as influence and shape the measures.

We are using Quality Health Inc. (QHi) which was developed by the Kansas Hospital Association for its Critical Access Hospital (CAHs). QHi is a well-developed benchmarking tool that has been in use for quite some time with CAHs in 15 states. In the past few years, QHi has been getting requests to extend and

adapt this program for use by provider-based rural health clinics associated with participating hospitals. This is a big program with 295 hospitals participating in 15 states. We currently have approximately 60 RHCs participating now - California, Wyoming, Colorado, Kansas, Michigan and Maine.

The cost for participation is \$200 a year for a clinic if you're in one of the 15 states that are supporting QHi. If not, the annual cost is \$500. For those clinics enrolling in this project, we will pick up that first year registration cost for the process. The slides I have shared with you provide a more detailed look at the QHi portal and available reports. I won't spend much time going over the different reports as you have them in front of you, but there are a variety of benchmarking and reporting tools built into the portal.

What we found to be attractive about QHi is it provides a portal that's easy to use, stable (it has been in use for a number of years), is updated regularly; is user driven; and is very easy to submit data.

We're not asking clinics to submit individual protected patient information. Rather, we are looking for de-identified "raw numbers" for each measure (i.e., the numerators and denominators). So for example, under the "Smoking Cessation Screening and Intervention Measure", which is a two part measure, we are asking clinics to report how many patients were seen during a given period (the denominator) and how many were screened for tobacco use (the numerator). For the second part of the measure, we are asking clinics to report how many patients of the screened patients report tobacco use (the denominator) and how many of those using tobacco are offered smoking cessation interventions (the numerator). Using these numbers, the program will calculate the appropriate ratios. After entering data, you'll have the chance to compare yourself to other clinics on the five core and any optional chosen measures. There's quite a bit of security built into the system so the only person that can see your individual clinic's data would be the QHi staff and research team. We, as researchers have signed data agreements protecting that confidentiality.

As you work with the QHi portal, you will be able to look at different state benchmarks and pick the peer group that you wish to be compared against. You will not have access to any individual clinic's data (except your own). We currently have 60 clinics to benchmark against. We hope to get to at least 100 clinics. This would provide you with a larger pool of clinics to benchmark against. This would provide greater flexibility to choose a specific peer group that makes sense for your clinic. For example, you might choose only to benchmark your clinic against other provider based clinics.

So, there's a quite a bit of flexibility and utility built into QHi. As we are running short on time, I think the best thing to do is stop now and field any questions.

(Bill Finerfrock): Before we go to the audiences' questions, I have a few of my own and if you covered this maybe it bears repeating, but I don't think I heard it but, how long of a time period are you going to ask people to report for?

(John Gale): We'd like at least two quarters, but it would be ideal if we could get clinics to report for a year. That would be perfect. It takes time to build a sufficient base of data to be able to benchmark well. So we're looking about a year total commitment for one year.

(Bill Finerfrock): Okay, and you mentioned that there would normally be a \$500 fee charged to folks to report their data and get these benchmark reports and what you're saying is that this project will pay that \$500 fee for the first year; if the clinic wants to continue to participate after that for their own purposes getting that data and they like the benchmark reports, for example, and they feel that they're relevant or of value, they could continue but at that point, they would then have to pick up the cost of the participation in QHi?

(John Gale): That's correct.

(Bill Finerfrock): And you gave the web address and I think you gave the - no, you didn't the web address, did you? For QHi?

(John Gale): I may not have and if I did or didn't, I apologize. Let me pull it up for you.

(Bill Finerfrock) I went onto the website and it wasn't clear on how folks would go and sign up. So that was one of the areas where you may want to try and get some additional information out or should folks just email you?

(John Gale): Yes, they should email. My contact information is in the slide set. So if you contact me I'll make sure that you get the paperwork and connect you with the folks at QHi. We work with (Stu Moore) and (Sally Perkins) who have been doing this quite a long time and are very, very good. And if -- I'm actually looking for the QHi website. The slides I gave you should have the information.

