

# Nebraska Rural Health Clinics

Performance Improvement and Measurement

**Fall Quality Conference**

November 2022



# Our Agenda

01

## Case Study

Lexington Regional  
Health Center

02

## RHCs

Relevance and  
strategic  
importance

03

## Nebraska

State and national  
performance  
benchmarks

04

## Measures

Making sense of the  
Tower of Babel

# **RHC Case Study**

Lexington Regional Health Center

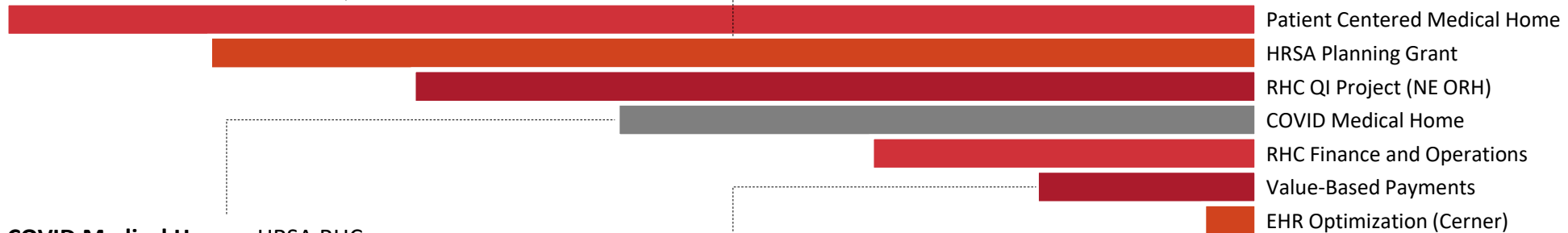
# Bringing It All Together

**Patient Centered Medical Home:** PCMH provides the platform and core operational standards as well as credibility for future VBP activities

