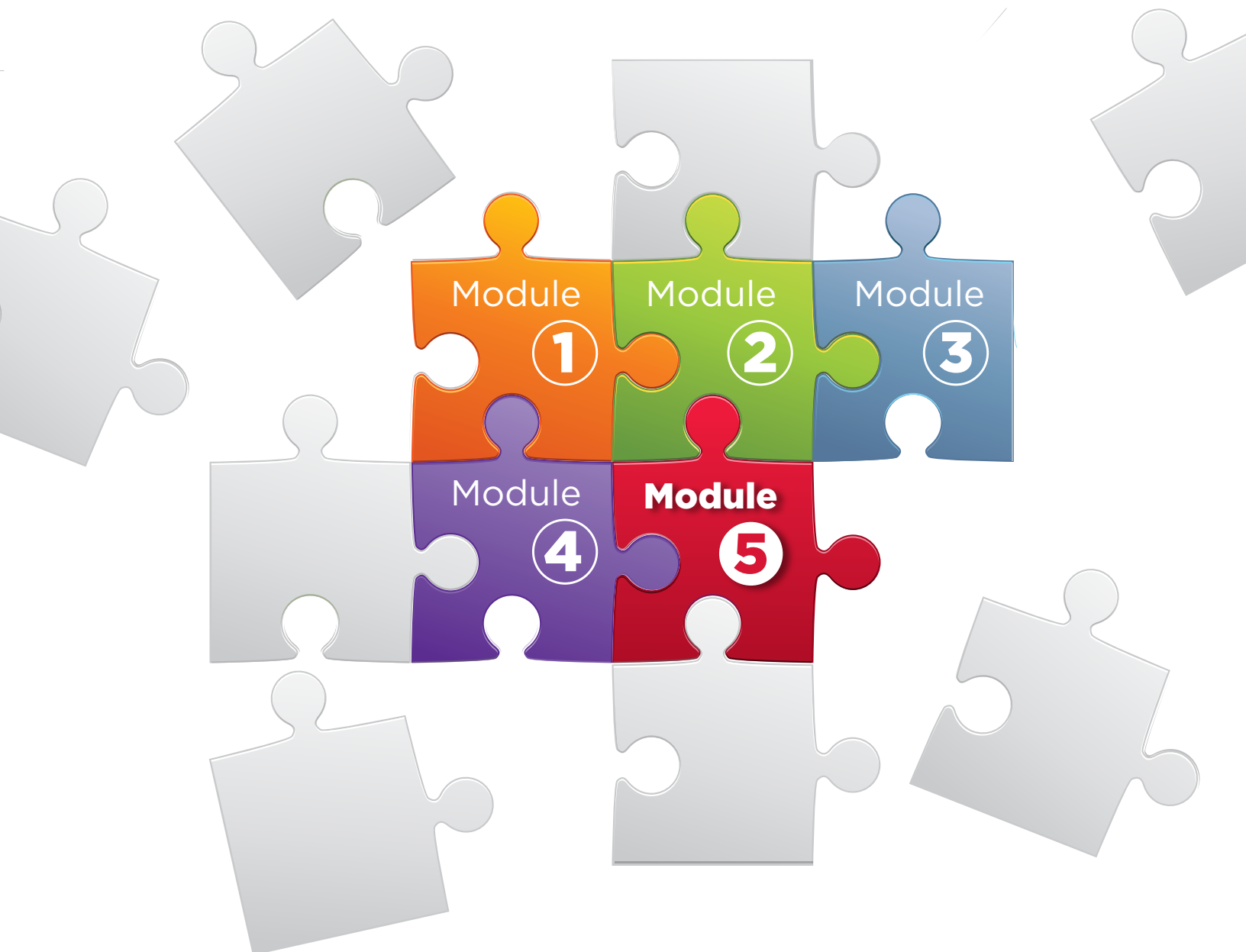




# Module 5

## RHC Performance Measurement and Quality Improvement

Rural Health Clinic Technical Assistance  
Educational Series



# MODULE 5

## RHC Performance Measurement and Quality Improvement



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This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under Cooperative Agreement #U14RH19776 State Offices of Rural Health Coordination and Development Program (SORHCDP) \$750,000.

This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.



