

Health Reform: Quality Workgroup
Monday, October 18, 2010
North Carolina Institute of Medicine, Morrisville
9:00am-12:00pm
Meeting Summary

Attendees

Workgroup Members: Sam Cykert (co-chair), Alan Hirsch (co-shair), Lacey Barnes, Mark Casey, Shirley Deal, C. Annette DuBard, Marian Earls, Brad Griffith, Gibbie Harris, Rick Helfer, James Jones, Anne Kissel, Eugenie Komvies, Jill McArdle, Sara McEwen, Steve Owen, Mary Piepenbring, Polly Godwin Welsh, Paul Wiles, Bill Wilson

Steering Committee Members: John Dervin, Ann Lefebvre, Elizabeth Walker

NCIOM Staff: Sharon Schiro, Rachel Williams

Other Interested Persons: Melissa Briggs, Marie Britt, Sana Syed, Art Eccleston, Markita Keaton, Ann Lore, Melanie Phelps, Chris Skrowronek, Renae Stafford, Kari Barsness, Steve Wagner

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

Mr. Hirsch briefly welcomed the group and went around the room for attendees to introduce themselves. Then he gave a brief overview of the meeting agenda.

Patient Scenarios

Samuel Cykert, MD

Co-Chair

Dr. Cykert gave a presentation that used case studies to identify failures in the quality of care transition. He asked the workgroup to identify the failures and suggest ways of preventing them. His presentation of the case studies can be found here: [Case Studies in Quality of Care](#).

Selected questions and comments:

- Comment: Perhaps with a case manager or someone else to make sure the patient in Case Study #1 understood which medicines to take he would not have been readmitted so many times.
- Case Study #1 involved a lack of health literacy. The patient had too many medications with new instructions and the providers were unaware of changes made to his regimen.
- Comment: Another breakdown in the system in Case Study #1 was that the hospital did not do an assessment to see if the patient was capable of being discharged into his home where he lived alone.
- Q: What kinds of forms are providers responsible for at discharge? A: Hospitals have a discharge sheet to the patient, a dictated discharge summary for medical care homes, and any insurance/Medicare forms which are different for each insurer. Many of these forms are done at different times and are done quickly to meet deadlines.
- Q: Is a telephone follow-up statistically less effective than a face-to-face follow-up? A: Yes. The telephone follow-up may be cheaper, but with various medications it can be hard for the patient to put together information over the phone. Studies have shown that face-to-face follow-up is more effective.
- Q: What prevents having one form? A: different insurers indicate they need different pieces of information. To have each requirement on one form would make the form very long and complicated. Also, many forms are local institutional traditions.
- Comment: We don't have a single source database of medications available at the time of discharge. That is something a fully operational HIE would have: one place where all information was available when filling out various discharge forms.
- Comment: An HIE would help the situation, but we would have to have culture and behavior change for it to be successfully adapted.
- Q: Are there no national guidelines over this? A: The federal government is dealing with this issue through implementing HIE. The ACA mandates that quality measures become public and there will be penalties for lack of performance. It is ultimately up to each state and local organization to solve the problem.
- Q: If this patient in Case Study #2 was with an insurance plan, wouldn't the insurers be able to see the bill for the visit and do something about making sure the patient received follow-up care? A: Medical coding on bills is very vague and it is hard to determine who really needs follow-up care and who doesn't. Emergency departments do not have the time or resources to diagnose things like cancer; therefore, a cancer diagnosis would not be on this particular patient's billing information.
- Comment: Case #2 also demonstrates the issue of patient responsibility. The patient knew he needed follow-up care and did not see the specialist.

Review of Quality Programs in NC

Sharon Schiro, PhD
Vice President
NCIOM

Dr. Schiro discussed a draft of a table with data about what quality initiatives exist in NC between transferring and receiving entities. Members were asked to fill in any gaps if they are aware of another initiative not included on the table and to inform Dr. Schiro so that she can add them onto the chart.

Selected questions and comments:

- Q: Is it sufficient for us to give you the quality initiative information to add it to the chart? A: Initiative and home information is good. If you can tell Sharon where it goes on the chart that is even better.
- Comment: There are more initiatives within each branch than there are between entities.
- Q: Are there any data available on what's working? A: A lot of published data are positive on the role of disease management. Case management has significant value, especially in coordinating transfers and reaching out to high-risk patients.

