

## **Health Reform: Quality Workgroup North Carolina Institute of Medicine**

1. NCHA should provide education to hospitals on the following issues related to PPACA:
  - Hospital acquired conditions: the importance of using the “present on admission indicator” and the meaning and implications of the quartiles (Sec 2702),
  - Quality reporting requirements (Sec 3014, 10305),
  - Value-based purchasing (Sec 3001, 10335), and
  - Importance of having a safety evaluation system to allow HBE provider to contract with hospitals with more than 50 beds. (Section 1311)
2. AHEC, REC, NCMS, CCNC, CCMC, and NCHQA should partner to educate physicians on the following issues related to PPACA:
  - Impact of the use of quality, efficiency, and resource use data by the public and Medicare (Section 10331),
  - Opportunities to provide input in to the development of quality measures (Sec 3003, 3013, 10303),
  - Penalties for not reporting quality data, and the advantages of integrating reporting and HER (Section 3002),
  - Value-based purchasing (Section 3007), and
  - The requirement for providers to have a system to improve healthcare quality to allow HBE providers to contract with them (Section 1311).
3. AHHC of NC should provide education to NC hospice providers on the implications of the PPACA value-based purchasing provisions. (Sec 3006)
4. AHEC and the NC Academy of Family Physicians should assume responsibility for educating primary care physicians, and the NCMS should assume responsibility for educating specialty physicians on the requirement to report adult health quality measures on all Medicaid eligible adults. (Sec 2701)
5. The NC HIE Board should develop mechanisms to reduce the administrative burden of the Medicaid eligible adult quality reporting requirement through centralized reporting through the NC HIE and alignment of NC quality measures with Federal requirements. (Sec 2701)
6. The NC HIE Board should store federally reported data at the state level and make it available for research, and quality and readmission reduction initiatives. These data should contain unique identifiers to foster linkage of datasets across provider types and time.
7. NCHQA should partner with NCHA and CCNC to improve transition in care, including forging of relationships between providers of care, developing mechanisms of communication including a uniform transition form, identifying and working with the NC-HIE Board to facilitate IT requirements, and developing mechanism for evaluating outcomes. Partner organizations should also work to:
  - Improve patient education at hospitals, with a focus on the health literacy checklist and teach-back methodology;

- Improve education of patients prior to hospital admission on their health status, treatment options, advance directives, and symptom management. Re-address goals of care as appropriate after hospital discharge;
  - Establish a crisis plan for each individual that addresses prevention as well as triggers and appropriate interventions ;
  - Personal health records, in the possession of the patient should be emphasized pending the availability of more robust HIE;
  - Align existing initiatives that address care transitions at state and local level ;
  - In each community, stakeholder alliances including provider groups, CCNC, home health representatives and hospitals should discuss leveraging appropriate local resources to apply the principles of excellent transition care to the extent possible. These alliances will become even more important with pending improvements in telemonitoring and home use of health information technologies;
  - Define essential elements for outpatient intake after hospital discharge (specific to particular conditions where relevant), and encourage adoption by physicians and other healthcare providers. Elements may include open access scheduling for recently hospitalized patients, enhanced after-hours access, medication reconciliation and emphasis on self-management;
  - Encourage collaboration and contracts between hospitals, LMEs, CABHAs, and other community providers (eg, pharmacists) to the extent legally allowed in order to better manage recently hospitalized patients;
  - Solutions utilizing transition principles should be applied to all patients regardless of payer; and
  - Encourage formal development of Medical Home Models that include the use of non-physician extenders to work with some patients (eg, stable diabetics), with physicians focusing on higher need patients.
8. The NC Health Care Facilities Association should work with the NCMS to develop safe-harbor legislation that protects algorithmic evidence-based care and to provide reimbursement for nurse practitioner services in SNFs. (Sec 3025, 10309)
  9. The NCMS should develop safe-harbor legislation that protects algorithmic evidence-based care to reduce unnecessary use of resources. (Sec 3003)
  10. The NC Network of Grantmakers should continue to track funding opportunities that are made available through the PPACA.