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## MODULE 4

# Helping RHCs Work Effectively with Other Key Rural Health Providers



### Target Audience and Objectives

This module is designed for State Office of Rural Health (SORH) staff with experience and interest in working with Rural Health Clinics (RHCs) in the areas of program evaluation, quality improvement, quality assurance, and performance improvement. Objectives for this module include:

1. Review current RHC requirements from the RHC Conditions of Participation related to performance measurement and quality improvement.
2. Review the history of CMS proposed revisions to the RHC regulations intended to transition from general program evaluation function to QAPI function.
3. Learn about the survey and certification process for RHCs and the option of utilizing deeming entities to conduct the initial survey.
4. Learn about the national RHC Quality Project, currently underway to develop quality measures for RHC reporting.
5. Understand the relationship between quality and payment for primary care providers and gain an understanding of the national initiatives currently in place and how they impact RHCs.
6. Identify activities for SORH to consider in supporting RHCs with developing and administering the program evaluation and other performance measurement and quality improvement programs.

### Introduction

In an effort to support SORH in working with RHCs, the NOSORH RHC Committee has produced learning modules on topics relevant to providing technical assistance services. The RHC Committee is now the Primary Care Committee. This is the fifth module in the series, and the focus is on evaluating performance and quality in the RHC setting. There are multiple interchangeable terms that may be used to refer to efforts to improve clinical and non-clinical outcomes in a healthcare facility, such as quality improvement, Continuous Quality Improvement (CQI), quality assessment, quality assurance, and performance improvement. Regardless of the particular term or phrase utilized, in today's environment, primary care practices must engage in quality-related activities to achieve the Triple Aim: 1) Improve the health of the population; 2) Enhance patient experiences and outcomes; and 3) Reduce the cost of care. RHCs are not exempt from the impact of national efforts to create a high value healthcare system, even though the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation for RHCs do not currently reflect the principles of the Triple Aim.

Primary care practices of all sizes and geographies across the US are faced with adapting to new initiatives that incentivize providers, through public reporting, financial reward, or penalties to demonstrate performance based on measurable indicators. Examples include Accountable Care Organizations, pay-for-performance programs, public reporting, and practice transformation. In many instances, the measures may not seem relevant to RHCs due to low volume, the current RHC payment methodology, and the fact that historically, CMS quality initiatives have excluded rural providers. However, in 2014 the US Department of Health & Human Services commissioned the



National Quality Forum to identify performance measurement challenges for rural providers. The [report](#), released in September 2015, recommends making participation in CMS quality measurement and quality improvement programs mandatory for all rural providers by allowing a phased approach and developing rural-relevant measures.

This module provides a summary of the current requirements for RHCs related to quality, a brief history of the efforts to revise the requirements, and a glimpse into the future as RHCs prepare to engage in incentive programs such as pay-for-performance. In addition, recommendations are included as a guide for SORH staff in the types of technical assistance and support they might consider providing to RHCs in quality and performance improvement, as well as examples of tools, resources, and promising practices from SORH engaged in these efforts.

## Current Requirements

To become certified by CMS as a Rural Health Clinic, clinics must meet certain requirements. The federal requirements (Conditions of Participation) are outlined in [Appendix G of the Medicare State Operations Manual](#). The RHC Conditions of Participation (CoPs) include requirements related to the location of the clinic; physical plant and environment; organizational structure; staffing; provision of services; patient health records; and the quality component: program evaluation. All RHCs must comply with the federally mandated CMS requirements. In addition, there may be state-specific requirements only applicable to RHCs in a particular state. For example, in Montana, RHCs are required to submit a copy of the Policy & Procedure Manual to the state for review. Four states (California, Louisiana, Nevada, and Washington) require licensure/certification for phlebotomists to draw blood, which is neither a CMS requirement nor the common national standard.

Clinics converting to RHC status are subject to survey and certification. CMS delegates the survey responsibility to the state survey agency (in most cases the state department of health), or clinics may

### SORH TA:

**Learn about regulatory requirements unique to your state and provide education to RHCs.**

undergo a survey conducted by an accreditation organization, a national accreditation body having applied to CMS and demonstrated the ability to meet or exceed the RHC Conditions of Participation. Two accreditation organizations or “deeming entities” have been approved by CMS to survey and accredit RHCs: The American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF) and The Compliance Team. The RHC regulations are subject to interpretation; therefore, compliance expectations may vary based on the background and expertise of the surveyor. The standards and measures of the deeming entities must include, at a minimum, the requirements of the CMS Conditions of Participation, but may include more stringent requirements as well.

