MICHIGAN RURAL HEALTH CLINIC NETWORK INNOVATIVE MODEL

BRINGING PATIENT FOCUSED CARE AND PRACTICE SUSTAINABILITY TOGETHER

MICHIGAN CENTER FOR RURAL HEALTH

Non-Profit State Office of Rural Health

- Board of Directors
- One of Three Independent SORHs

Rural Health Programming

- CAH & RHC Quality Improvement
- Financial and Operation Improvement
- Education (Grand Round Programs/ECHO – CEUs)
- Workforce – Dedicated recruitment and retention
- EMS
- Northern Michigan Opioid Response Consortium

MICHIGAN RURAL HEALTH CLINIC NETWORK

The Michigan Rural Health Clinic Network (MRHCN) is an initiative started in 2011 by dedicated RHCs throughout Michigan and the Michigan Center for Rural Health with a goal to measure and improve the quality of care in Michigan RHCs.

RHC NETWORK HISTORY

RHC Technical Assistance

Quarterly meetings

2011 RHC Survey

Focus on RHC landscape and needs

2011 – Survey inquired about RHC Quality Network that would model the MICAH QN

June 2011

9 participants/20 RHCs

Michigan Peer Review Organization (MPRO)

Yes, they would like to pursue the idea!

September 2017

Formalized the RHC Quality Network,

Elected an Executive Board,

Adopted Bylaws

Added membership Opportunities Changed name to **Michigan Rural Health Clinic Network**

WHAT ARE THE BENEFITS OF A MICHIGAN RURAL HEALTH CLINIC NETWORK

- Representation RHCs in Washington before Congress and federal agencies
- Free POND - Practice Operations National Database and Quality Health Indicators access, providing essential financial and quality benchmarking data.
- Experts available to provide information about policies affecting practice in rural areas
- Networking opportunities with other rural health clinic providers, policy-makers, and representatives from businesses serving rural health clinics
- Timely publication of legislative alert on issues of importance to rural health clinics
- Opportunities to be at the forefront of policy development by serving on the Executive Board
- Exclusive arrangements with businesses that work with RHCS
- Discounted Educational Programs
- FREE Online webinars

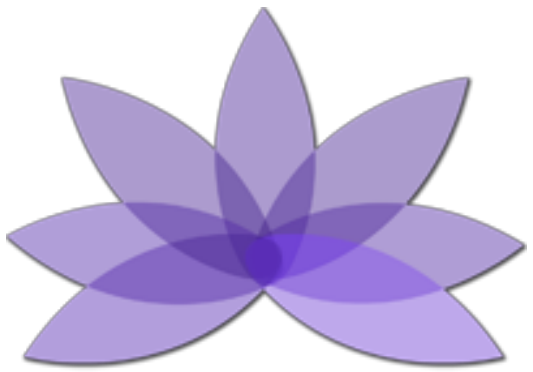
IMPROVING QUALITY REPORTING

Quality Health Indicators is our database software that is used by the clinics to report data and use for benchmarking clinical quality metrics. It allows them to share best practices.

QHI ALLOWS SMALL CLINICS TO:

- Collect, track and trend data unique to their specific environment
- Evaluate current performance every month and integrate successful solutions from other benchmark hospitals and clinics
- Participate in a nationally recognized initiative to demonstrate healthcare quality in rural America

PRACTICE OPERATIONS NATIONAL DATABASE



- POND™ is a unique benchmarking program which focuses on ***rural-relevant financial, operational, productivity and compensation measures***.
- POND™ is available to RHC clinics who have completed the membership application process.
  - Enrollment and webinar training began in February 2018.
- Nationally over 100 clinics.

MCRH'S ROLE

- Technical Assistance & Support
- Network Listserv
- Fund four face-to-face meetings
- Provide Education Sessions
- Practice Manager Workshop
- Billing and Coding Workshop

TAKING IT TO THE NEXT LEVEL

WHAT'S MEANINGFUL TO RHC LEADERS…?

RHC Practice Leaders

- Meeting Conditions of Participation
- Quality Patient Care
- Cost Reporting
- Patient Outcomes
- Policies and Compliance
- Revenue Opportunities
- Efficient Work Flow

MEASURING QUALITY CAN BE COMPLICATED

Does your RHCs experience push back from your providers?

Does limitations of IT/EHR systems prevent clinics from participating with performance incentive?

Is there a lack of RHC staff/resources attributed to focusing on quality improvement/incentives?

CHANGING OUR THOUGHTS ABOUT QUALITY REPORTING

Separate the reporting of "quality" from patient focused care management and practice transformation.

