
National Rural Health Day
Celebrating the Power of Rural!
NOVEMBER 20, 2014
Rural Quality Showcase
Federal Office of Rural Health Policy


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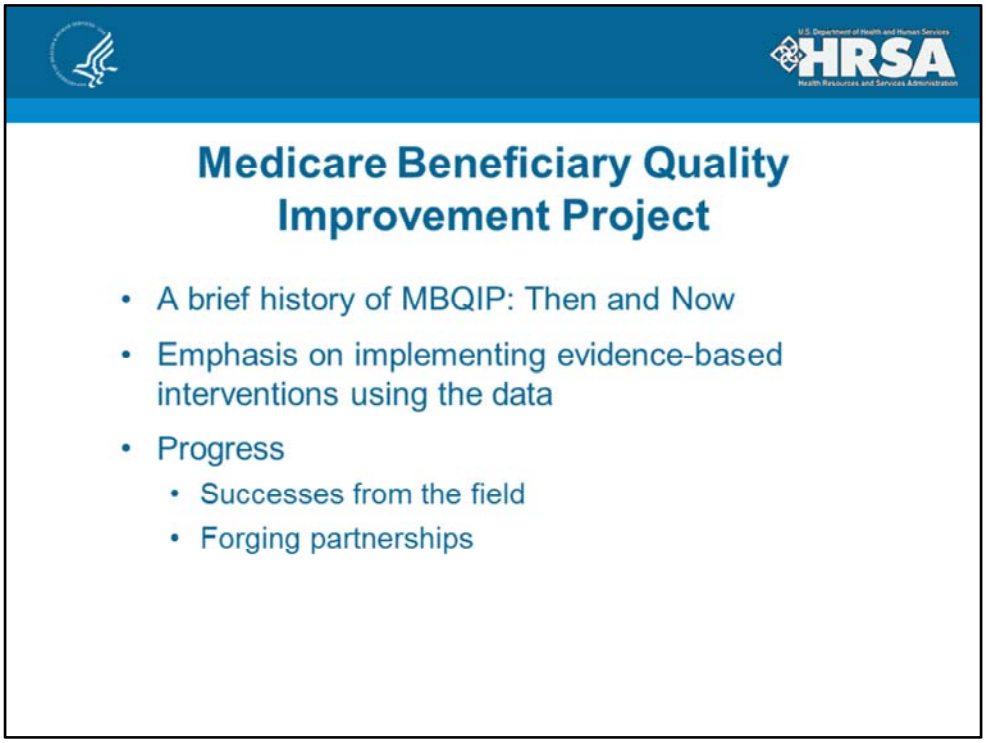
#PowerofRural

HHS Rural Quality Efforts

ORHP Rural Quality Goal



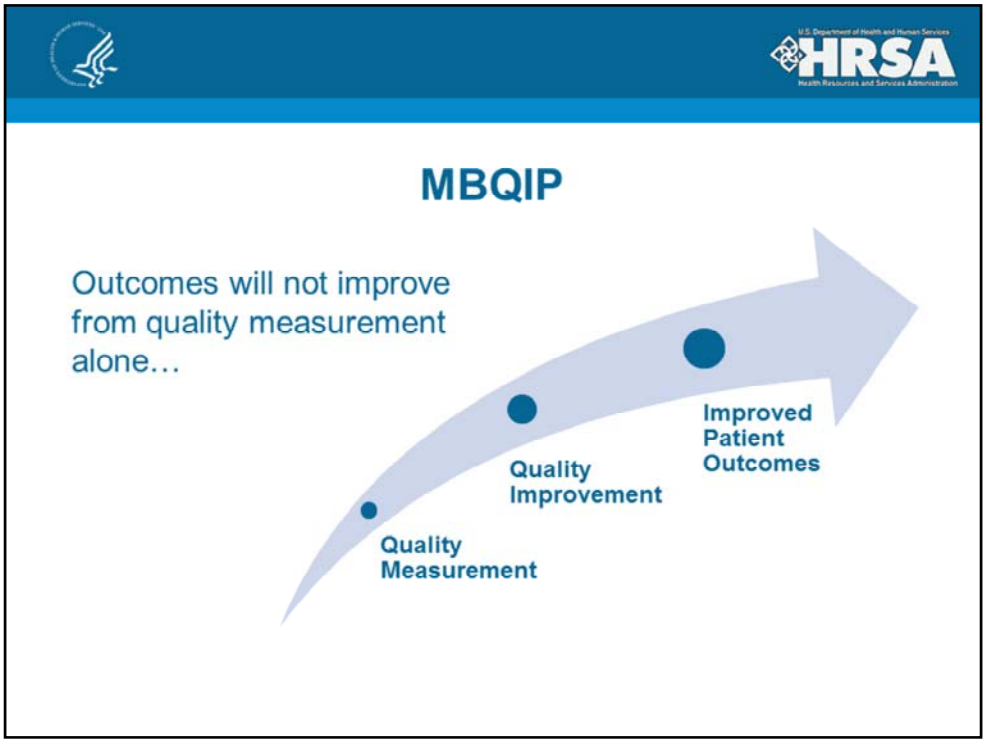
Volume to value, rural relevant measures, address low number issues in CAHs – MBQIP as a strategy

