

Health Reform: Safety Net Workgroup
Wednesday, September 17, 2010
North Carolina Institute of Medicine, Morrisville
9:00 – 12:00
Meeting Summary

Welcome and Introductions

Samuel Cykert, MD, Associate Director, Medical Education and Quality Improvement North Carolina AHEC Program

Alan Hirsch, JD, Executive Director, NC Healthcare Quality Alliance

Mr Cykert and Mr. Hirsch welcomed the group and everyone introduced themselves.

Hospital Quality: an Update on Work as it Relates to Health Reform

Paul Wiles, President & CEO, Novant Health, Inc

Mr. Wiles provided an overview of hospital quality efforts and how they relate to and will be affected by the Affordable Care Act (ACA). In NC the NC Center for Quality within the Hospital Association has been working on helping hospitals be as safe as possible. The Center has established a Hospital Compare website. Moving forward it is important to use uniform quality measures to measure and publicly report the data. In addition Novant Health has been a part of the Medicare physician –pay-for- performance trial. It took almost two years for the rules to be determined such that the experiment worked in a payer neutral manner. This highlights the fact that if all the ACA rules must go through the Office of Budget and Management it may take a long time for rules to be finalized and implemented.

In terms of quality measures a key issue is that not all quality metrics correlate with cost savings in the near term. For instance efforts to improve heart disease and diabetes measures are high cost but savings from the impact of these efforts may not yet be evident.

Overall, the hospital industry has some key questions regarding reform. In terms of accountable care organizations (ACOs): are hospitals supposed to be the ACOs or a part of another organization's ACO? What is it about the new ACO efforts that are different? In terms of the exchanges: as they are developed how will they interact with hospitals? How will hospitals interact with exchanges across the region?

This workgroup can contribute by cataloging what quality measures are available, what are groups doing in terms of measuring quality, and identifying what measures the state should focus on. It is important to think about how to get meaningful data out to the public in order to highlight what is done well, in addition to what is done poorly. The three things that need to be done are: 1) figure out what to measure 2) make sure it is collected uniformly and 3) make it available.

Click on the links below to see Mr. Wiles' handouts and slides:

[Hospital Quality Update Presentation](#)

[NC Quality Center Overview](#)
[Summary of Healthcare Reform](#)
[Effect of Reform on Quality](#)
[Reform Implementation Timeline](#)

Questions:

- What should be measured?
 - The hospital association has posted the quality measures that they are confident in.
 - Also, it will be beneficial to look to the various professional groups to find measures that are appropriate for each specialty
- Where was the Pay-for-performance project?
 - The Winston-Salem area, with a majority of the participating population in that metropolitan area?
- Are readmission rates being measured?
 - The Cleveland Clinic recently published an article that highlighted the issue of whether higher readmissions were really a measure of lower quality. The issue is how to view quality improvement efforts. Is it to improve quality in order to improve costs or is it to improve quality for quality's sake. The concern is if the quality measurement methodology moves toward focusing only on costs and that quality is dragged along behind.

Comments:

- There is nuance to the issue of measuring readmission rates. For some diseases a high readmission rate is to be expected while for others readmission rates should be low. On aggregate the measure may not quite catch/measure poor care
- JAMA studied this issue and found that for individuals that were very sick care management efforts did not prevent readmissions but for individuals with moderate diseases good care management did end up providing better quality and lower costs. It is important to define "preventable readmissions"
- Readmission rates are the starting point for looking at the totality of care: transitions and where patients should be going after specific events.
- Readmissions are a good metric for thinking about ACOs. Hospitals often react that poor readmission rates are not their fault, that it is a transition of care problem. But conceptually it is a good measure because ACOs will be taking responsibility for the system and for transitions of care.

Multi-Payer Advanced Primary Care Practice Demonstration Project

Alan Hirsch, JD, Executive Director, NC Healthcare Quality Alliance

Mr. Hirsch gave an overview of the NC Multi-Payer Advanced Primary Care Practice Demonstration. The project aims to include Medicaid and many private health insurers and to create a common payment method across multiple payers to reduce administration costs. His presentation can be found here: [NC Multi-Payer Demonstration](#).

Questions:

- How are we going to get information out to the community health centers and get them involved?
 - Part of HIE will be about that. The education piece won't be limited to individual practices. We need to engage practices and have a coordinated strategy to get the word out.
- As infrastructure is built for HIE is there a piece that will push data onward? Allowing for the exchange of data is huge, but can the same infrastructure be used to report data to the federal government as required?
 - Ultimately the plan is to do that.