Use quality reporting as a tool to measure success with RHC strategies and goals.

CARE MANAGEMENT BASED PROGRAMS DRIVE IMPROVED PATIENT OUTCOMES AND INCREASES REIMBURSEMENT & INCENTIVES

Care Management Services

- Initial Preventive Physical Examination
- Annual Medicare Wellness Visit
- Managing Chronic Disease via Preventative Medicine
- Chronic Care Management
- Transitional Care Management
- Virtual Communications
- Population Health via Social Determinants of Care

Performance Measures via CPT category II codes

- HEDIS
- PCMH

Advanced Payment Models

- ACO and Shared Savings
- Physician Group Incentive Program
- Value-based Payment Models
- Risk Adjusted Coding
- Medicaid APM
- Clinically Integrated Network

Behavioral Health Integration

- BHI
- Psychiatric Collaborative Care Model (Psych CoCM)
- Substance/Opioid Use Disorder and MAT

RHC'S IMPROVING HEALTH OUTCOMES

Strategy #1 –Drive Effectiveness of Care & Disease Management	• CCM Patients with specific disease states are routinely targeted for intervention. • Create Cohorts for specific disease states • Manage chronic disease via Preventative Medicine
Strategy #2 -Increasing Access to Health Care Services	• Behavioral Health (screenings, BHI) • OUD/SUD Treatment Services
Strategy #3 -Reduce disparities by addressing social determinants of health	• SDoH screenings • Build Community Resources • Utilize CHIR & 211 Services

STRATEGY #1 –DRIVE EFFECTIVENESS OF CARE & DISEASE MANAGEMENT

STRATEGY GROUP #1: Will Drive Effectiveness Of Care & Disease Management In RHCs By Working Together To:

Increase the number of RHCs providing care management services

-Identify barriers associated with not providing CCM and Developing solutions

Improve care management processes

-Mapping workflow processes

-Sharing best practices, tools and resources

Prove the value of care management in primary care

-Creating cohorts and measuring success

MANAGING CHRONIC DISEASE VIA PREVENTATIVE MEDICINE

Annual Physicals

- Adult Wellness Visits
- Well Child Visits
- Medicare Annual Wellness Visits
- Welcome to Medicare Visits

Planned Chronic Condition Visits

- Diabetes
- Hypertension
- Hyperlipidemia
- Obesity
- CHF
- Persistent Asthma/COPD

Transitional Care Management

Chronic Care Management

Closing Gaps in Care

- HEDIS
- Clinical Alerts
- Registries

CHRONIC CARE MANAGEMENT IN PRIMARY CARE

Mapping Workflow Process via Best Practices

Address barriers to providing services

- Training
- Funding

Leverage insurance companies

- To recognize the value of care management;
- provide adequate reimbursement for the services;
- Expand coverage

STRATEGY #1: DRIVE EFFECTIVENESS OF CARE & DISEASE MANAGEMENT

Goal 1: Increase the number of RHCs providing care management services			
Key Action Steps	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**
Add CCM Environmental Scan components to Annual RHC Survey	Baseline information in the following categories: # of RHCs providing care management services # Transitional Care Management Define care teams at the practice level (RN, MA, MSW) Prevention – what screenings are currently used to identify if a patient needing CCM List of commonly used Community Resources	MRHCN Annual Survey	MCRH staff
Survey to be deployed	Survey will be sent out to Michigan RHC listserv	Number of completed surveys returned	MCRH Staff/RHC Administrators
Determine top 3 barriers to providing CCM services	Solutions to share with Mi RHCs Apply for Grants/Resources to assist with RHCs to add CCM to workflow Increase in RHCs proving CCM services	Survey 2021	Strategy Group 1

STRATEGY #1: DRIVE EFFECTIVENESS OF CARE & DISEASE MANAGEMENT

Goal 2: Improve care management processes			
Key Action Steps	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**
Sharing best practices, tools and resources	Michigan RHC Clinic Leaders will have best practices, tools and resources at their disposal	Number of resources in repository	Strategy Group 1
Share Job Descriptions	Michigan RHC Clinic Leaders will have access to robust job descriptions to be utilized in their own practices	Number of resources in repository	
Goal 3: Prove the value of care management in primary care			
Key Action Steps	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**
Determine existing incentives program align and drive change	Increased Revenue	Clinic Self Reporting	Strategy Group 1
How utilize staff to the fullest	Reduce Cost	Clinic Self Reporting	Strategy Group 1