Increased voluntary reporting

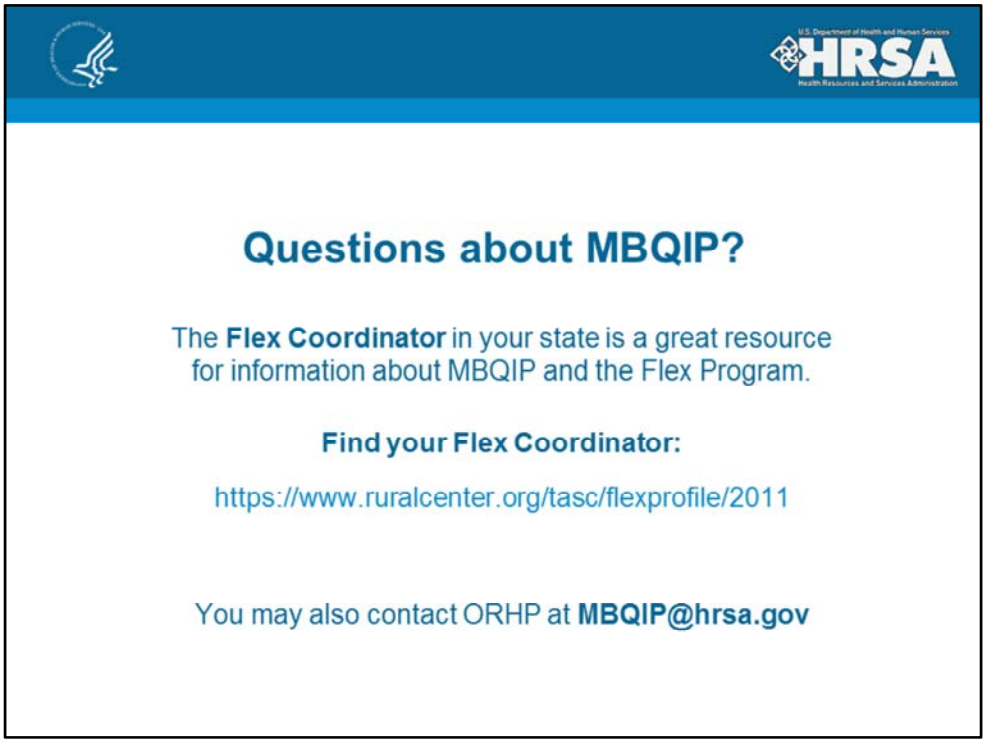
Data reports → Use for QI

States have:

- Started important conversations with hospitals and quality partners
- Begun sharing among each other: how to use data, how to build relationships with QIO for example, etc
- Group of states in Midwest participating in target-setting pilot; measure(s) was selected and a target for improvement was set, will be looking at outcomes soon
- Partnerships with CMS, Special Innovation Project EDTC measure led by Stratis Health in MN, 8 states participated and helped lead the way for national roll-out of the EDTC measure, other outcomes: reporting tools, QI resources
- Other important partnerships and activities with AHRQ, CMS, etc that Marty Rice will be discussing with you in just a moment



Need to emphasize that data collection and analysis takes time. CAHs are not going to see an immediate benefit from MBQIP/reporting data right away just because they are *reporting* data ("quality measurement" bullet…where most CAHs in MBQIP are currently stuck). They need to use the data to determine where their needs are (either individually as CAHs or in a cohort of other CAHs in their state) before they will see quality improvement (through implementation of QI activities) and improved patient/data outcomes. States/CAHs are NOT yet doing this and are getting frustrated that MBQIP is beginning to be a waste of their time – but it's because they are not taking the next steps beyond simply just reporting.