It is important to note that surveys for initial certification of new RHCs are classified as “Tier IV”

### SORH TA:

**Find out the process for RHC survey in your state. Are surveys conducted by the state survey agency? Deeming entities? Or both? How much are the fees? Assist RHCs in pursuing survey & certification. Find your CMS regional contact [here](#).**



on the CMS Survey and Certification Budget Call Letter outlining survey priorities for state survey agencies. This means that RHC surveys are not a top priority. Some states no longer complete initial RHC surveys and in these states, clinics are required to utilize one of the deeming entities. In some states utilization of a deeming entity is not required but is recommended due to the lengthy wait times for RHC surveys. For clinics already certified as RHCs, the state survey agency will continue to be responsible for recertification surveys, which occur sporadically and are always unannounced. Both deeming entities (and some state survey agencies) charge fees for the RHC survey process.

## CMS Quality Requirements:

The current CMS Conditions of Participation require RHCs to conduct a biennial program evaluation. This is the only requirement related to performance measurement and quality improvement and is the minimum standard. RHCs may, and are encouraged to, implement a more comprehensive quality program.

The biennial program evaluation is an evaluation of the clinic's total operation and utilization. Facilities in operation for one year or more at the time of the initial RHC certification survey will be cited with a deficiency if the program evaluation has not been carried out. Facilities operating less than one year at the time of the initial RHC certification survey must have, at a minimum, a written plan for carrying out the program evaluation. The evaluation may be conducted by the clinic staff or may be outsourced to a professional contractor or consulting group.

According to the CoPs, the program evaluation must include a review of the clinic's utilization, policies and procedures, and clinical records. The purpose of the evaluation is to:

1. Determine if utilization of services is appropriate;
2. Determine if policies and procedures are being followed; and
3. Recommend any necessary changes.

### Sec. 491.11 Program evaluation.

- (a) The clinic or center carries out, or arranges for, a biennial evaluation of its total program.
- (b) The evaluation includes review of:
  - (1) The utilization of clinic or center services, including at least the number of patients served and the volume of services;
  - (2) A representative sample of both active and closed clinical records; and
  - (3) The clinic's or center's health care policies.
- (c) The purpose of the evaluation is to determine whether:
  - (1) The utilization of services was appropriate;
  - (2) The established policies were followed; and
  - (3) Any changes are needed.
- (d) The clinic or center staff considers the findings of the evaluation and takes corrective action if necessary.

A clinic must have a written "Program Evaluation Plan" that identifies who is responsible for ensuring that the plan is completed, what is to be reviewed, and what is to be done with the findings. The full evaluation must be completed every 24 months and must include:

- Review of processes, functions, services, and utilization of clinic services including at least the number of patients served and the volume of services;
- Total Medicare encounters;
- Total Medicaid encounters;
- Total third-party encounters;
- Total self-pay encounters.

A policy and procedure review is required as part of the program evaluation, as well as a chart review of a representative sample of both active and closed clinic records. The clinic must appoint a professional advisory group to participate in the biennial evaluation process.



The following is an excerpt from the [State Operations Manual](#), the manual utilized by state survey agencies as a guideline for interpreting the Conditions of Participation.

### **§491.11 Condition of Coverage: Program Evaluation**

An evaluation of a clinic's total operation including the overall organization, administration, policies and procedures covering personnel, fiscal and patient care areas must be done at least biennially. This evaluation may be done by the clinic, the group of professional personnel required under [42 CFR 491.9\(b\)\(2\)](#) which includes one or more physicians and one or more physician assistants or nurse practitioners, or through arrangement with other appropriate professionals. The surveyor clarifies for the clinic that the State survey does not constitute any part of this program evaluation.

The total evaluation does not have to be done all at once or by the same individuals. It is acceptable to do parts of it throughout the year, and it is not necessary to have all parts of the evaluation done by the same personnel. However, if the evaluation is not done all at once, no more than a year should elapse between evaluating the same parts. For example, a clinic may have its organization, administration, and personnel and fiscal policies evaluated by a health care administrator(s) at the end of each fiscal year; and its utilization of clinic services, clinic records, and health care policies evaluated 6 months later by a group of health care professionals.

If the facility has been in operation for at least a year at the time of the initial survey and has not had an evaluation of its total program, report this as a deficiency. It is incorrect to consider this requirement as not applicable (N/A) in this case.

A facility operating less than a year or in the start-up phase may not have done a program evaluation. However, the clinic should have a written plan that specifies who is to do the evaluation, when and how it is to be done, and what will be covered in the evaluation. What will be covered should be consistent with the requirements of [42 CFR 491.11](#). Record this information under the explanatory statements on the Survey Report Form (SRF).