**HRSA Planning Grant:** Enabled our team to focus on specific measures

2019

2023+

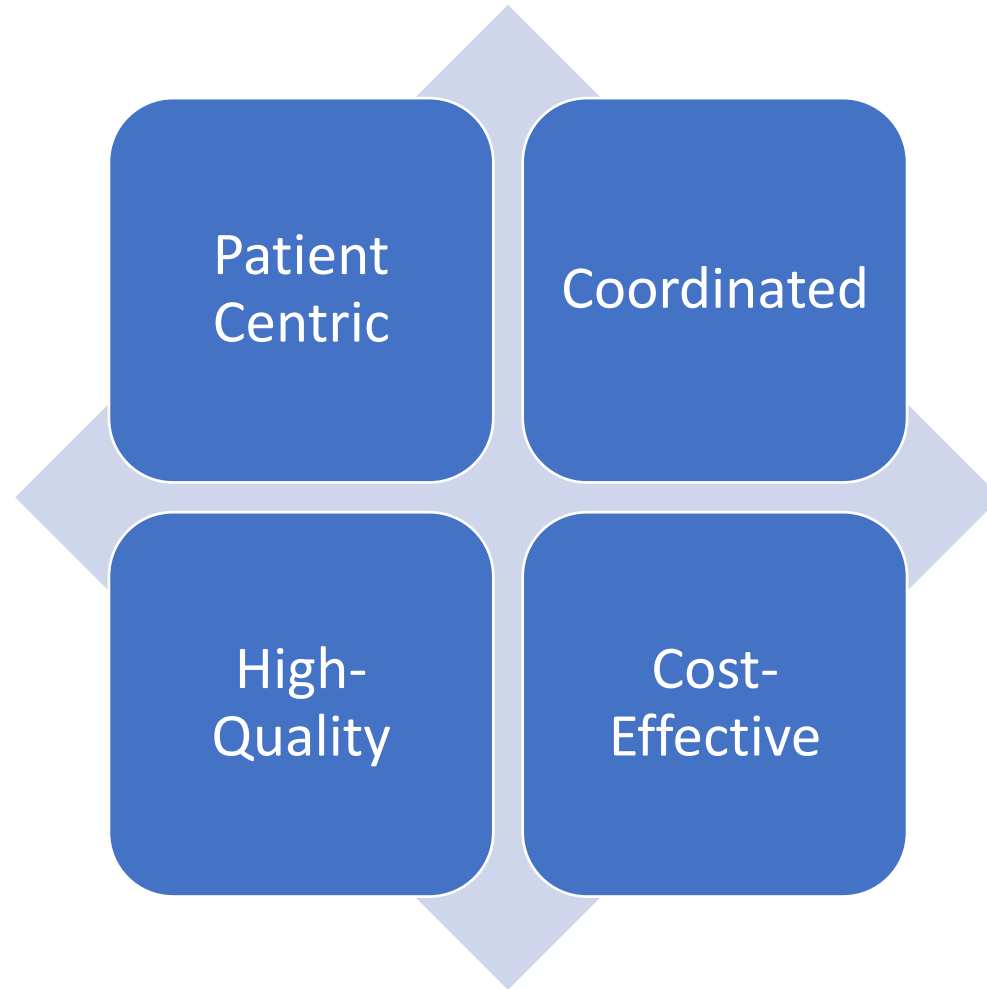


**COVID Medical Home:** HRSA RHC Confidence grant-funded expansion of core PCMH model

**VBP Participation:** Leverage investments in RHC performance to engage private and public third-party payers

**EHR Optimization:** Utilize CDC grant to automate analytics related to COVID-focused, population-based outreach, prevention and treatment

# Patient Centered Medical Home



# RHC QI Project (PDSA)

Technical assistance

Data collection

Cohort sessions

LRHC chose to work on documentation of home medications



Results: Increased documentation to 94%

# Emerging Infectious Disease Medical Home

The Compliance Team's on-going EID Certification addresses:

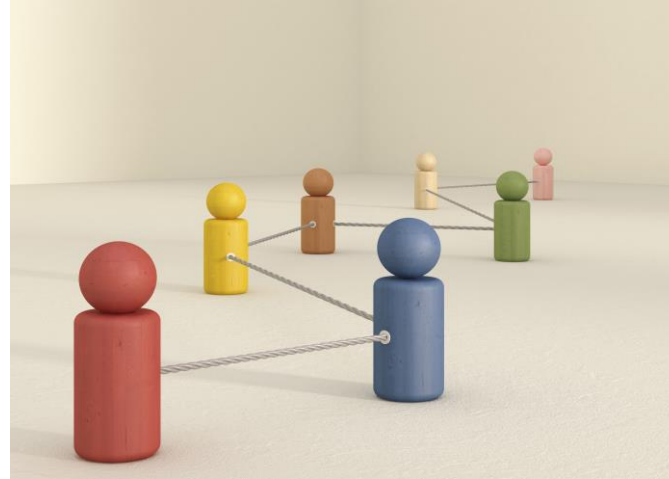
- Safe Working Environment/Infection Control/Risk Exposure
- EID Testing and Management of Equipment
- EID Vaccination for Adult and Pediatric Population
- Vaccine Storage and Handling
- Community Mitigation
- Telehealth Services