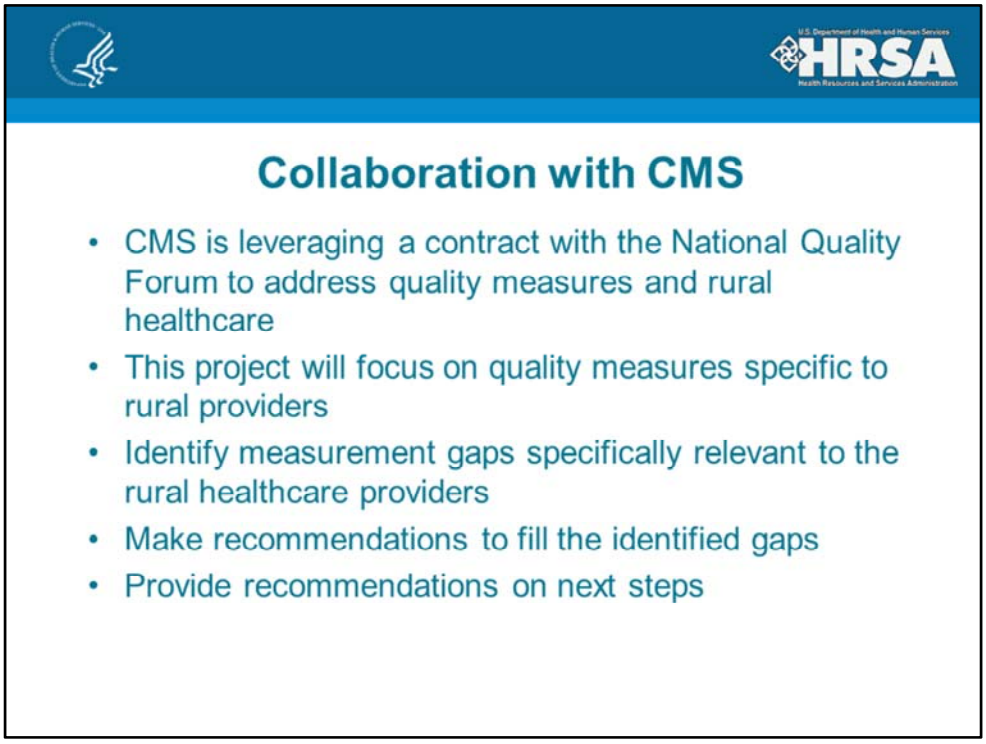


If you have further questions…

Your State Flex Coordinator is a great resource for information about MBQIP or the Flex Program.

..and…

the State Contact Information and Flex Profile pages on the TASC website include contact information for your Flex Coordinator.



This project will focus on quality measurement use specific to rural providers and the associated challenges in quality measurement use and lower volumes for certain ICD and CPT codes.

Many of the measures in place are not relevant to CAHs and Rural providers

Low volume

Procedure specific

The purpose of this work is to inform HHS of efforts and challenges related to value-based purchase/payment measures as well as recommendations to improve specifications and testing of policies and measures targeted at Medicare and Medicaid providers.

CMS Measures Under Consideration (MUC)

- HHS is required to make publicly available a list of certain categories of quality and efficiency measures it is considering for adoption through rulemaking for the Medicare program.
- CMS compiles a list of these proposed measures in a list named the "MUC" list
- ORHP submitted and CMS accepted the Emergency Department Transfer Communication measure into the 2014 MUC list

Collaboration with the Agency for Healthcare Research and Quality (AHRQ)

- ORHP and AHRQ have aligned to develop a new Quality Improvement website
- Built on the principles of quality and the MBQIP program
- In association with the National Rural Health Resource Center
- https://www.ruralcenter.org/tasc/mbqip


HRSA
Small Health Care Provider
Quality Improvement Program
(SHCPQI)