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## Program Evaluation Committee

The CoPs require that a group of professional personnel carry out the program evaluation. The composition of this group of individuals (sometimes referred to as the “Program Evaluation Committee” or “Professional Advisory Group”) varies from clinic to clinic; however, individuals required by regulation include the Medical Director of the RHC, one or more non-physician providers, and an outside community member not employed by the RHC. While not required, nursing staff should be included as well, if applicable. If the clinic provides behavioral health services, a member of the behavioral health staff should be included. If the RHC is a provider-based entity, various members of the administrative staff of the parent entity may be invited to participate, such as the CEO, CFO, CNO, or CQO (Chief Quality Officer).

As stated above, one member of the committee must be an individual who is not a member of the clinic staff. This individual may be a professional such as a local attorney, city official, pharmacist, clergy, etc., or a patient who uses the clinic’s services. The community member is useful in providing input and perspective from the community. This individual must not receive compensation from the organization.

### SORH TA:

**According to CMS, the Program Evaluation is one of the most commonly cited deficiency areas. Provide training & education for RHCs to improve compliance.**

#### SOURCES:

HRSA, AAAASF, [The Compliance Team](#)

## Quality Requirements Specific to Deeming Entities:

As noted previously, two accrediting organizations have been approved by CMS as deeming entities to survey RHCs: the [American Association for Accreditation of Ambulatory Surgery Facilities, Inc.](#) and [The Compliance Team](#). Each deeming entity is required, at a minimum, to assess compliance based on the requirements of the CMS Conditions of Participation; however, the deeming entities may incorporate more stringent requirements into the survey and accreditation process. The AAAASF quality standards do not differentiate from the CMS CoPs; however, The Compliance Team quality standards for RHCs include the requirement of a written quality improvement plan, a patient satisfaction survey, and measurement and reporting of outcomes measures. The AAAASF standards are accessible [online](#). The Compliance Team standards are available by submitting a request via the organization’s [website](#).

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## The CMS Proposed Rule for QAPI

On February 28, 2000, CMS issued a proposed rule to incorporate revisions to the RHC program requirements, including replacing the biennial program evaluation with a more comprehensive Quality Assessment and Performance Improvement (QAPI) program. The final rule was issued on December 23, 2003; however, during the time between the issuance of the proposed and final rules, a law was enacted requiring that action must be taken on proposed rules within three years of issuance for the rules to become effective. Since more than three years had passed since the proposed rule was issued, CMS withdrew the final rule on September 22, 2006, leaving the program evaluation requirement in place. In announcing the withdrawal of the final rule, CMS indicated the intention to reissue a new proposed rule at some time in the future, however, to date, this has

not occurred. Although it is not required, RHCs may voluntarily implement a QAPI program as outlined in the final rule.

## Summary of the QAPI Final Rule Withdrawn by CMS

*Mandates the establishment of a Quality Assessment and Performance Improvement initiative by RHCs.*

- QAPI initiative must be appropriate to the complexity of the RHC operations, data driven, and focused on improving outcomes in patient safety, quality of care, and patient satisfaction.
- Must include objective measures for at least four organizational processes and clinic utilization.
- For each of the organizational and clinical processes the RHC must:
  - Develop performance measures and outcome measures
  - Use the performance measures to track and analyze performance
  - Set priorities for performance improvement efforts based on high-volume, high-risk services, chronic conditions, patient safety, and patient satisfaction
  - Conduct distinct improvement projects. The number and complexity of improvement projects will depend on the size and resources of the RHC
  - Document the QAPI projects
- An information system designed to support the QAPI effort is suggested and will be considered a QAPI project
- The professional staff, administration, and board are responsible for setting the scope and priorities of the QAPI program.

## The Changing Environment

In an effort to create a high-quality healthcare system in the US, payers, providers, government agencies, delivery systems, and other organizations are developing quality improvement initiatives to improve primary care practice performance. Quality improvement involves continually assessing performance, making changes in areas where opportunities for improvement are identified, monitoring those changes, and refining the process as needed. Historically, these activities have not been incorporated into the primary care practice environment and, as presented in this module, are not mandatory requirements of the RHC program.