# Value-Based Payments



EHR integration



Create a portfolio of  
performance data



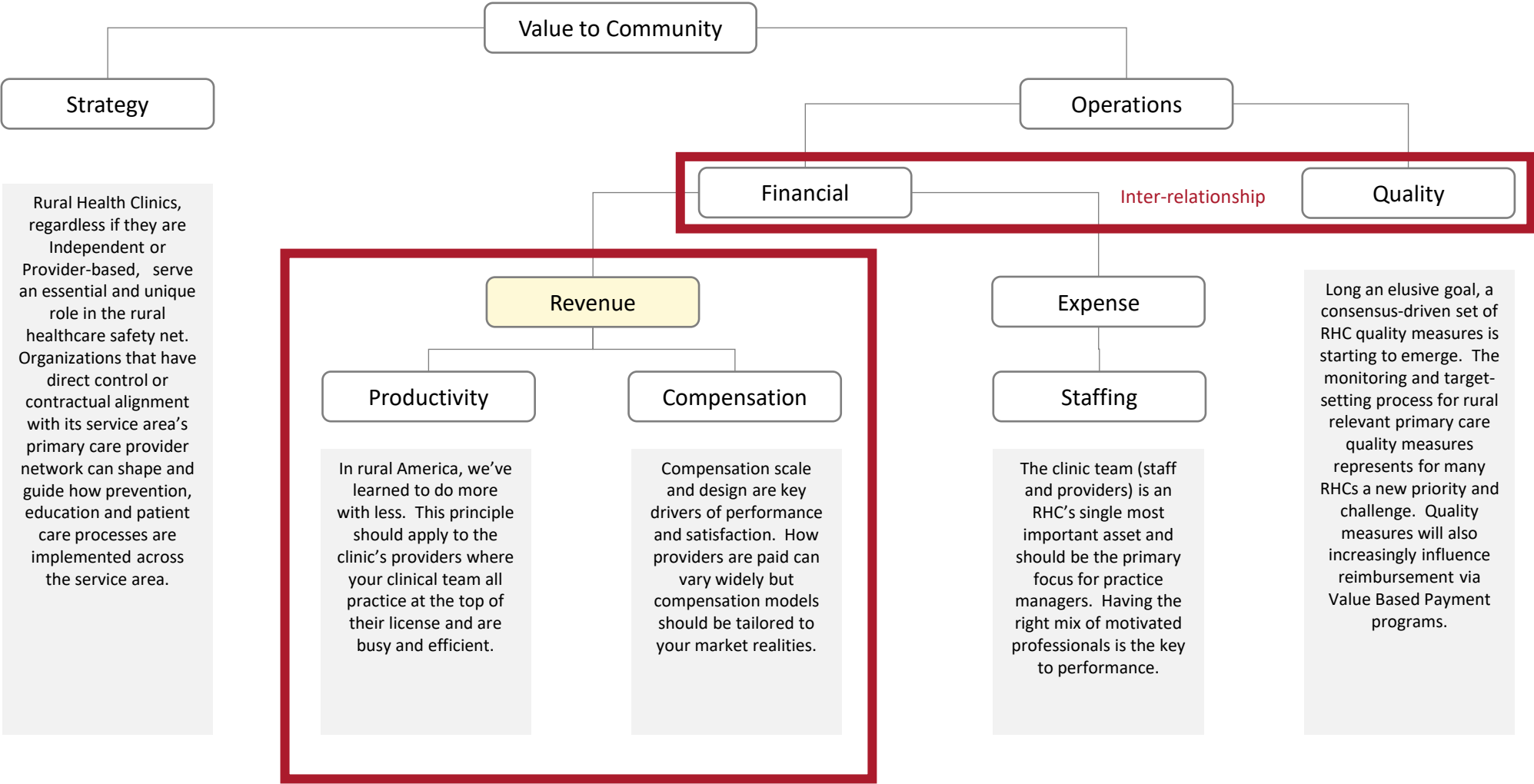
Increased reimbursements  
with lower cost for our  
community



# Rural Health Clinics

Relevance and Strategic Importance

# RHC Performance Model



Ramifications of the RHC Modernization Act

# Nebraska

State and national performance benchmarks

# Nebraska RHC Scorecard

## 2021 Lilypad Cost Report Scorecard

### State of Nebraska

#### Summary Statistics

Unique RHC Sites (CMS POS)	
Completed Cost Reports / Incomplete	
RHCs Meeting Min Productivity	
% Meeting Min Productivity	

State of Nebraska		
PB-RHC	IND/HOFB	TOTAL
126	12	138
82 / 37	2 / 0	84 / 37
55	1	56
67.1%	50%	66.7%

NOSORH Region C		
PB-RHC	IND/HOFB	TOTAL
2748	632	3,380
599 / 181	129 / 22	728 / 203
429	77	506
71.6%	59.7%	69.5%

Total Visits	
Total Adjusted Visits	
Variance	
Cost per Visit	
Cost per Adjusted Visit	
Variance	
Medicare Visits	

476,174	5,045	481,219
483,050	7,311	490,361
(6,876)	(2,266)	(9,142)
\$294.10	\$188.56	\$292.99
\$289.91	\$130.12	\$287.53
\$4.19	\$58.44	\$5.46
103,689	1,018	104,707

6,162,540	1,653,554	7,816,094
6,434,098	1,804,522	8,238,620
(271,558)	(150,968)	(422,526)
\$286.29	\$187.58	\$265.40
\$274.20	\$171.88	\$251.79
\$12.08	\$15.69	\$13.61
1,017,181	251,576	1,268,757

