

**Health Reform: Quality Workgroup**  
**Wednesday, December 8, 2010**  
**North Carolina Institute of Medicine, Morrisville**  
**9:00am – 12:00pm**  
**Meeting Summary**

**Attendees:**

*Workgroup Members:* Samuel Cykert (co-chair), Alan Hirsch (co-chair), Lacey Barnes, Shirley Deal, Polly Godwin Welsh, Brad Griffith, Jim Jones, Jill McArdle, Greg Randolph, Samuel Warbuton, Steve Wegner, Bill Wilson

*Steering Committee Members:* Ann Lefevbre, Elizabeth Walker-Kasper

*NCIOM Staff:* Kimberly Alexander-Bratcher, Sharon Schiro, Rachel Williams

*Other Interested Persons:* David Atkinson, Joanne Campione, Larry Fox, Tracy Linton, Melanie Phelps, Renae Stafford

**Welcome and Introductions**

*Samuel Cykert, MD, Associate Director, Medical Education and Quality Improvement, North Carolina AHEC Program, Co-chair*

*Alan Hirsch, JD, Executive Director, NC Healthcare Quality Alliance, Co-chair*

Dr. Cykert welcomed everyone to the meeting and asked everyone to introduce themselves.

**Gap Analysis Review**

*Samuel Cykert, MD, Co-chair*

*Alan Hirsch, JD, Co-chair*

Dr. Cykert led the workgroup in a review of the draft recommendations created by the gap analysis subcommittee. Each provision assigned to the workgroup was analyzed and current initiatives in North Carolina that address each provision were identified. The subcommittee also suggested who the responsible party should be for each of the provisions and identified areas in which legislation could be helpful. A summary of the gap analysis can be found here: [Quality Gap Analysis—Summary and Recommendations](#).

Selected questions and comments:

- Sections 3014, 10305: Public availability of quality and efficiency measures

- Q: How will the system adjust for attribution bias (i.e. if a patient is seeing more than one doctor for one condition)? A: These issues have not been worked out yet. What we do know is that a website will have quality measures based on provider data. It may come down to having multiple reports.
- Section 10331: Physician compare website—public reporting of physician quality data
  - Q: How do you educate the public on interpreting quality data? A: We should look at other physician-compare models to see what has worked and what hasn't worked. We need to educate ourselves on what a physician-compare is going to look like before we educate the public.
- Section 2701: Standardized reporting format
  - The gap here falls primarily with the education of providers. Practitioners are not convinced that quality measures will be a part of their practice in the future but they will be.
    - Connecting the quality measure to long-term outcomes helps providers realize their importance and accept the measures more easily.
  - As far as suggesting measures to the federal government, I don't think North Carolina should try to reinvent the wheel. We should use measures already set up by other groups who already have quality measures in place (i.e. HEDIS).
- Section 3013: Quality measure development
  - The HIE Challenge Program will provide grants to states to fund technology and pilot programs in five challenge areas: achieve health goals through health information exchange; improve long-term and post-acute care transitions; enable patients to have access to their own health information; develop tools and approaches to search for and share granular patient data for a given time period; and, foster strategies for population-level analysis. North Carolina will apply for grants in two areas.
- Section 3025: Hospital readmission reduction program
  - We need better real-time data because a lot of times patients are readmitted to the hospital without the doctors knowing they were admitted for a first time. Also, we need a way of identifying impactable admissions vs. unavoidable admissions (i.e. chemotherapy treatment or HIV treatment). There is a behavioral component to readmissions that needs to be identifiable, too. This is an area that needs a lot of attention and a lot of work.
    - Medication management comes up a lot with impactable readmissions since there is not good communication between hospitals, nursing homes, etc.
    - Many nursing homes send patients to the hospital for admission as a liability issue. There should be some legal protection for nursing homes that act in the best interest of the patient rather than just sending people to the hospital.

## **Next Steps**

Some things the workgroup would like to discuss during the next meeting are reports from the legislation subcommittee, the education subcommittee, and a new transitional care subcommittee; models that could be used to educate providers; and what other quality initiatives exist that the group could use as a model.

## **Public Comment Period**

No further public comments were given.