To survive and sustain in today's environment, primary care providers, including RHCs, must begin to engage in the challenging task of practice transformation in order to participate in programs based on improving the quality and cost of care. Brief descriptions of examples of some of these types of programs and initiatives and whether or not they currently apply to RHCs are provided below. As noted previously in the introduction on page 4, in many instances, these initiatives may not seem relevant to RHCs; however, it is anticipated that participation in quality measurement and performance improvement programs will become mandatory for all rural

### SORH TA:

**Provide tools and resources to RHCs to assist with meeting the requirements in order to be reimbursed for chronic care management. The case management component may be outsourced to vendors.**





providers through a phased approach and rural-relevant measures. Currently pay-for-performance programs are in place that result in reductions or increases in reimbursement based on performance. By proactively engaging in quality improvement and practice redesign efforts, RHCs can work toward improved quality, better health for the community, improved patient and provider experiences, reduced cost of care, and increased revenue.

**Accountable Care Organizations:** Groups of physicians, hospitals, and other providers, who come together voluntarily to engage in care coordination for Medicare patients. When an ACO succeeds both in improving quality and reducing cost the savings it achieves are shared. ***Since Medicare ACOs are focused on providers reimbursed on the fee-for-service model, RHCs are not eligible to participate. However, there may be local or state-specific ACOs through Medicaid and other payers that might include RHCs.***

**Chronic Care Management Reimbursement:** Beginning January 1, 2016, Medicare began reimbursing RHCs for CPT code 99490 for providing non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions. A patient centered care plan must be in place, as well as case management services and EHR technology. Detailed information on all currently allowable care management services are provided by [CMS](#). (Scroll down to RHC — Chronic Care Management section.) This applies to all RHCs.

**Hospital Outpatient Quality Reporting (OQR) Program:** Requires hospitals to submit data on the quality of care furnished in outpatient settings. Hospitals receive a 2% reduction in their annual payment update under the Outpatient Prospective Payment System (OPPS) if they do not comply. ***This impacts some provider-based RHCs.***

**Medicare Access & CHIP Reauthorization Act of 2015 (MACRA):** Combines three existing programs— the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBM), and Meaningful Use, along with a new program—

clinical practice improvement activities, into a single program, the Merit-Based Incentive Payment System (MIPS). ***This value-based payment program will most likely be applicable only to fee-for-service Medicare providers, but rule making is still underway so it is unclear whether or not it will impact RHCs.***

**Medicare and Medicaid EHR Incentive “Meaningful Use” Program:** Provides incentives to eligible health professionals and hospitals as they adopt, upgrade, or demonstrate meaningful use of certified EHR technology and meet certain criteria. Beginning in 2015, eligible providers that had not attested to meaningful use for 2014 experienced a 1% penalty in Medicare reimbursement. The penalties will increase to 2% in 2016 and 3% in 2017. Providers enrolled in the program must attest by a certain date each year to avoid the penalty. ***RHCs are not eligible for Meaningful Use as facilities; however, some individual RHC providers qualify for, and participate in, the MU program.***

## SORH TA:

**Learn about national quality improvement and pay-for-performance initiatives. Provide educational opportunities for RHCs such as webinars and conference calls. Keep track of the latest developments through NOSORH and NARHC.**

**Patient Centered Medical Home:** A care delivery model using a team-based approach whereby patient treatment is coordinated through the primary care physician to ensure patients receive the necessary care when and where they need it, in a manner they can understand. ***RHCs that become recognized as patient centered medical homes are eligible for incentive programs, demonstration projects, and accreditation.***

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### Value Based Payment Modifier Program:

Provides for differential payments under the Medicare fee schedule to physicians, groups of physicians, and other eligible professionals based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare fee-for-service program. Under the Value Modifier, performance on quality and cost measures can translate into increased payment for high quality, efficient care and decreased payment for low performance. ***This program does not currently impact RHCs.***

### National RHC Quality Project

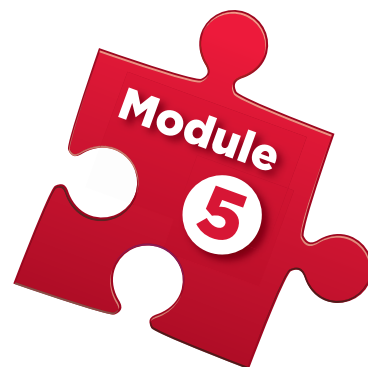
The HRSA Federal Office of Rural Health Policy (FORHP) convened a group of national RHC experts to develop a core set of proposed RHC quality measures. Key stakeholders including SORH staff, state RHC associations, and NARHC were engaged to recruit at least ten RHCs to participate in the project. The goals of the project include:

- **Phase 1** (Completed): Work with a steering committee of RHC and quality experts, with the

RHC cohort, to identify a core set of RHC quality measures meeting the following criteria:

- Prevalence/volume in RHCs
- Internal importance for quality and performance measurement
- External importance for public reporting and payment reform
- Scientifically sound
- Consistent with/comparable to existing national measure sets
- Allow comparison with primary care provider organizations
- Actionable and feasible for RHCs

- **Phase 2** (Current): RHC Cohort will pilot test, evaluate, and refine the measures. Sixty RHCs are participating from six states. Data is submitted to the Quality Health Indicator (QHi) project, a web-based benchmarking program developed in Kansas to provide a mechanism for rural facilities to compare selected quality measures with other similar hospitals and clinics.