\$39,531,415

COST

for Medicare Patients

\$39,497,511

REIMBURSEMENT

for Medicare Patients

\$33,904

LOSS

in Medicare Reimbursements

#### Visit and Cost Metrics (Actual)

Physician Visits per FTE Physician	
Physician Cost per Physician Visit	
APP Visits per FTE APP	
APP Cost per APP Visit	
Leverage Coefficient Delta (3.0)	
PCP Visits per PCP FTE	
Cost per PCP FTE	

State of Nebraska		
PB-RHC	IND	TOTAL
3,255	2,776	3,247
\$140.11	\$43.96	\$138.65
2,287	1,670	2,282
\$76.65	\$85.52	\$77.00
1.881	2.441	1.891
2,744	2,380	2,739
\$875.365	\$448,723	\$869,786

NOSORH Region C		
PB-RHC	IND	TOTAL
3,493	3,645	3,523
\$133.52	\$97.37	\$126.10
2,587	2,780	2,629
\$66.51	\$51.97	\$63.14
1.876	1.725	1.846
3,014	3,160	3,045
\$913.104	\$605,486	\$848,638


#### General Metrics (Actual)

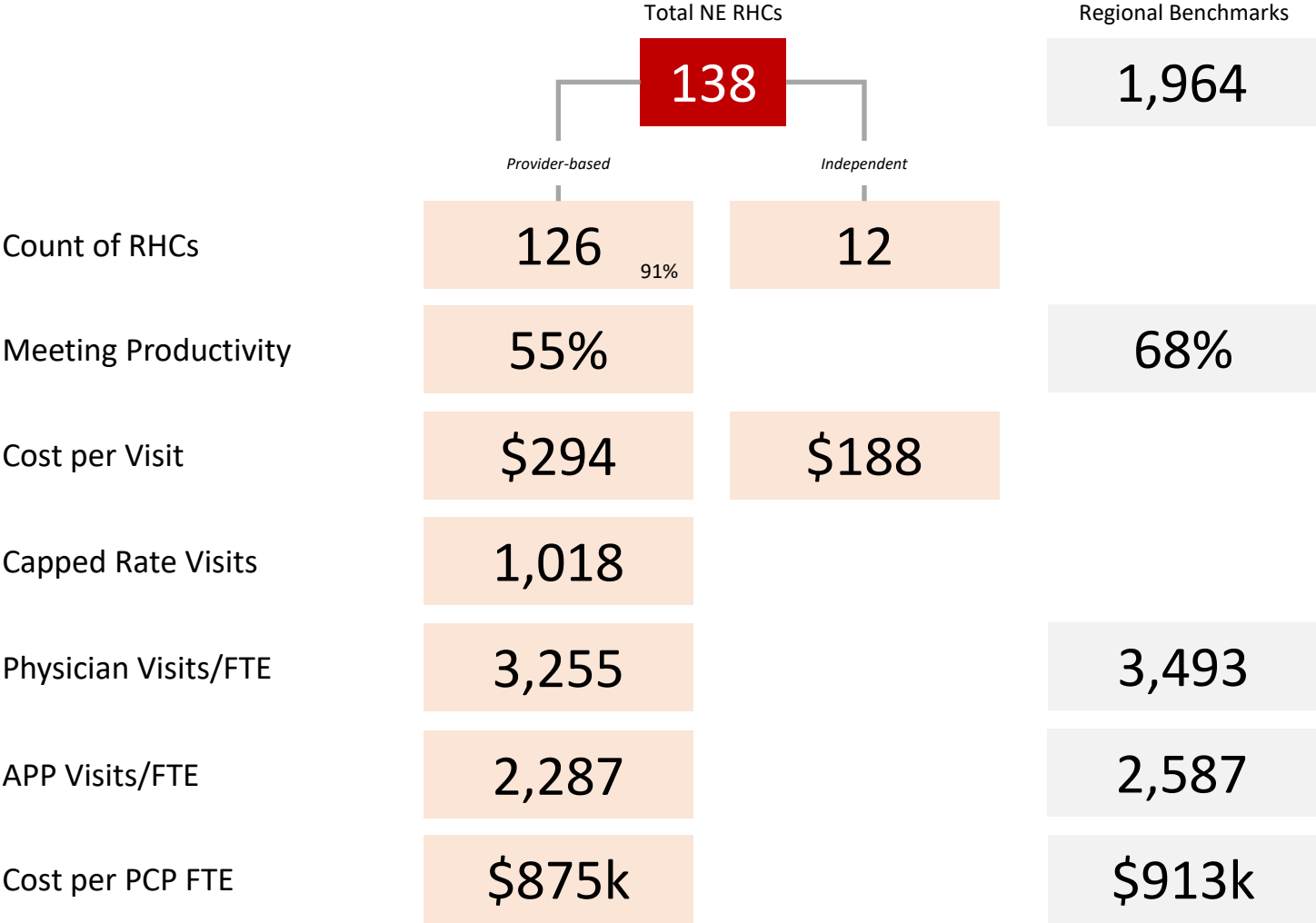
Medicare Percent of Visits	
Total Overhead per Visit	
Total Visits per Vaccination	
Medicare Patients per Vaccination	
Cost per Vaccine Injection	

