

**Ohio Rural Health Clinic (RHC)
Quality Network Meeting
Aug. 28, 2014
Columbus, Ohio
10:00 a.m. – 3:30 p.m.**

Attendees: Priscilla Davis (JSI), Paddy DiPadova via conference call (JSI), Jennifer Jones (ODH), Amy Justice (Fayette County Memorial Hospital Medical and Surgical Associates), Lea Ayers LaFave (JSI), Tina Turner (ODH), Jaime Parsons (Viola Startzman Clinic), Heather Reed (ODH), Theresa Ulrich (Perry County Family Practice), and Jennifer Williams (FCMH Medical and Surgical Associates).

Meeting Summary: The meeting opened with an overview of the day's agenda and introductions. Lea Ayers LaFave from JSI described the aim for the day to collectively identify priority health issues and select three core measures to improve the health status of Ohio's rural residents.

Dr. LaFave provided an overview of the performance management system framework that incorporates performance standards, performance measurement, quality improvement and reporting progress. Attendees shared related approaches in their respective clinics in areas such as setting goals and communication expectations through regular meetings and the use of white boards. Information on the types of indicators was reviewed, using an example also presented during a 2014 Ohio Rural Health Clinic (RHC) quality network webinar.

Jennifer Jones, SORH Program Coordinator, presented a brief overview of State Office of Rural Health (SORH) activities and support for the RHC quality network project, explaining that the SORH's goals include: providing RHCs and clinics pursuing certification with an opportunity to measure, benchmark and improve the quality of care provided; bringing together and strengthening the RHC community in Ohio; and providing an opportunity for clinics to share experiences and best practices.

Tina Turner, Rural Health Administrator and SORH Director, presented an overview of the Critical Access Hospital (CAHs) Quality Improvement (QI) Network started in 2004 by the SORH's Flex Program, which is a model for the RHC Quality Network. She provided information on Ohio's CAHs, the Flex Program, a timeline describing how the CAH QI Work Group developed and grew in numbers over time, the measures identified for benchmarking and the project objectives.

Priscilla Davis from JSI presented an overview of findings from the landscape assessment conducted by JSI. The assessment included key informant interviews, a statewide survey of RHCs and clinics interested in or pursuing certification, and a review of state and regional needs assessments, reports and health data.

Using a list of various health issues identified through the assessment process, a vote was taken among the clinic representatives to identify priority health issues. The top five issues identified were diabetes, hypertension, asthma/COPD, oral health and access to care. Each of these issues was further discussed using a prioritization matrix to consider six areas: the severity of health consequences, the number of people impacted, the disproportionate adverse impacts, the economic/social cost, the impact on

multiple issues and the feasibility (to impact). Weights were applied for each of the six areas and total scores calculated.

Results of the prioritization process were discussed by the group. Access to care received the highest total score, and the group recognized the issue as important. Given the complexity and number of factors involved with the issue, the group decided to potentially imbed access to care considerations into a clinical measure (similar to a controlled blood pressure measure example presented by Dr. LaFave, which included number of days to appointment from date of request). The issue of diabetes received the second highest overall score.

The group referenced a list of measures used for the PCMH Pilot Project in Ohio provided by ODH, as well as a crosswalk of quality measures by domain of care for PQRS and Meaningful Use provided by JSI, and decided to select measures participants are already gathering.

Clinic representatives then unanimously decided on the following three indicators:

- NQF 0059 - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- NQF 0061 - Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)
- NQF 0064 - Comprehensive Diabetes Care: LDL-C Control <100 mg/dL

Next Steps

- Recruiting additional clinics for future meetings is important.
- A meeting summary will be developed and shared with the RHC contact list.
- The Ohio SORH suggested possible development of an Ohio RHC Quality Network listserv for sharing communications, though this will need to be explored further.
- Additional next steps include identifying a format for reporting and system or method for benchmarking. Establishing deadlines for regular reporting was suggested to provide structure.
- Training or education to ensure a standard process of reporting/documentation and understanding of the criteria was also suggested.