SHCPQI Program: Background and Purpose

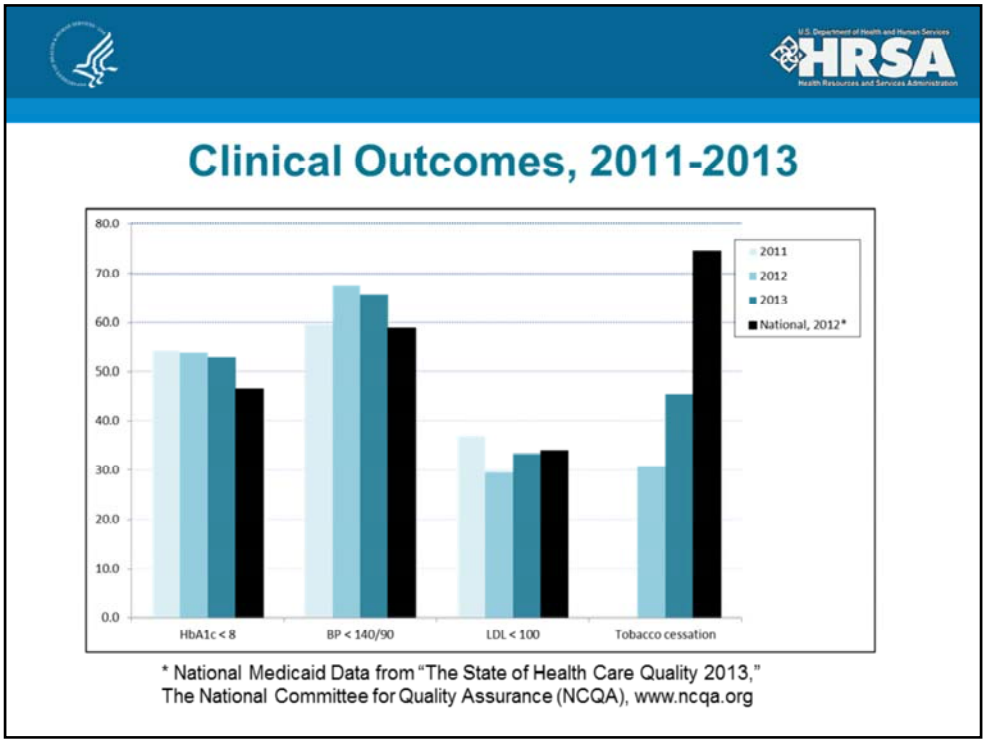
- Authorized under the Public Health Service Act, Title II, Section 330A(g) in 2002
- IOM report, "Quality Through Collaboration: The Future of Rural Health", November 2004
- SHCPQI Program – pilot program in 2006
- Three-year grant program
- Assist rural providers with implementation of quality improvement activities
- Primary care/outpatient setting

SHCPQI Program: Goals and Objectives

- Promote evidence-based culture
- Coordinated delivery of care
- Improved health outcomes for patients
- Better engagement of patients and caregivers
- Enhanced chronic disease management
- Focus on diabetes and cardiovascular disease
- Prepare organizations for pay-for-performance
  - Collect and report clinical quality measures

Snapshot of the Current Program

- 29 Grantees
  - Federally Qualified Health Centers
  - Critical Access Hospitals
  - Rural Health Clinics
  - Tribal entities
  - Networks
  - Public Health Departments
- Medical Home (PCMH), ACO, MU
- Care coordination
- Patient engagement and satisfaction
- Utilization (ER use, readmissions)



Diabetes data reported through PIMS for the 3 years

Comparison to National data

- From National Committee for Quality Assurance (NCQA) – Medicaid data, most comparable to HRSA grantees/safety net
- Hard to find data that is exactly comparable to the measures we are using – apples to apples comparison
- For the most part, we are doing better than the national average

Not a lot of change over the 3 years:

- Start w/population of focus
- Lab values/EHR
- Takes 2-4 years to show improvements in outcomes

FirstHealth of the Carolinas

- Nonprofit healthcare system: 3 hospitals, 7 primary care clinics, 3 dental clinics, 6 health/wellness centers
- Transition Care Clinic
  - Patients following hospitalization or ER visit
  - High risk for readmission
  - Referrals for primary care provider and other services
  - Insurance eligibility
  - Medication assistance

How to participate

- Eligibility
  - Public or non-profit private health care provider
  - Located in a Rural County ***or*** Eligible Rural Census Tract within an urban county
- Next competitive funding opportunity announcement expected to be available fall 2015/winter 2016 for an August 1, 2016 start date

Questions

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Rural Health Clinic Quality Reporting Pilot