21.8%	20.2%	21.8%
\$28.72	\$78.98	\$29.34
9.9	8.4	9.9
2.3	1.5	2.3
\$125.38	\$92.55	\$124.97

16.5%	15.2%	16.2%
\$29.26	\$61.26	\$36.24
13.8	16.1	14.2
2.7	3.2	2.8
\$141.11	\$119.69	\$137.11

Produced exclusively for Gregory Wolf on Saturday, May 21, 2022  
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 Lilypad<sup>SM</sup>



# Measures

Making sense of the Tower of Babel

# Why Quality Measurement is Important

- Research demonstrates that health care frequently fails to meet the current standards of quality care
- Errors, suboptimal management of disease, and overutilization/underutilization of services occur when evidence-based health care is not provided
- The consequences include higher mortality, increased morbidity, decreased quality of life, higher costs of care
- Low-quality care and inconsistencies in quality are linked to health care disparities
- Failure to measure quality suggest that the extent of these issues are not understood at the practice-level
- Quality measurement accelerates internal clinical improvement

# Hierarchy of Quality Measures (QM)

- Structural measures
  - The foundation of QM - evaluates infrastructure/capacity of health care organizations to provide care (e.g., equipment, personnel, or policies)
  - Examples - % of providers using an electronic health record, % of diabetics tracked in a patient registry, staff to patient ratio
- Process measures
  - The building blocks of QM that focus on evidence-based steps that should be followed to provide good care
  - When executed well, increases the likelihood of a desired outcome
  - Examples – medication reconciliation, colorectal cancer screening, use of aspirin for patients presenting with ischemic vascular disease

# Hierarchy of Quality Measures (cont.)

- Outcome measures
  - Evaluate/assess the results of care on a patient's health, such as clinical events, recovery, or health status
  - Outcome measures are slots into which process blocks fit
  - Process and outcome measures go hand in hand as improving a process can result in an improved outcome
  - Examples: optimal asthma control, long-term complications of diabetes, controlling high blood pressure
- Composite measures
  - Combines individual measures to produce one result that gives a more complete picture of quality for a specific area or disease
  - Examples – comprehensive diabetes care, substance use screening and intervention, optimal vascular care



# What to Measure?

- Choose measures that:
  - Are relevant to your RHC and the patients you serve
  - Address perceived or known gaps in care
  - Align with practice goals
  - Align with nationals/regional quality initiatives such as MIPS or Medicaid managed care quality reporting requirements
  - Actionable
- Focus on process and outcome measures
  - Evidence-based process measures linked to effective outcomes, are more useful for performance management in primary care
  - Outcome measures are the gold standard
  - For purposes of day-to-day quality measurement and management - focus on process and outcome measures

# Best Practice RHC Quality Measures

The **National Quality Forum** is responsible for coordinating the development and ratification of clinical quality measures. The following five NQF metrics have been identified via research by John Gale from the Maine Rural Health Research Center as the most rural relevant.