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## The RHC Quality Project Measures

### Core Measures — Collected by all participants

- 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 - May be used by participants to best meet their practice needs

- 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: Lipidprofile

- 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

It is widely known that quality reporting and performance improvement will eventually cease to become an option for RHCs - these activities will be a required necessity. This pilot project provides a vehicle to:

- Gain access to quality reporting tools
- Engage a cadre of like-minded RHCs to benchmark performance and learn from one another
- Influence and shape measures to monitor RHC quality performance
- Document and improve clinic performance.

For more information, contact John Gale, Researcher, Maine Rural Health Research Center at [jgale@usm.maine.edu](mailto:jgale@usm.maine.edu).



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## Promising Practices for SORHs in Performance Measurement and Quality Improvement

### Kansas

#### Quality Health Indicator (QHI) Project:

The Quality Health Indicator (QHI) Project is an economical, Web-based quality benchmarking program specifically designed, developed and driven by small rural hospitals and rural health clinics to compare selected quality measures with other similar hospitals and clinics. It was developed through a partnership of the Kansas Rural Health Options Project (KRHOP), Kansas Department of Health and Environment Office of Rural Health (KDHE), Kansas Hospital Association (KHA) and the Kansas Hospital Education and Research Foundation (KHERF). The website is managed by the Kansas Hospital Association. Participating hospitals and clinics benchmark against self-defined peer groups to learn from the best practices of other organizations to adopt new processes in four categories of measures: Clinical Quality, Employee Contribution, Financial Operational and Patient Satisfaction. QHI is currently being used by more than 1200 users in over 270 small rural hospitals and 86 clinics in 16 states: Arizona, California, Colorado, Illinois, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Missouri, Nebraska, New Mexico, Oregon, Washington and Wyoming.

QHI allows small rural hospitals and clinics to:

1. Collect, track and trend data unique to their specific environment;
2. Evaluate current performance every month, set targets for improvement and integrate successful solutions from other benchmark hospitals and clinics;
3. Participate in a nationally recognized initiative to demonstrate healthcare quality in rural America.

QHI was originally developed and continues to be funded by Medicare Rural Hospital Flexibility Program (FLEX) grant funds. QHI operations are maintained by contributions from states and individual hospitals and clinics participating in Partners in Healthcare Quality (PiHQ), a multi-state benchmarking and quality initiatives project.

For additional information, please contact Stu Moore, Program Manager QHI, [smoore@kha-net.org](mailto:smoore@kha-net.org) or Sally Othmer, Senior Director Data and Quality Reporting, [sothmer@kha-net.org](mailto:sothmer@kha-net.org).

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### Michigan

#### RHC Quality Network:

Peer-to-peer sharing is one of the benefits of the Michigan Rural Health Clinic Quality Network (MI RHC QN), sponsored by the Michigan Center for Rural Health (MCRH). What started as a small, informal quality network with only 15 active members in June 2011 has continued to grow and gain enthusiastic members. Today, representatives from over 50 of Michigan's 170 clinics participate in the network and attend its quarterly meetings held in Mt. Pleasant, MI. The quality network is part of the MCRH's recent effort to ramp up their work with RHCs, which also includes a focus on ICD-10 and practice management and engage clinics in collecting a cohesive set of data. This has become increasingly important because payers are providing RHCs incentive payments based on data and because of the implementation of Meaningful Use standards for Medicaid patients. MCRH looked at a core group of RHCs in the quality network and compared what they were doing with various initiatives and came up with a set of Quality Assessment Performance Improvement Measures. The measures include three core measures that network members must collect at minimum—for high blood pressure, tobacco use, and BMI (body mass index). Participation in the RHC quality network and its data collection is voluntary.

For additional information, please contact John Barnas, Executive Director, Michigan Center for Rural Health at [john.barnas@hc.msu.edu](mailto:john.barnas@hc.msu.edu).