- >4,000 RHCs in 44 states
- See more than 1.6 million Medicare beneficiaries each year
- Last group of primary care providers not required or incentivized to report quality measures (other than via Medicaid Meaningful Use and ACOs) – unlikely that will continue indefinitely
- Proactive attempt to review NQF-endorsed ambulatory measures for RHC-relevance
- Approx. 60 identified measures
- University of Southern Maine testing voluntary reporting of a subset of measures by a cohort of RHCs (5 core, 13 menu)

RHC Quality Pilot Measures

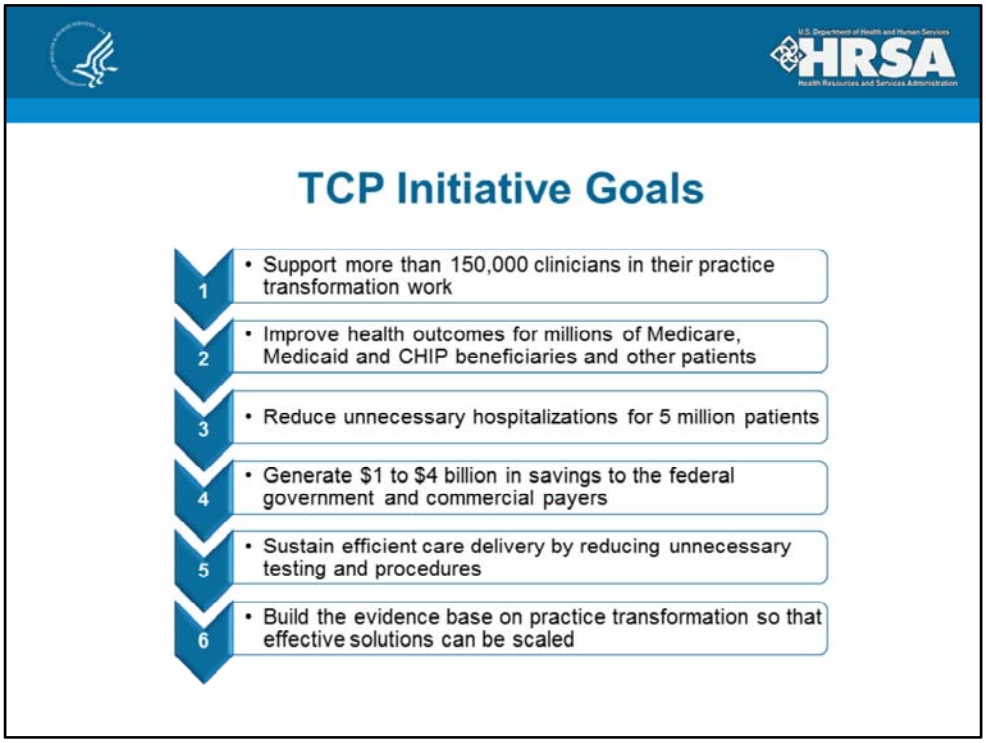
Core Measures
NQF # 18 - Controlling High Blood Pressure
NQF # 28 - Tobacco Use Assessment and Cessation Intervention
NQF # 38 - Childhood Immunization Status
NQF # 59 - Diabetes: Hemoglobin A1c poor control
NQF # 419 - Documentation of current medications – adult/geriatric
Optional Measures
NQF # 24 - Body Mass Index – Pediatric
NQF # 36 - Asthma – use of appropriate medications
NQF # 41 - Influenza Immunization
NQF # 43 - Pneumonia vaccines – older adults
NQF # 56 - Diabetes: foot exam – adult/geriatric
NQF # 57 - Diabetes: Hemoglobin A1c testing
NQF # 61 - Diabetes: Blood Pressure Management
NQF # 62 - Diabetes: Urine protein screening
NQF # 63 - Diabetes: Lipid profile
NQF # 68 - Ischemic Vascular Disease – use of aspirin – adult/geriatric
NQF # 73 – IVD: Blood Pressure Management – adult/geriatric
NQF # 75 - Ischemic Vascular Disease: Complete Lipid Profile and LDL-C Control <100 mg/dL
NQF # 421 - BMI screening and follow-up – adults

Transforming Clinical Practice Initiative

- CMS recently announced this initiative to work with 150,000 clinicians
- Aligns with the criteria for innovative models set forth in the Affordable Care Act:
  - ✓ Promoting broad **payment and practice reform** in primary care and specialty care
  - ✓ Promoting **care coordination** between providers of services and suppliers
  - ✓ Establishing **community-based health teams** to support chronic care management
  - ✓ Promoting **improved quality and reduced cost** by developing a collaborative of institutions that support practice transformation

