Working with Colorado's Rural Health Clinics to Support Operations and Quality Improvement

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Abstract

The Colorado Rural Health Center's (CRHC) Healthy Clinic Assessment (HCA) project has worked with the state's rural health clinics (RHCs) over the past three years to assess clinic basic business operations, compare current operations to industry-accepted best practices, identify gaps and make recommendations for improvement. With an increasing emphasis on quality improvement, patient outcomes, and data collection and reporting to demonstrate outcomes, CRHC has started work to assist clinics in moving across the continuum forming a foundation of strong and consistent day-to-day operations followed by active participation in structured quality improvement and patient safety initiatives.

Project Goals and Objectives

The project's goals are to provide support and assistance to rural health clinics as they strengthen their basic business operations and transition to active participation in quality improvement activities such as CRHC's Improving Communication and Readmission (iCARE) program, Patient Centered Medical Home (PCMH), Accountable Care Collaborative (ACC) (Colorado's Medicaid accountable care model), and more.

Working on several fronts, CRHC is striving to provide assistance to clinics in creating a strong business foundation. By conducting Healthy Clinic Assessments, CRHC's Quality Improvement Specialists are assisting clinics in identifying gaps with the ultimate goal of helping all clinics achieve a score of 90% or higher on the assessment; a score which is a general indicator of sound and efficient operational processes.

Through this project, CRHC is also providing clinics with linkages and facilitation to transition into quality improvement activities. Specifically, CRHC is working to encourage clinic participation in its iCARE program, PCMH activities, or ACC models. Through this project CRHC established the goal of having 50% of clinics formulate an action plan for participation in these types of programs by the end of the funding year.

Finally, CRHC sought to create linkages between a clinic's service offerings and community needs. To begin this work, CRHC created a clinic profile template outlining clinic demographics and services offered with the goal that at least 50% of project clinics would create an action plan to expand services and/or engage in new ways with their communities.

Through this multifaceted approach, clinics have the opportunity to make improvements to patient experience, quality of care, and financial viability and efficiencies – all tenets of the Institute for Healthcare Improvement's (IHI) Triple Aim and a key cornerstone of the current health reform landscape.

Background

The Colorado Rural Health Center (CRHC) is Colorado's State Office of Rural Health. CRHC is one of three SORHs that is structured as an independent, non-profit organization; whereas most other SORHs are part of the State government or State university system. CRHC was established in 1991 with a mission to enhance healthcare services in the state by providing information, education, linkages, tools, and energy toward addressing rural health issues. Its vision is to improve healthcare services available in rural communities to ensure that all rural Coloradans have access to comprehensive, affordable, high quality healthcare. CRHC serves rural hospitals, clinics, private physician's offices, and other rural healthcare providers and communities statewide. As the recipient of the Health Resources and Services Administration's Medicare Rural Hospital Flexibility Program Grant (Flex), Small Rural Hospital Improvement Program Grant (SHIP), and State Office of Rural Health (SORH) grant, CRHC provides services for the state's 29 Critical Access Hospitals, and other rural hospitals.

This project specifically focuses on Colorado's Rural Health Clinics (RHC). The purpose of the federally certified Rural Health Clinics program is to encourage and stabilize the provision of out-patient primary healthcare in underserved rural areas through the use of physicians, physician assistants (PAs), nurse practitioners (NPs) and certified nurse midwives (CNMs). Colorado has 52 federally certified RHCs. To be a federally certified RHC, clinics must meet certain eligibility requirements including, but not limited to: being located in a rural and underserved (Health Professional Shortage Area or Medically Underserved Area); be staffed by one or more physicians and one or more physician assistants, nurse practitioners or certified nurse midwives; have a physician on site at least once every two weeks to provide medical direction, medical care services, consultation, and supervision; a PA, NP or CNM must be on-site and available to see patients 50% of the time the clinic open for patients; provide outpatient primary care services, diagnostic and therapeutic services commonly furnished in a physician's office, and provide six basic laboratory services. In terms of reimbursement RHCs receive an all-inclusive, per visit Medicare reimbursement for outpatient primary care services provided. Independent, free-standing RHCs are reimbursed by Medicare up to the federally-established cap of $79.17 per visit; however, not all of them are reimbursed up to the cap. There is no per visit Medicare reimbursement cap for provider-based RHCs affiliated with a hospital that has fewer than 50 beds. Colorado Medicaid reimburses all RHCs at a cost-based rate which is based on Medicare rates. In addition to 52 federally certified RHCs, Colorado also has approximately

50 rural health clinics that are not federally certified. Although RHCs that are not federally certified are not held to these federal requirements, they must continue to meet state requirements. Even though none of the rural health clinics nor CRHC receive any federal funding to support these efforts CRHC has historically provided services and resources to these clinics as they are a vital part of the rural health community. Three Quality Improvement Specialists, employed by CRHC, provide support and technical assistance to the RHCs throughout the state.