(Bill Finerfrock): So <http://www.qualityhealthindicators.org>. And then there's a link for QHi and you just click on that and then that would - you have to create the account I think that's what someone has to figure out the accounts or to log in and create it.

(John Gale): Yes, and we can help with that. There is some basic paperwork to fill out that provides us with contact information, explains some of the security features and the expectations for participation, and discloses who will be working with the data and the limitations on its use.

(Bill Finerfrock): Okay.

(John Gale): You know, we can get that out very quickly and if you can fill that out and send it to us, we'll connect you with (Sally) and the group.

(Bill Finerfrock): And in the event that there are some folks on the call who either don't have the slides in front of them, why don't you go ahead and give them your email address.

(John Gale): Certainly, it's [jgale@usm.maine.edu](mailto:jgale@usm.maine.edu)

(Bill Finerfrock): Okay. And if, you know, we - if folks didn't hear that or whatever, you can send me an email at [info@nrhc.org](mailto:info@nrhc.org) and we can get you - or connected to (John) as well. Operator, at this point, why don't we open up the lines for anybody who may have any questions, whether it's about the research project, the whole initiative to come up with a delivery system reform, rural health clinics, anything on this topic, any of our folks listening in would like to ask? So, Operator, you would give the instructions?

Coordinator: Thank you. We will now begin the Question and Answer session. If you'd like to ask question, please press Star 1. Please ensure that your phone is unmuted and clearly record your name when prompted. To withdraw your question, please press Star 2. One moment please to see if we have any questions or comments. And again as a reminder, if you do have any questions or comments, please press Star 1 and record your name.

(Bill Finerfrock): There's got to be a few questions out there, or did everybody in shock pass out?

Coordinator: We have a question from (Amy Zimmerman). Your line is now open and please announce your city and state.

(Bill Finerfrock): Amy?

(Amy Zimmerman):Hi, I am from Oakley, Kansas.

(Bill Finerfrock): Okay, go ahead (Amy).

(Amy Zimmerman): I currently put data into QHi for our critical access hospital. Would there - additional fee in this as well if I add on the rural health clinic component?

(John Gale): I believe it's \$200 for participating hospitals and we would pick that up as well.

(Amy Zimmerman): Okay. And then you talked about a year worth - a year's worth of participation? Would that year start - like would we go back to January? Or would it start from the time that we sign up?

(John Gale): Probably best to start from the time you sign up, otherwise, I mean, I think it might be a lot of work to go back and start pulling information.

(Amy Zimmerman): Okay. And then also I don't have any slides or information and I had a very difficult time writing down any contact information. The phone was cutting out a little bit and it was pretty fast, so...

(John Gale): Let me give you my email again (Amy), I'm sorry. It's [jgale@usm.maine.edu](mailto:jgale@usm.maine.edu).

(Bill Finerfrock): And the slides are also up on the NARHC website or you can send me an email. I'd be happy to send you a copy of the slides if you prefer to do that. You can email me at [info@narhc.org](mailto:info@narhc.org) and we can send you a copy of the slides.

(Amy Zimmerman): Okay, thank you.

(John Gale): You're welcome.

Coordinator: Sir, your line is open. Please state your city and state.

(Bill Finerfrock): Go ahead, caller?

Coordinator: (Sue Sheeley), your line is open.

(Sue Sheeley): Hi, this is (Sue) from Kearny County Hospital Lakin, Kansas. And our question was about getting those emails and contacts also from you. And I think we just want to clarify it's [info@narhc.org](mailto:info@narhc.org) for the slides?

(Bill Finerfrock): Yes, that's correct.

(Sue Sheeley): And was it [jgale@usm.maine.edu](mailto:jgale@usm.maine.edu)?

(John Gale): Correct.

(Sue Sheeley): Okay. I think that's all we wanted...

(Bill Finerfrock): Okay.

(Sue Sheeley): We also are a critical access and we already report to QHi so we did not know if we needed to register a new account in order to be in the pilot project.

(Bill Finerfrock): Just - if so, if you're already - how do you like the QHi system?

(Sue Sheeley): We love it.

(Bill Finerfrock): What...