Comments:

- We need to be sensitive about not putting out about 14 measurement bundles. In the future, we should put it all together so that providers aren't overwhelmed.
 - If HIE works correctly, we will have one set of measures and it will work.
 - But if we need 80 measures to get paid what will happen to small practices?
- If there are feelings that policy makers are imposing a system on providers and patients CCNC was founded to act as a venue for practices to speak through the system.

Facilitating transitions: A group discussion

The group discussed answers to the following questions:

1. What does health reform require or encourage in terms of transitions of care?
2. What is in place now?
3. What are the gaps?
4. How do we address the gaps?

Questions:

- How do all the various care managers communicate?
 - More efficient to have a point person and then have a hand-off to the next care manager.
- Does part of the protocol include helping individual understanding?
 - Case managers can use a telephone call or home visit to check on medications. It is difficult to do home visits but it is helpful and effective since the case manager can see the medication.
 - Care managers have done motivational interviewing training.
- How big is the mental health problem?
 - 20% of admissions to CCNC are behavioral health patients.
 - If behavioral health is the underlying issue that share gets much bigger. It doesn't show up in billing or discharge and there is an educational piece that needs to happen.
- Has BCBS made any efforts in the transition issue between inpatient and outpatient doctors?
 - They have pieces that touch on that. Still working on behavioral health issues but claims system cannot recognize which practitioner gives care. They will be reaching out in the next couple of months to medical homes. BCBS has case managers in a sense that are working on transition issues but it hasn't been very effective in the community.

Comments:

- The condition of patient determined by EMS before hospitalization is significant. There is a huge database that could be used to identify trends and problems. The database includes response rates, diseases, protocols and equipment.
- Public health has an established quality program. It is important to get health directors on the same page and to tie into public health resources.
- A major flaw in transitions is that there is no measure of what is a successful measure. If a person moves between medical care homes there is no mention of the nature of the move. Measures should include process not only results.
- Historically CCNC has identified high risk patients through claims. But it is important to learn how to identify individuals before claims are submitted, so when an individual is admitted and meets the high risk criteria they are identified.
- We need to understand why individuals are admitted. Looking through the networks, topping the list is behavioral issues. Some of those have to do with acuity of disease. Some individuals will require lots of admission. For example a person is readmitted because of uncontrolled diabetes but is there an issue with that patient that is preventing the patient from understanding or controlling their diabetes. It may be important to look at the individuals who are readmitted a lot and see if there is a behavioral health aspect.

Discussion of Workgroup goals: Where do we go from here?

Overall question put to the group: What are suggestions about what to discuss at the next meeting? What do we want to talk about?

Overall there was consensus that it would be beneficial to “map” out the current health care system, as it relates to quality, in order to begin to determine how the ACA will impact NC as well as what areas need improvement and what opportunities are available.

Comments:

- Do we need to build an understanding of who is doing what and who is involved in this issue? It will be difficult to make policy recommendations without an understanding of ongoing efforts
- Maybe it will be helpful to start with describing the components of the health care system and then work through the map and see how each requirement affects each part of the system.
- A part of that might be mapping out and identifying transitions within the system
- Once there is a map then it would be possible to write out how each recommendation affects the different parts of the system
- Would it be possible to see what every different organization, i.e. nursing homes, hospitals, etc., is required to measure?
- See this as two stage process: 1) know how each part of the system interacts. 2) fill in the details and include who ACA fits in
- It will be necessary to include what the federal government is doing because there are many provisions where the detailed requirements are still unknown.
- Another important piece would be to include identifying opportunities. The issue is identifying grant opportunities and make sure that the state does not miss any opportunities.

- It would be helpful to discuss how to help reduce the burden of the new reporting requirements on providers.
- Understanding current federal requirements, along with new ACA requirements, is important
- Sees the “map” as providing an overview of the components of the system that relate to quality measures and it will allow laying over the ACA requirements and seeing how they fit
- Ideally someone will be tracking the rulemaking process as well as the grant releases
- A function of this group may be to identify “low hanging fruit”, areas with solvable problems that can be addressed. Trying to improve medication management is an example
- Maybe the issue is not about figuring out how to improve the totality of quality but maybe it is about seeing opportunities in the ACA to improve specific areas
- Central to all of this is that quality improvement efforts need to be consumer driven. Cannot leave the consumer out of these discussions.