STRATEGY #2 – INCREASE ACCESS TO HEALTHCARE SERVICES

STRATEGY GROUP #2 : This Strategy Group Will Drive Increased Access To Healthcare In RHCs By Working Together To:

- Identify, analyze and implement strategies to increase access to healthcare services available to RHCs
- Determine barriers associated with access to healthcare and determine actions needed to overcome barriers/obstacles
- Share best practices, tools and resources
- Monitor initiatives by utilizing standardized, approved evidence-based guidelines and programs to measure success

BEHAVIORAL & MENTAL HEALTH SERVICES

Depression/Anxiety Age Appropriate Screenings (ages 12 years and older)

Mapping Workflow Process via standard protocol using evidence-based (HEDIS) criteria

- Tools utilized for screening
- To include how to manage the interpreted scores
- Standardized referral process as applicable
- Re-evaluation once diagnosed (follow up criteria)

Leverage local, regional and state programs to help move Behavioral Health Initiatives

Evaluate MSW and roles and responsibilities

SUBSTANCE USE TREATMENT SERVICES

- OUD/SUD Age Appropriate Screenings (look at HEDIS/NQF measures)
- Mapping Workflow Process via standard protocol using evidence-based (HEDIS) criteria
  - Tools utilized for screening
  - To include how to manage the interpreted scores
  - Standardized referral process as applicable
  - Re-evaluation once diagnosed (follow up criteria)
- Look at opportunities to provide OUD/SUD training or education (regional/state)
- Leverage local, regional and state programs to help move OUD/SUD Initiatives
- Address barriers to providing services (lack of providers, training, education)

TELEHEALTH SERVICES

Assess needs- Are these needs aligned with Behavioral Health/OUD/SUD or do we have other areas of focus?

Begin assessing alternative options for areas with Professional Shortages using Telehealth

Identify Programs that serve needs or enhance/support Primary Care Providers:

- RAD-IT
- ECHO
- Contracting with Regional Partners through current initiatives

Explore sustainability via Billing and Coding education then provide training at RHC-QN

- Fee for service vs. FQHC vs. RHC
- SUD/Mental Behavioral Health

MASTER OF SOCIAL WORK / LICENSE MASTER OF SOCIAL WORK

- Determine how many clinic have MSW/LMSW
- How are they being utilized
- Are there collaborative opportunities (university, training opportunities ,etc.)
- What can MSW/LMSW provide clinics
- How can services be billed
- Identify training opportunities to expand current services/expertise
- Collaborate with universities for LLMSWs

STRATEGY #2 – INCREASE ACCESS TO HEALTHCARE SERVICES

Goal 1: Identify, analyze and implement strategies to increase access to healthcare services available to RHCs			
Key Action Steps	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**
Create Behavioral Health Survey to assess % Michigan clinics that provide patients with Integrated Behavioral Health or Behavioral Health Services	Completed Survey that will be ready to deploy to Michigan Clinics	Number of Surveys emailed or sent to RHC Clinics	Strategy Group #3
Survey Michigan RHC ListServ	Survey will be sent out to Michigan RHC listserv	Number of completed surveys returned	MCRH
Tabulate Survey Data (baseline)	Strategy #2 will extract baseline data from surveys that will be used for Behavioral Health Access Initiatives	Survey results will be used to tabulate baseline Behavioral Health Access data	Strategy Group #3 (leads and/or members)
Goal 2: Determine barriers associated with access to healthcare and determine actions needed to overcome barriers/obstacles			
Key Action Steps	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**
Identify top 3 Barriers/Obstacles to providing Behavioral Health Services	Identified common Barriers/Obstacles clinics face when initiating or offering services and develop strategies to assist Michigan RHC's address barriers	Survey-will list data by percent of surveyed related to barrier	Strategy Group #3 assistance of MCRH related to survey distribution