(Sue Sheeley): Easy to work with...

(Bill Finerfrock): Go ahead.

(Sue Sheeley): The thing about it is it's easy to work with and you can manipulate it so that you are - you're reporting or being benchmarked against other facilities that are much like you instead of just a group of facilities. So, for example, we do OB and we could only benchmark ourselves against other hospitals that do OB. So, it's a great program to work in.

(Bill Finerfrock): Good. That's - so I was hoping you'd say and someone's whose actually been using it to, you know, to insurances to your rural health clinic colleagues that, you know, it is user-friendly and you don't need a PhD in information technology - maybe you have that, I shouldn't presume you don't, but...

(Sue Sheeley): Yes, we don't and...

(Bill Finerfrock): It's a user friendly system.

(Sue Sheeley): It very much is. So do we - do you think we need to register separately as a RHC so that we can be included in the pilot project?

(John Gale): That's a good question. I think there is a little bit of paperwork that is specific to the clinic, but I'll double check with (Sally) as well. And if you want to send me an email, say I'll get that information and get back to you right away.

(Sue Sheeley): Okay, great. Thank you.

(John Gale): Thank you.

Coordinator: And (Maddox), your line is still open and please state your city and state.

(Maddox): Rockville, Indiana.

(Bill Finerfrock): Okay, go ahead. What's your question?

(Maddox): My question is, we applied for rural health status several years ago and we're a small community health clinic so we have to save up our money up to do these things. And we applied, and we got the grant. We got the permission to do this. And the next step was policy. So we went through all of our policies and our policies had to be approved by a certain person for the state. So we saved up our pennies and we did that.

The next thing we had to go through was an inspection. Now, we are still sitting here waiting on an inspection. The state has us listed as a rural health clinic, but we don't get paid status as a rural health clinic. So all these things in your paperwork today, I find very interesting because we're doing all these meaningful use things. Every, single one of those I could pull reports out for you today. And yet, we're not actually a rural health clinic. So how - where do we fit in?

(Bill Finerfrock): In terms of your participation in this particular project?

(Maddox): Right.

(Bill Finerfrock): (John)?

(John Gale): No, you're not. I - I'm assuming that are waiting for your inspection? I know it can take some time but if you're awaiting that process, I wouldn't have trouble with you participating.

(Maddox): Well, we would love to - we would love to participate because we're already doing it as I said I can, you know, we could downstairs and pull this information up for you right now. We are already meeting the 25 meaningful uses. We do it every year and have for the past three or four years.

But I guess my question is it's really hard for us with our small staff and not getting paid more than what we get paid and funding is very hard to get increased is to now take on, you know, doing other reports when they have us as a rural health clinic, but we're not getting paid for a rural health clinic.

(Bill Finerfrock): Well, if you would contact me separately, you know, at the email address I gave at [info@narhc.org](mailto:info@narhc.org) then what we could do is make some inquiries and see what's going on and we can talk about, you know, where you are in the process, how long you've been at what stages in the process and see if we can't figure out what we can do there. So to try and expedite you're completion of the RHC certification process.

Separately, you know, I understand what you're concerned about and, you know, because of this strain on resources, if you're not in a position to be able to participate, we certainly understand.

If you are what (John)'s saying is that even though you have not completed the process for the purposes of the research and analysis, they would consider you a rural health clinic and allow your data to be imported into the project and calculated with the other data. You would then get those quality reports and that cost would be picked up by the project here. So...

(Maddox): So we wouldn't have to pay anything?

(Bill Finerfrock): Right, the \$500 registration fee that normally would have been levied for reporting your data and getting the reports from QHi, the project is going to pay for that. So, there's no direct cost. Obviously, there would be a staff cost in terms of the indirect cost. Someone going in and loading up the data.

So that may factor into your decision. So, you know, consider what you want to do there and then if you would contact me separately, we'll be happy to look into why the certification process seems to be taking longer than perhaps it should.

(Maddox): Okay. I'd appreciate that because like I said, we're doing the work anyway and we could give you data that you need because these little communities out here in the rural area are very, very much needed.