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## South Carolina

### Center for Practice Transformation:

The Centers for Medicare & Medicaid Services recently initiated the Transforming Clinical Practice Initiative (TCPI). TCPI includes Practice Transformation Networks (PTNs) that were selected by CMS to work with practices and practice organizations over the next four years in sharing, adapting and furthering comprehensive quality improvement so they are prepared for broad-based payment reform. Three PTNs include South Carolina in their targeted coverage areas. These PTNs will provide different types of practice support to practices participating in their practice transformation networks. Support may include workshops, webinars, resources, population health data tools and consultation.

The South Carolina SORH will provide practice transformation support services, including monthly webinars, online learning and direct in practice consultation and assistance, and will be working collaboratively with the PTNs.

The Center for Practice Transformation (CPT) within the South Carolina SORH helps primary care practices and their providers prepare for changes in health care reimbursement while ensuring optimal health outcomes for patients.

The SCORH CPT team includes experts in the following areas:

- Access to Capital and Grant Funding
- Health Care Payor Organizations including MCOs Meaningful Use
- Medical Home Development
- NCQA PCMH Recognition (Staff include NCQA PCMH Certified Content Experts and an NCQA PCMH)
- Application (Reviewer-in-Training)
- Quality Improvement Techniques and Reporting Provider & Community Engagement
- Rural Health Clinic Billing and Policies & Procedures SC Health Information Exchange On-boarding Telemedicine
- Workforce Management
- Care Coordination (Techniques)
- Care Integration Models including oral Practice Transformation Networks

For additional information, please contact Michele Stanek, Associate Director, Center for Rural and Primary Healthcare at [stanek@scorh.net](mailto:stanek@scorh.net)





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## Program Evaluation and Quality Programs

### How the SORH Can Help:

1. Develop a tool kit of sample Program Evaluation resources. Examples are included in the resource section of this module.
2. Direct RHCs to experts who can assist with developing quality programs and/or consultants who can conduct the annual program evaluation if the clinic wishes to outsource.
3. Provide education and training in the current program evaluation requirements and other performance measurement and quality improvement topics through Webinars and conferences.
4. Collect Frequently Asked Questions related to the program evaluation, and performance measurement and quality improvement and distribute Q&A to RHCs.
5. Share best practices of high performing RHCs with all RHCs in your state.
6. Start an RHC Quality Network to provide a venue for RHCs to collaborate and engage in shared learning.
7. Train staff member(s) in performance measurement and quality improvement to be utilized as a resource to RHCs.
8. Reach out to your state survey agency to learn more about their expectations for the program evaluation component of the CoPs during RHC surveys and educate RHCs.
9. Develop relationships with the deeming entities and promote this option to RHCs.
10. Be proactive in learning about national initiatives such as pay-for-performance, value-based purchasing, and ACOs and share the information with RHCs.
11. Through NOSORH, keep track of the progress of the national RHC Quality Project and distribute the information to RHCs.



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## Resources

### Code of Federal Regulations

<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-491?toc=1>

### RHC Surveyor's Guidance from CMS Manual 100-7, Appendix G

<https://www.cms.gov/files/document/appendix-g-state-operations-manual>

### Final Rule CMS 1910-F

Rural Health Clinics: Amendments to Participation Requirements and Payment Provisions; and Establishment of a Quality Assurance and Performance Improvement Program; Published December 24, 2003 but did not become effective.  
<http://www.gpo.gov/fdsys/pkg/FR-2003-12-24/html/03-31572.htm>

### Medicaid Promoting Interoperability Incentive Program

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms>

### CMS Rural Health Clinics Center

<https://www.cms.gov/center/provider-type/rural-health-clinics-center.html>

### CMS, Rural Health Clinics — Conditions of Coverage and Conditions of Participation:

<https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs>

### Starting a Rural Health Clinic, How to Manual (HRSA FORHP)

<https://www.hrsa.gov/sites/default/files/ruralhealth/pdf/rhcmanual1.pdf>

**CMS QualityNet** A collection of information related to CMS quality improvement efforts for all types of providers, including training programs.  
<https://www.qualitynet.org/>

### CMS Quality Models

<https://innovation.cms.gov/initiatives/#views=models>

### Quality Improvement Organizations (QIO)

The QIO in each state may be able to provide information and resources to assist in the development of a quality improvement program for RHCs.  
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs>

### Quality Incentives for FQHCs, RHCs, and free clinics: A Report to Congress (2012):

<https://www.healthit.gov/sites/default/files/pdf/quality-incentives-final-report-1-23-12.pdf>

### Quality Assessment and Performance Improvement (QAPI) Program:

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapidefinition>

### RHC Accreditation Standards and Checklist, for Accreditation of Rural Health Clinics; American Association for Accreditation of Ambulatory Surgery Facilities, Inc. AAAASF 2014.