STRATEGY #2 – INCREASE ACCESS TO HEALTHCARE SERVICES

Goal 3: Share best practices, tools and resources			
Key Action Steps	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**
Develop Strategies based on findings from Goal #2	Individual Strategies will be developed to address top 3 barriers to implementing Integrated Behavioral Health	Survey will provide preliminary or baseline data, strategies addressing top 3 barriers with attendance or participation will be tracked.	Strategy Group #3 in coordination with MCRH
Standardize Depression Screening Workflow	Michigan RHC Clinic Leaders will have resources to educate, train, refer and track patients screened for Depression. Improved Depression Screening Scores in Michigan RHC's	NQF0418 Depression Screening and Follow-up Criteria and input into QHIE	Strategy group #3 with assist MCRH
MCRH Behavioral Health Coding and Billing Training	Participants will have increased knowledge and resources to appropriately Code and Bill Behavioral Health Services	Number of participants or Clinics in attendance, survey participants on content of speakers/knowledge gained	MCRH
Academic Detailing (OUD/SUD)	Participants will have completed all requirements of AD training and receive certificate of proficiency	Number of participants who completed training	MCRH, MHA assist Strategy Group #3 Lead
Funding Opportunities	Provide funding opportunities for clinics across Michigan to start up Integrated Behavioral Health, recruit Behavioral Health professionals, provide education or extended learning opportunities to BH professionals	Number of clinics participating in programs	MCRH with assist from Strategy Group #3
Goal 4: Monitor initiatives by utilizing standardized, approved evidence-based guidelines and programs to measure success			
Key Action Steps	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**
Behavioral Health Access	Survey completed by RHC's Pre and Post	Google Survey, Survey Monkey	Strategy Group #3 with assist MCRH
Depression Screening and Follow-Up	NQF0418 Depression Screening and Follow up Pre and Post	RHC's report data to QHIE monthly* or quarterly	MCRH Participants (clinics)
Training, Education	Strategy #2 will improve access to healthcare by providing training and education opportunities in collaboration with MCRH or other partners for targeted initiatives	Track training/education and attendance	Strategy Group #3 with assist from MCRH

STRATEGY # 3 - REDUCE DISPARITIES BY ADDRESSING SOCIAL DETERMINANTS OF HEALTH

STRATEGY GROUP #3 :This Strategy Group Will Increase Efforts To Address SDOH In RHC Settings

Providing assistance in bring screening tools to your practices

Determine barriers associated with to SDOH screenings

Share best practices, tools and resources

SDOH SCREENINGS

What screenings are your practices currently completing for SDOH?

Tools utilized for the screening

Workflow

-Annually vs every visit

-Paper vs electronic

-Follow up criteria

SDOH COMMUNITY RESOURCES

What community resources do you utilize?

What community resources do you find that are lacking or difficult to find?

PCMH Initiative 10.0 – Linkage to Community Services

- 10.5 refers directly to social determinants or health
- Assessment and education process must include intake form or screening tool related to social determinants of health, followed up with conversation in which patients are asked whether they or their family members are aware of or in need of community services

DATA ELEMENTS FOR SDOH COVER A RANGE OF DAILY LIFE BEYOND THE HEALTHCARE DELIVERY SYSTEM

- Employment
- Food insecurity
- Housing
- Financial strain
- Utility needs
- Education
- Social support
- Physical activity
- Mental health
- Substance abuse
- Immigration
- Exposure to violence
- Transportation

https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

EXAMPLE ANALYSIS

PROMEDICA

Social Determinants of Health Screening Summary

Internal Practice Name
Health Specialists of Lenawee

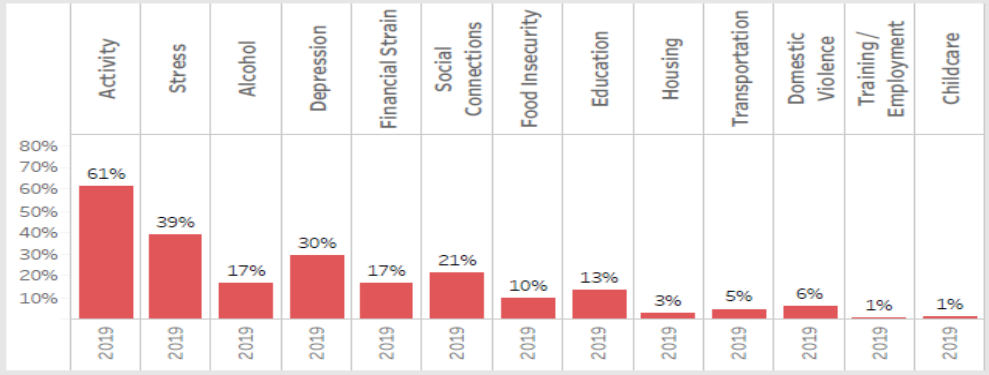
SDOH Surveys between 1/31/2017 and 11/30/2019 — **All Screens**

SDOH Screening Summary

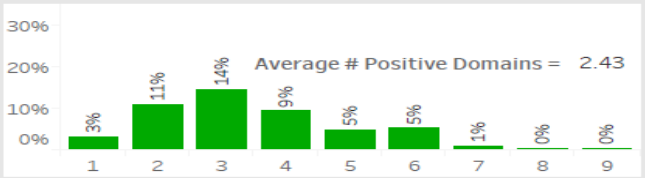
Positive Screens / Patients: Medium or High Total Risk