CRHC and other national partners have been working diligently over many years to advocate for rural health clinics, trying to secure federal funding, recognition, and regulatory updates. One obstacle to these efforts is the lack of data available from RHCs. CRHC continues in its attempts every year to gather data from clinics regarding their payer mix, unduplicated patient counts, and other information to try to quantify the population served and the impact these clinics have on their communities and to the healthcare landscape in general. Through a combined effort with ClinicNet, an organization dedicated to advocating for community funded safety net clinics throughout Colorado, CRHC was able to determine that the state's RHCs cared for 175,000 unduplicated patients in 2010. Data collection efforts will continue as the profile and awareness of RHCs in Colorado and nationally continues to grow.

As part of its work with rural health clinics, CRHC identified the need to assist them with assessing and improving their basic business operations. CRHC contacted a local billing firm to customize a tool they originally developed to assess clinic billing and claims processes. Working with the billing firm, additional categories were added to the Healthy Clinic Assessment (HCA) to provide a comprehensive examination of a clinic's basic business operations. These operations include: telephone protocol; appointment-setting processes; check-in/check-out procedures; visit preparation; and accounts receivable processes and follow-up.

Methodology

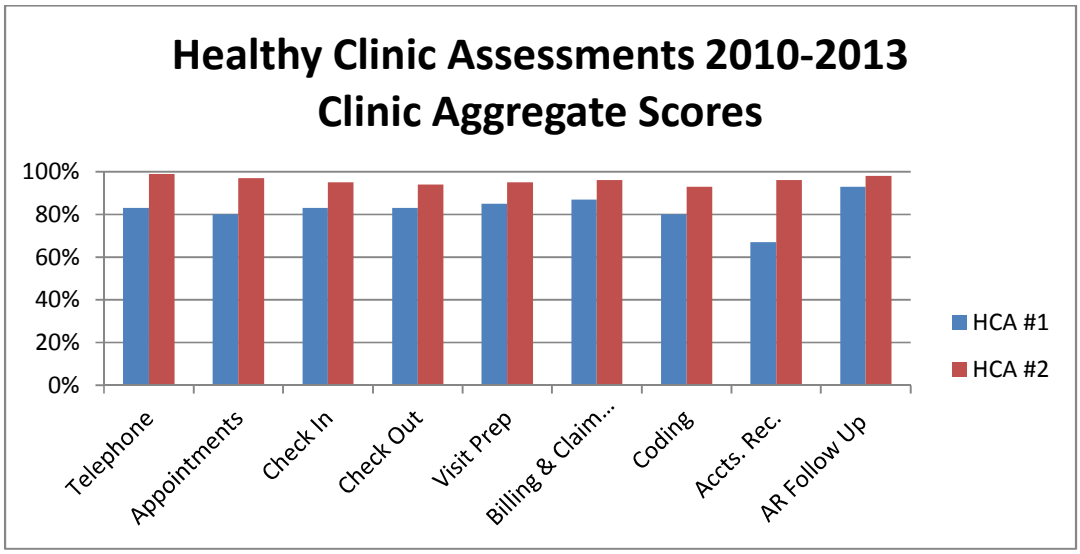
To begin this work, CRHC identified six rural health clinics located in 5 counties primarily in Northeast and South Central Colorado. The clinics were chosen based on the interest they had communicated in participating in this type of work and their previous engagement in other activities. The population potentially impacted through this project is 341,796 located in 5 Colorado counties covering over 6,900 square miles. The percentage below poverty level according to the 2010 US Census ranges from 7.5%-13.4%.

The participating clinics signed a project charter which outlined the project activities and technical assistance that would be supplied by CRHC as well as delineated the data and reporting that would be required of the clinics. CRHC's Quality Improvement Specialist held a

kick-off meeting or conference call with the administration of each clinic and arranged a time to conduct their first Healthy Clinic Assessment. In an effort to provide customized service to meet each clinic's needs, the Quality Improvement Specialist reviewed the assistance each clinic had received in the year prior to the project. While most clinics needed a full HCA, there was one clinic that required only follow-up assistance in one or two HCA categories. HCAs were scheduled at each clinic along with a follow-up site visit or conference call to review the assessment results. At the same time, CRHC worked with clinics to provide information and linkages to quality improvement initiatives. Three of the six clinics are currently participating in iCARE and, while technical assistance related to iCARE is provided separately from this initiative, the Quality Improvement Specialist's involvement in both projects provides continuity and synergy to provide holistic assistance for clinic needs.