(Bill Finerfrock): Yes.

(Maddox): And thank you for the information today. We appreciate it.

(Bill Finerfrock): Sure, thank you.

Coordinator: And again as a reminder if you do have any further questions or comments, please press Star 1 and record your name. Again, please Star 1. And we do have a question from (Gary Lucas), your line is open and please state your city and state.

(Bill Finerfrock): Go ahead (Gary).

(Gary Lucas): Hello everybody. This is (Gary Lucas). Just have a quick question regarding the expected level of training that you anticipate needing about providers and quality reporting staff on things like documentation and coding and reporting considering this information either has to come from the clinical notes or from information gathered by other staff.

(Bill Finerfrock): (Gary), before someone answers, (Gary), where are you from?

(Gary Lucas): Atlanta, Georgia.

(Bill Finerfrock): Oh, great, okay. (John), you want to take a stab at that?

(John Gale): Sure. What we are finding quite honestly is that most of the clinics that are interested already have an electronic health record although that is not a requirement, I appreciate that there are some clinics still on paper records. Participation would involve a little more extraction work and the development of a sampling framework (that we could help with). For the most part we've found that there's really about an hour training done by webinar by (Stu) and (Sally) at QHi on the use of the portal and how to enter data.

And I don't know if I can really speak well yet on how much work the clinics are having to do in terms of the internal process of pulling data. The one piece of information we've had from some - has been that they sometimes have to go back to their vendor to get the right template to pull the information.

But beyond that, I think, based on what we are hearing from the clinics that are participating, that the process is relatively straightforward. Once they figure out the data points - what fields they're drawing from in the EHR, they are fairly straight forward to report. Just basically numerators and denominators for the measures in question.

So I'm pretty sure it's a probably a good about an hour for the training from what we've heard. I've been through the training and that web based training takes about an hour. I'm not sure about your internal process.

(Bill Finerfrock): Do you have a practice management software or some type of electronic software? Are you on a paper record, still?

(Gary Lucas): We actually represent and teach providers documentation clinical improvement. So we're on the education side.

(Bill Finerfrock): Oh, okay.

(Gary Lucas): Coding and billing, so they have a deep interest in understanding the difference between treating patients and then providing codes when their payments tend to not change so what's the difference for that and we just want make sure we're monitoring that and providing assistance where (unintelligible)...

(Bill Finerfrock): Okay, great. Thanks for participating today, appreciate it. Operator, any other calls or questions, I mean?

Coordinator: I show no further questions.

(Bill Finerfrock): We'll give folks - if anybody has a last question or anything else that quick's - pops up, we'll give you another 30 seconds to kind of indicate - Operator, if you would just remind folks once again how to ask a question?

Coordinator: Thank you and again as a reminder if you do have any further questions or comments, please press Star 1 and record your name. Again, please press Star 1.

(Bill Finerfrock): And (Paul) while we're waiting, do you want to go ahead and give out your email address again for folks who wanted to comment on the - on this whole process?

(Paul Moore): Thank you (Bill), I sure I will. That - once again that email address is [RuralDSR@hrsa.gov](mailto:RuralDSR@hrsa.gov). And part of our charge here at the Federal Officer of Rural Health Policy is to represent rural providers and the issues and bring those issues to the HHS table and so we want to make sure that not only your provider type but you specifically our address.

So feel free to drop us a line, let us know your thoughts on this whole delivery system reform and not only your thoughts, but your suggestions and we'll be glad to hear about it and we'll pass it on.

Coordinator: Excuse me, just a - we do have two questions that came through.

(Bill Finerfrock): Okay, great. Go ahead.

Coordinator: (Nam), your line is now open.

(Nam): Oh, okay, hi, this is (Nam), I'm calling from Lakeview in Oregon.

(Bill Finerfrock): Okay.

(Nam): And we had a critical access hospital and we just opened up the rural health clinic in February so we are still pretty new with the clinic. And we are using a different system called CPSI so I was wondering with QHi would that be an additional of entering of data that would be required?

(John Gale): CPSI is your electronic health record?

(Nam): Yes.