	2019
Encounters	511
Distinct Patients	499
Declined Screening	47
Agreed to Screen	464
% Agreed to Screen	91%
Positive Screens	227
Positive Distinct Patients	225
% Low Total Risk	38.6%
% Medium Total Risk	32.3%
% High Total Risk	16.6%
% Unknown Total Risk	12.5%
4+ Positive Domains	95.0

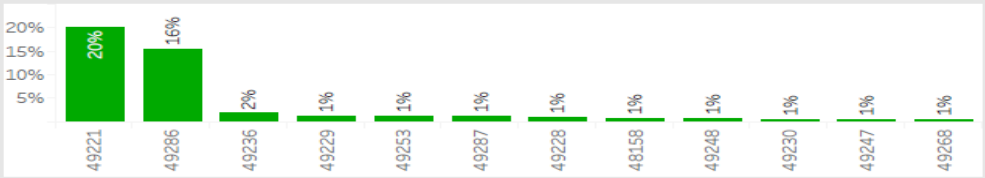
% All Screens at Risk by Domain



At Risk in Multiple Domains



Screens at Risk by Zip Code



Data Sources: Pilot Data from 1/31/2017 - 7/31/2017; Wellopp Data from 8/1/2017 - 8/1/2019; Epic Normalized Survey Data from 5/31/2019 +

Notes: This report uses the Screen Date and not the Encounter Date for the date range of the report. Also, Total Risk within Epic excludes Activity, Alcohol, Stress, and Education when calculating the medium and high risk levels. Total Risk within Wellopp excludes only Activity, Alcohol, and Stress (3 new domains in Epic.)
The Depression screen changed from PHQ2 to PHQ8 on 10/12/2018, resulting in a decrease in the high risk Depression scores after this date.
The Social Connections scoring logic changed with the implementation of Epic in June 2019, which resulted in higher social isolation risk.

STRATEGY #3 – REDUCE DISPARITIES BY ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Goal 1: Increase the number of practices using SDOH screening tools			
Key Action Steps	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**
Create Survey to determine % of MI RHC's that screen patients for SDOH	Completed survey that will be ready to be deployed to RHC ListServ	Number of surveys sent or emailed to RHC's	Strategy Group #3 to develop survey
Survey Michigan RHC ListServ	Survey will be sent out to RHC Listserv	Number of surveys returned	MCRH to assist with distribution of survey
Tabulate Survey Data (baseline)	Strategy #3 will extract baseline data from surveys that will be used to show improvement in SDOH Screening post initiatives	Survey results will be used to tabulate baseline SDOH screening across MI RHC	Strategy Group #3 to tabulate/present data
Identify SDOH screening tools that support best practices and standardize scoring	Strategy #3 will identify screening tools	Screening tools will be identified	Strategy #3 leads and group partners
Identify opportunities to fund SDOH screening across Michigan (or regional areas)	Secured funding to implement statewide SDOH screening	Number of clinics with newly implemented SDOH Screening	Strategy #3 and MCRH assist
Identify reporting platforms to upload or enter SDOH data	Secure platform to track and trend local, regional and statewide SDOH impact	Data abstracted from SDOH tracking tool	Strategy #3 and MCRH assist (may be in conjunction with SDOH Screening tool)

STRATEGY #3 – REDUCE DISPARITIES BY ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Goal 2: Determine barriers associated with to SDOH screenings			
Key Action Steps	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**
Identify top 3 barriers to SDOH Screening	Strategy Group #3 will identify and share with RHC QN Top 3 barriers to SDOH screening	Surveys deployed on October 1, 2020 and returned by and tabulated by December 1, 2020	Strategy #3 lead & group partners
Identify Interventions related to Barriers and share with RHC-QN	Opportunities will be identified and shared with RHC-QN to remove barriers of performing SDOH Screening		
Goal 3: Share best practices, tools and resources			
Key Action Steps	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**
Provide education session related to SDOH screening, implementation and best practice in clinics to the RHC QN	Increased screening of SDOH in MI Clinics	Number of clinics attending training/education that report implementing SDOH post education	Strategy #3
Bring expert presenter/peer professional to speak to SDOH and impact on health and well being	Increased awareness of SDOH on health outcomes	Number of participants in attendance	Strategy #3 with assistance of MCRH