**John Gale, Director of Policy Engagement**  
john.gale@maine.edu

NQF 0018

Controlling Blood Pressure

NQF 0028

Preventive Care: Tobacco

NQF 0038

Childhood Immunization

NQF 0059

Diabetes: Hemoglobin A1c

NQF 0419

Current Medications

# **Practice Operations National Database (POND®)**

RHC Reporting and Benchmarking System

# RHC Performance Improvement Network

POND®, Advanced Analytics  
and LAKE®

Focused *Bootcamps* (half-day  
or full-day) on targeted  
operational areas

1. DATA	2. EDUCATION
The first and most durable component is a reporting and benchmarking system. It provides a common set of information to compare performance, identify variances and track improvement over time. Data should be a mix of data from RHCs as well as publicly available data.	Rural healthcare leaders must contend with constantly changing regulations, compliance requirements, billing process and operational demands. The network will help leaders stay current with content and processes they need to be successful.
3. TRAINING	4. ADVISORY
Staff turnover and succession planning make technical assistance and training essential because that is the means through which staff develop and renew skills. The network will provide a syllabus of operational topics including Compliance, Coding, Documentation, Billing, Contracting, Throughput, Registration/Scheduling, etc.	As the network matures or new challenges emerge, it is likely that some providers will require more intensive, customized support. The network can provide access to tailored advisory services such as revenue cycle management, payer contracting, financial management, recruitment, etc.
NETWORKING	
The foundation for an effective RHC network is the ability to create and foster a broad range of relationships, whether peer-to-peer or among different actors such as provider organizations, clinicians, health systems, policy makers, member organizations or state agencies. To achieve this, the most important factors are communication, trust, coordination, and responsiveness.	

Webinars and in-person  
performance improvement  
meetings linked to CAH  
programming

Individualized consulting  
engagements based on  
opportunities gleaned from the  
network activities

**This is where SORHs shine:** Bringing providers together to share information, learn from one another and commit shared resources toward performance improvement

# POND Reports

**2019 POND Summary Report**  
Rural Health Center

Category	Value	Target	Delta
Financial Metrics			
Net Income	\$115,900	\$115,900	\$0
Operating Expenses	\$1,159,000	\$1,159,000	\$0
Productivity Metrics			
Net Patient Visits	479	479	0
Net Patient Visits per FTE	687	687	0

Lilypad's flagship report, the **POND Summary Report** includes RHC-specific financial, staffing, provider compensation, productivity and clinical metrics with customized peer group and national benchmarks.

**2019 Cost Report Scorecard**  
Rural Health Center

Category	Value	Target	Delta
Volume	1,159,000	1,159,000	\$0
Financial	\$115,900	\$115,900	\$0
Cost	\$1,159,000	\$1,159,000	\$0
Staffing	479	479	0

The **Cost Report Scorecard** includes multi-year trended volume, financial, cost and staffing ratios as well as state, regional and national benchmarks from all US RHCs based on current Medicare Cost Reports.

**2019 Site Audit**  
Rural Health Center

Category	Value	Target	Delta
Summary Statistics			
Net Patient Visits	479	479	0
Net Patient Visits per FTE	687	687	0
Medicare Cost Report Integrity Analysis			
Net Income	\$115,900	\$115,900	\$0

The **Site Audit** combines data from multiple public sources to provide summary statistics as well as a proprietary Medicare Cost Report integrity analysis and an evaluation of the out-of-pocket obligations for Medicare patients.

**2019 Award Ranking Report**  
Rural Health Center

Category	Value	Target	Delta
Performance Metrics			
Net Patient Visits	479	479	0
Net Patient Visits per FTE	687	687	0
Medicare Cost Report Integrity Analysis			
Net Income	\$115,900	\$115,900	\$0

The **Lilypad Award Ranking Report** displays your RHC's annual performance in five weighted rural-relevant performance metrics according to the industry's only comprehensive RHC ranking and ratings program.

# POND<sup>®</sup> Technical Assistance

01

## Report

Enter data into POND to generate a set of management and benchmark reports

**Validate your data**

02

## Review

30-60 Zoom session with us to review your POND reports and discuss options

**Go over your reports**

03

## Plan

30-60 Zoom session to answer questions and help identify priorities

**Discuss opportunities**



Lilypad is a Maine-based analytics firm that provides mobile and web-based applications for rural primary care practices. We adhere to a core business principle that accountable physicians/clinical leaders and administrators require sound data and simple, innovative tools to be successful in their roles within the emerging value-based care delivery environment.

**Gregory Wolf, President**  
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