Review of Quality Provisions in Federal Legislation

Sharon Schiro, PhD

Dr. Schiro discussed another draft of a table with federal quality provisions as legislated by the ACA and when they are to be implemented. Members were asked to fill in any gaps with information about quality initiatives in place as well as any missed provisions.

Selected questions and comments:

- Comment: Have not found anything in bill specific to community health centers. If anyone knows if and where regulations for community health centers is please let us know.

Filling in the Gaps and Setting Priorities: A Group Discussion

Alan Hirsch, JD

Co-Chair

Mr. Hirsch led the group in a discussion to answer these key questions:

1. What information are we missing?
2. Where are the gaps between health reform requirements and existing programs?
3. How do we break the work into meaningful chunks?
4. How do we prioritize our work? By date of implementation? By provider type? By impact?

Selected questions and comments:

- Q: What were the problems in trying to implement NCHQA's HIE previously? A: There were not any problems. NCHQA was ready to build a data warehouse, but then the ACA was passed and since the federal government was going to be putting money into an HIE we did not see the sense in spending our money to make our own that might not be compatible with the new federal system.
- Comment: One challenge of taking data from multiple systems is the different ways each system identifies providers. We should have an interim solution.
- Q: Have we determined the cost of the system? A: We are paying on speculation of what the value is assumed to be. It will take a while for the system to mature and for us to know the true costs.
- Comment: Key piece is patient education.
- Q: Would rapid re-structuring of healthcare delivery systems make this jump easier, rougher or no different? A: Yes, yes and yes. It depends. A regional extension center has rules on who can sign up. Unless the government changes the rules, the extension center may be at a disadvantage. Small practices could have an advantage because they can change things quickly without having to go through corporate tape. However, small practices could also be disadvantaged due to economies of scale: small practices do not have the means to have case-management specialists or educators on staff.
- Comment: There is concern over the consolidation of providers as a result of the new regulations. Large hospital systems can add efficiency and quality, but they can also add costs.
- Q: What kinds of outcomes are currently being measured by insurers to determine quality? A: What they can. They are able to look at readmission rates, ER utilization, number of hospital days and admissions, number of specialist visits, etc.
- Q: Medical care homes don't have to meet benchmarks on ER use and other quality measures? A: We don't want there to be discrimination against places that are taking care of sicker patients.
- Q: We currently pay too much for things we shouldn't be paying for and not enough for things we should. If we reach integrated system, is there a way to change that? A: Now we use a fee-for-service system. The more tests ordered the more the provider gets paid. Under a capitation system, if the cost of care was greater than the amount given doctors did not get paid as much. We are not going to go back to a capitation system; however, we need to create that level of accountability.
- Q: Can we transform to get providers to do more of the right things through the payment system? A: Yes. A per-member-per-month (PMPM) system can layer on care management on top of fee-for-service.
- Q: Are hospitals doing anything now to prevent readmissions? A: They are looking at it. Health Research and Education Trust pointed out that when you want to change

something you need to measure it so that you know what to change. Hospitals are looking at readmissions now because it will be something consumers will look at.

Next Steps

Samuel Cykert, MD

Dr. Cykert asked the workgroup what the next steps should be and what the group would like to focus on for the next couple of meetings.

Selected questions and comments:

- Comment: It seems like some measures require more collaboration than other measures. We should focus on measures that need a large group like this to collaborate between entities.
- Comment: I see part of our role as educating providers on what requirements and measures are going to be.
- Comment: I am concerned with physician buy-in. If we create an “ideal” system and doctors don’t buy into it then it will not be successful. Doctors tend to use evidence-based practices, so I would like spend some time looking at scientific evidence of quality measures being linked to better clinical outcomes.
- Transitions between care providers seem to be the biggest issue.

Public Comment Period

No comments were given.

The next meeting will be held on November 18, 2010, at the **North Carolina Medical Society** located at **222 North Person Street, Raleigh, NC, 27601**.

Meeting Adjourned