Measurement

CRHC tracks a number of elements in each Healthy Clinic Assessment category: telephone protocol; check-in; check-out; visit preparation; accounts receivable; accounts receivable follow-up. Elements are giving a score of 1, 3, or 5 indicating whether the element was Not Met, Partially Met, or Met, respectively. All elements in a category are totaled to arrive at a total category score. Each category score is then averaged together to arrive at an overall average HCA score per clinic. For any element that is either "Not Met" or "Partially Met", CRHC provides a recommendation for improvement based on industry-accepted best practices. For those clinics that receive top scores, CRHC works to compile best practices to share with other RHCs. Below is a graph of the results of two HCAs conducted for a different project to illustrate the improvement potential. The first HCA was conducted at the beginning of the project; the second HCA was conducted at the end of the project.



Preliminary findings for this project's clinics are described in the Findings section. For those clinics that have already taken the next step and engaged in quality improvement programs, CRHC has also been collecting measures. Three of the six clinics participating in the project have engaged in CRHC's Improving Communication and Readmission (iCARE) program.

Findings

Results of the preliminary HCAs are currently being tabulated however a few emerging trends have already been identified. Clinics have demonstrated a consistent need for the following assistance: implementing or improving an existing no-show policy; tracking referrals; consistently and correctly collecting demographic and insurance information; collecting back balances; creating a consistent check-out process; verifying insurance; provider coding and billing training; ICD-10 training; and conducting regular coding audits, and coding certification. CRHC will be working to supply resources to clinics as they work to achieve improvements and efficiencies in these areas.

In terms of the second project objective to work with clinics on their transition to quality improvement participation, three of the six clinics are participating in CRHC's iCARE project. None of the target clinics are pursuing patient centered medical home at this time. Although it is too soon to report data from the iCARE project, most clinics have overcome the first substantial hurdle they encounter when participating in quality improvement initiatives: data collection and reporting. There are currently twelve rural clinics participating in iCARE, including three of the six clinics involved in this project. All iCARE clinics are asked to report 13 diabetes measures monthly. At the start of the project, only half of the participating clinics were reporting any project data. As of this report, 83% are now reporting some level of iCARE project data, including all three clinics from this project's cohort.

Finally, the third objective is to work with clinics on identifying services and creating linkages to community needs. The clinic profile template which will be used to gather this information is being finalized and set to be distributed to the participating clinics for completion by the end of the year. Once completed, CRHC will analyze the profiles to identify trends, commonalities, and gaps between the clinics.

Conclusions

The value of this type of work in the current healthcare environment is high. In a recent survey conducted by the American Academy of Family Physicians of its members, improving access to healthcare in rural and underserved communities, helping family physicians deal with the

business aspects of running a practice, and helping family physicians implement quality improvement processes in their practice were three of the top ten concerns cited by physicians (www.medpagetoday.com, September 27, 2013). Additionally, the focus on reporting data, quality, and outcomes for clinics continues to increase. For example, the federal Office of Rural Health Policy is in the beginning stages of a pilot project for RHCs to determine relevant quality measures and pilot a reporting mechanism and structure. Transformation projects, such as this one, that can provide assistance to clinics as they address these concerns represent a critical form of support for clinics as they continue to position themselves for success in the future. Equally however, it is important to customize the support available to meet clinics' individual needs.

Moving forward, CRHC has requested funding to continue the work started through this project. Plans include working with the same clinic cohort in the next phase of this work to: repeat the HCA to determine gains made and identify any additional areas for improvement; foster increased participation in quality improvement activities to 90% of project participants and analyze available data through iCARE to determine the impact on the health of their populations; and compare clinic service profiles against county data sets to determine alignment and gaps with the health needs of the counties these clinics are serving.

Personal Leadership Experience

The NOSORH Leadership Institute has provided me a great opportunity to expand my knowledge and leadership skills. I have appreciated the variety of topics presented, the peer learning, networking, and real-life examples of applicability. The discussions presented new ways of looking at a variety of topics and their relevance extends beyond the rural work we are involved in.

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