

Health Reform: Quality Workgroup
Wednesday, August 18, 2010
North Carolina Institute of Medicine, Morrisville
9:00 – 12:00
Meeting Summary

Attendees

Workgroup Members: Sam Cykert (co-chair), Alan Hirsch (co-chair), Mark Casey, Shirley Deal, Marian Earls, Brad Griffith, Gibbie Harris, Mark Holmes, Eugenie Komivies, Jill McArdle, Sara McEwen, Steve Owen, Greg Randolph, Sen. Josh Stein, Woody Warburton, Steve Wegner, Polly Godwin Welsh, Bill Wilson

Steering Committee Members: Ann Lefebvre, Elizabeth Walker

Staff: Kimberly Alexander-Bratcher, Thalia Fuller, Sharon Schiro, Pam Silberman

Interested Persons: John Dervin, Tracy Linton

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 and Mr. Hirsch welcome participants, gave introductions, and asked workgroup members and participants to introduce themselves.

Overview of health reform and structure of the health reform workgroups and workgroup charge

Pam Silberman, JD, DrPH, President & CEO, North Carolina Institute of Medicine

Dr. Silberman gave an overview presentation of the main provisions in the Patient Protection and Affordable Care Act (“Affordable Care Act or ACA”) and the structure of the health reform workgroups. Click here to view the presentation: [Health Reform overview](#).

Overview of Workgroup’s specific provisions from the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010

Sharon Schiro, PhD, Vice President, North Carolina Institute of Medicine

Dr. Schiro gave a more detailed presentation of the health reform provisions related to Quality. Click here to view the presentation: [Workgroup overview](#). Click here to see the specific sections of the Affordable Care Act which the workgroup will review: [ACA Quality provisions](#).

Discussion:

- Physician Quality Reporting Initiative (PQRI)
- Need to partner with organizations across to state to help create systems, not just ensure compliance but also recommend processes that could affect outcomes in a positive way
- Agency for Healthcare Research and Quality (AHRQ) funding is available to share quality information with providers and students

Update on health reform implementation for Quality (NC)

C. Annette DuBard, MD, MPH, Director of Informatics, Quality, and Evaluation, NC Community Care Networks, Inc.

Dr. DuBard gave an overview of the Community Care of North Carolina (CCNC) networks' implementation efforts focused on the federal health reform provisions. She specifically discussed the CCNC quality measure reporting and provider portal. Click here to view the presentation: [Community Care Networks, Inc.](#)

Discussion:

- There are an estimated 4500 primary care providers in North Carolina
- Per Member Per Month (PMPM) payment are provided to primary care medical home.
- CCNC reports network and practice level data to the practices and network and state level to the state. They conduct annual audits with AHEC. Approximately 26,000 charts and 1250 practices were reviewed in 2009. They use a random sample of patients to be able to determine statistical significance at the network level. Practices can see how they compare to county, network, and state CCNC providers.
- CCNC Provider Portal:
 - web-based secure portal to access practice and CCNC patients for providers, hospitals, and others that provide care to the patients
 - able to display information from Medicaid system including providers and care management, medication information, calculations about medication adherence
 - future iteration (2 months) will include patient history with more details about visits and diagnosis, reminders about needed exams as flags, registry and population management, practice reports – quarterly and annually, patient level information on results of audit, should help with cost containment measures, patient education materials are available in various languages and at a low reading level
- Barriers for Medicaid population include multiple providers across patients.
- Audits:
 - heavy emphasis on chart review
 - need to move to focus on PQRI
 - CCNC accountable to the state, but only a small portion of patients seen in practices capable of quality reporting, need physicians across the state to be able to utilize system fully

- Information technology barriers
- CCNC Quality measures:
 - reviewed annually to update/modify
 - difference between quality measure (physician average) and gap in care (patient issue)
 - reports are available to public at network and state level (practice level are not public yet, states doing that are mainly using multipayer reporting, problem with small number of patients in each insurance group)
 - need to merge administrative data from multiple payers to know regional information not just individual payers

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

Dr Cykert gave an overview of the state implementation efforts focused on the federal health reform provisions. Click here to view the presentation: [State Quality Improvement](#).

Discussion:

- Improving Performance in Practice (IPIP) - American Board of Medical Specialties and NC Hospital Association should be included on list of original contributors, 1st year -18 pilot practices, 2nd year – 75 practices, 3rd – 150 & continuing to grow, current efforts include initiatives with the Office of National Coordinator for Health Information Technology (US DHHS) and Macroelectronic Center of NC (MCNC)
- Provider Incentives –Medicaid incentives can total \$63,750 over several years depending on practice type and patient mix
- Meaningful Use – feedback on quality in 2012, enable comparison between physicians
- Regional Extension Center – 3465 providers needed of 10,500 primary care providers (MD, PA, NP, etc.), need to enroll in first year to truly prepare for meaningful use within two-year timeframe, current outreach to Community Care of North Carolina (CCNC), Office of Rural Health and Community Care, and safety net providers
- Variety of quality programs: Quality Improvement Consultants help practices figure out which programs for which they will qualify.

Discussion of Workgroup goals

Discussion:

- Future agenda items – evaluating evidence as it becomes available, then disseminating it to providers, incentives versus penalties, specific sources of

funding; value (cost) versus quality, overuse as a measure of poor quality (some are already included in quality measure sets)

- Overlap of several NCIOM Health Reform workgroup goals: need to prioritize provisions by implementation date, and related funding opportunities

Public comment period

The next meeting of the Quality Workgroup will be Friday September 17, 2010 at the NCIOM offices in Morrisville at 9:00 AM.