(John Gale): You would pull the data from your EHR and it would have to be entered into the QHi portal. I don't think they have an electronic transfer as yet.

(Nam): Okay. And the other question I had was since our rural health clinic is so new we did not have any substantial data so if we would like to participate in this do you think this is still too early for us to start participating? Or is it okay for us to join at this point?

(John Gale): I think it would be fine. I think what it would give is data to benchmark against as I am guessing you don't have historic data to benchmark against your current performance. This would give you an opportunity to look at those measures compared to other clinics and operations so I don't think it would be too early at all.

(Nam): Okay.

(Bill Finerfrock): (Nam). You said you're a new rural health clinic, but are you - is it a brand new clinic? Or was it an existing clinic that is now been converted a rural health clinic.

(Nam): No, we are a brand new clinic, so we were a critical access, and we just opened up this clinic in February.

(Bill Finerfrock): Okay, good because many of our RHCs, you know, a traditional medical practice that converts and so there - I was just curious if there was data from prior to being a rural health clinic that could be used in - as part of this process but if you're brand new you just don't have that. Okay.

(Nam): Yes.

(Bill Finerfrock): Great, thank you.

(Nam): Thank you.

(Bill Finerfrock): Yes, next caller?

Coordinator: And our last question comes from (Ellen). Please state your city and state. Your line is open.

(Ellen): Hi, this is (Ellen) from Hermann, Missouri.

(Bill Finerfrock): Okay, go ahead (Ellen).

(Ellen): Our question is we have four rural health clinics and we have not implemented an electronic medical record as of yet in our four clinics. And I'm wondering if any of the clinics are not on electronic records are reporting for quality measures if it's stated possible to do quality indicators?

(Bill Finerfrock): You mean, to participate in this particular initiative?

(Ellen): Yes, on the initiative.

(Bill Finerfrock): Well, although you may not be on an EA chart, do you have a practice management software program?

(Ellen): We do.

(Bill Finerfrock) I mean, I'm not - I don't know what product you have as far as a practice management software, but that may be able to generate report that would give you the data that you could enter into the QHi portal.

(Ellen): Okay, so, (John), we could inquire and you could talk to us about the product because we're using NextGen so you would be able to talk to us about the product line that we're using.

(John Gale): Yes, and I might arrange a call with (Sally) or (Stu) to talk about that process just to - so that if...

(Ellen): Okay.

(John Gale): But, yes, please send me an email. I'd be happy to do that.

(Ellen): I will do that.

(John Gale): Thank you.

(Ellen): Thank you.

(Bill Finerfrock): If there are no other questions, we're coming up pretty close to 3:00 p.m. so we will take this opportunity to finish out the call. I want to thank everybody for participating today and particularly I want to thank (Paul Moore) with the Federal Office of Rural Health Policy and (John Gale) with the University of Southern Maine and the School of Public Health and encourage everyone to the extent that your able to participating and contributing data to this research project.

It will be incredibly important for us to be able to have that data to help design future initiatives where we want to try and incorporate quality so that we ensure that whatever may be done is relevant for the rural health population. So, thank you all for participating and please encourage others. If you know people who would benefit from participating in these regular Rural Health Clinic Technical Assistance calls, to sign up.

They can go to the NARCH website under "Resources". There will be LISTSERV and you just sign up for the Rural Health Clinic Technical Assistance LISTSERV and anybody who's on that will get those announcements. We will be scheduling another Rural Health Clinic Technical Assistance LISTSERV in the not too distant future so be on the lookout for that.

I do want to mention that there is the possibility for some change in this Rural Health Clinic Technical Assistance series. The project is up for renewal via the Federal Office of Rural Health Policy. It is certainly our hope that we will continue to be involved with this project, but stay tuned for any news or information about that.

That probably won't incur until sometime this summer but, you know, hopefully you have found these useful as well as the LISTSERV's that we operate useful and hopefully we'll have some information on that in that not too distant future. So, again, thanks everyone for participating and that concludes today's call.

Coordinator: This concludes today's conference call. Thank you for participating. You may disconnect at this time.

END