TCP Initiative Framework

- Practice Transformation Networks (PTNs) to provide on the ground support to practices
- Support and Alignment Networks (SANs) to achieve alignment with medical education, maintenance of certification, more
- Alignment with existing work of Quality Improvement Organizations


TCP Initiative Goals
1
• Support more than 150,000 clinicians in their practice transformation work
2
• Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
3
• Reduce unnecessary hospitalizations for 5 million patients
4
• Generate $1 to $4 billion in savings to the federal government and commercial payers
5
• Sustain efficient care delivery by reducing unnecessary testing and procedures
6
• Build the evidence base on practice transformation so that effective solutions can be scaled

TCP Initiative Information

- Transforming Clinical Practice Initiative Website:
  http://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/
- Practice Transformation Network
  http://innovation.cms.gov/Files/x/TCPI-FOA-PTN.pdf
- Support and Alignment Network
  http://innovation.cms.gov/Files/x/TCPI-FOA-SAN.pdf
- Acquisition questions: tcpi@cms.hhs.gov

Questions

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The Office for the Advancement of Telehealth is identifying performance measures to evaluate the efficacy, impact and cost of using telehealth capabilities to deliver emergency medical care to rural communities, including but not limited to, emergency care to stroke victims and other common emergency clinical services. A multiyear telehealth evaluation will identify, pilot test, and then compare several evaluation measures, including-

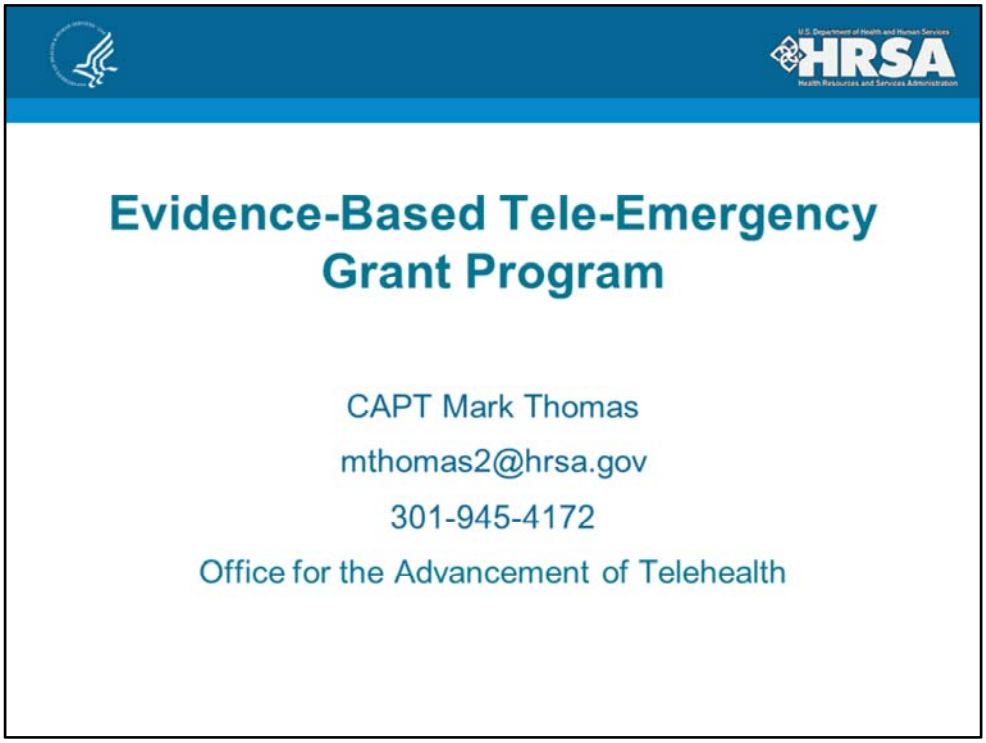
Clinical quality, starting with National Quality Forum (NQF) – approved measures.

The effect on the existing local healthcare delivery system.

The effect on costs to patients.

The effect on costs to public and private payers.

Upon completion of the data collection and study period, ORHP hopes to clarify for stakeholders, including payers, health programs, and patients, the potential (and promising) impact telehealth systems have on increasing access to quality care, anytime, anywhere, for CAHs and isolated community health programs.



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Have a happy…

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