<https://www.aaaasf.org/documents/medicare-rural-health?hsLang=en>



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**Rural Health Information Hub,  
Rural Health Clinics:**

<https://www.ruralhealthinfo.org/topics/rural-health-clinics>

**Agency for Healthcare Research and Quality**

Resources for developing QAPI programs and current trends. <http://www.ahrq.gov/qual>

**Institute for Healthcare Improvement** is home to such well known programs as the Triple Aim, the 100,000 Lives Campaign, the 5 Million Lives Campaign, and the Partnership for Patients. This organization provides a host of programs and information to assist with conducting quality improvement and patient safety programs. <http://www.ihl.org>

**The National Quality Forum (NQF)** is a nonprofit organization that operates under a three-part mission to improve the quality of American healthcare by:

- Building consensus on national priorities and goals for performance improvement and working in partnership to achieve them;
- Endorsing national consensus standards for measuring and publicly reporting on performance; and
- Promoting the attainment of national goals through education and outreach programs.

One of the key functions of NQF is to review, approve, and catalog the various quality improvement measures used by CMS and other quality programs. A complete list of measures and their descriptions, as well as additional information on quality improvement, can be found through the following website:

<http://www.qualityforum.org>

**National Committee for Quality Assurance (NCQA) & Patient Centered Medical Home (PCMH)**

<http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx> or [www.ncqa.org](http://www.ncqa.org), a good resource for QI resources.

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## Sample Program Evaluation & Quality Management Worksheets

**1. Healthcare Business Specialists, sample rural health clinic annual evaluation (2010).**

*\*Please note: RHCs are no longer required to perform annual evaluations. RHCs may conduct the evaluation on a biennial schedule.*

<http://www.ruralhealthclinic.com/resources>

<http://www.ruralhealthclinic.com/s/2010-Sample-Annual-Evaluation-Report.pdf>

**2. Sample Evaluation Report from Missouri Department of Health (2012).**

<https://ruralhealthinfocenter.health.mo.gov/wp-content/uploads/health/2012/04/RuralHealthEvaluationReport.pdf>

**4. Example of a Program Evaluation policy developed by RHCs in Virginia.**

<https://nosorh.org/wp-content/uploads/2016/03/Sample-Program-Evaluation.pdf>





## Acronyms

AAAASF	The American Association for Accreditation of Ambulatory Surgery Facilities, Inc
ACO	Accountable Care Organization
AHRQ	Agency for Healthcare Research and Quality
CFR	Code of Federal Regulations
CHIP	Children's health Insurance Program
CMS	Center for Medicare and Medicaid Services
COPs	Conditions of Participation
CPT	Current Procedural Terminology
CQO	Chief Quality Officer
FLEX	Medicare Rural Hospital Flexibility Program
FORHP	Federal Office of Rural Health Policy
FQHC	Federally Qualified Health Center
IHI	Institute for Health Care Improvement
HIT	Health Information Technology
HRSA	Healthcare Resources and Services Administration
MACRA	Medicare Access & CHIP Reauthorization Act of 2015
MIPS	Merit-Based Incentive Payment System
MU	Meaningful Use of Electronic Health Records
NARHC	National Association of Rural Health Clinics
NCQA	National Committee on Quality Assurance
NOSORH	National Organization of State Offices of Rural Health

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## Acronyms (CONTINUED)

NQF	National Quality Forum
ONC	Office of the National Coordinator for Health Information Technology
OPPS	Outpatient Prospective Payment System
OQR	Outpatient Quality Reporting
PCMH	Patient Centered Medical Home
PI	Performance Improvement
PiHQ	Partners in Healthcare Quality
PQRS	Physician Quality Reporting System — System used by Fee For Service physicians to report quality measures
PTN	Practice Transformation Networks
QA	Quality Assurance
QAPI	Quality Assurance Performance Improvement
QHi	Quality Health Improvement
QHN	Quality Health Network
QI	Quality Improvement
QIO	Quality Improvement Organization
RHC	Rural Health Clinic
REC	Regional Extension Center
SORH	State Office of Rural Health
TCPI	Transforming Clinical Practice Initiative
VBP	Value Based Purchasing