

Health Reform: Quality Workgroup
Thursday, March 17, 2011
North Carolina Institute of Medicine, Morrisville
1:00pm-4:00pm
Meeting Summary

Attendees:

Workgroup Members: Sam Cykert (co-chair), Alan Hirsch (co-chair), Shirley Deal, C. Annette DuBard, Polly Goodwin Welsh, Brad Griffith, Gibbie Harris, Anne Kissel, Eugenie Komvies, Steve Wegner

Steering Committee Members: Ann Lefebvre, Elizabeth Walker

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

Other Interested Persons: Art Eccleston, Maria Fernandez, Markita Keaton, Carol Koeble, Andy Landis, Cindy Morgan

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.

Transitions of Care Sub-Committee Update

Samuel Cykert, MD

Dr. Cykert updated the workgroup on the progress of the Transitions of Care Subcommittee. The committee has drafted recommendations to improve transitions of care in context of the ACA. Recommendations focused on effective patient education, selection of high-risk patients, personal/electronic health records, medication reconciliation, self-management skills, telephone contracts between facilities, communication with case managers, increased access after discharge, and follow-up care.

Dr. Cykert's presentation, with a complete listing of draft recommendations, can be found here: [Update on NCIOM Transitions of Care Subcommittee.](#)

A draft of the committee's report can be found here: [Summary of Discussions and Recommendations](#).

Selected questions and comments:

- Q: What is the timeline for the roll out of the health information exchange (HIE)? A: Currently, the goal is to release the request for proposal for core services towards the end of June. Value added services will also be a part of the proposal process. Basic services should be available by the end of the year. A vendor for the HIE will be chosen soon based on cost and quality. Modules will be added in phases before 2012.
 - Once the infrastructure for the HIE is ready individual facilities will have to adopt the system.

Overview of Provisions/Gap Analysis/Recommendations

Kimberly Alexander-Bratcher, MPH, Project Director, North Carolina Institute of Medicine

Ms. Alexander-Bratcher led the workgroup in a discussion of the proposed recommendations. Recommendations addressed hospital education, physician education, hospice care, Medicaid eligible adult reporting, HIE data storage, safe harbors, and transitions of care. A final recommendation for continually perusing funding opportunities was also included.

Many workgroup members commented on which organizations should be involved with educating practitioners and facilities. Additions included specialty societies to physician education recommendations; Carolina Center for Hospice and End of Life Care to hospice care recommendations; CCNC and DMA to Medicaid eligible adult reporting recommendations; and provider groups, state psychiatric facilities, and developmental centers to care transitions recommendations.

The presentation can be found here: [Overview of Recommendations](#).

A summary of the recommendations can be found here: [Recommendation Summary](#).

Selected questions and comments:

- Nursing homes should be allowed to have a treatment center. There are problems getting a doctor who knows the patient and has incentive to take the time to make a decision about whether to admit that patient to hospital. Getting the right doctor, all the information needed, and having the ability to do necessary treatments in reasonable amount of time are important in improving quality and reducing transitions.
 - The default solution for many nursing homes is to send a resident needing care to the emergency department (ED).

- One study has shown that having a nurse practitioner (NP) in a long-term care facility reduces ED admissions. This should be included in the recommendations.
 - Q: What's the barrier to having NPs in those facilities? A: The biggest barriers are financial. There is also a policy barrier regarding the coding and billing of services by NPs.
 - Financial alignment between hospitals, health systems, and medical homes gives significant incentives for medical home practices to employ NPs or physician assistants (PA). Some barriers are resolved when you address financial incentives and accountability.
- The more ways to disseminate information regarding Medicaid eligible adult reporting the better. A lot of the reporting requirements have time schedules and are not on top of everyone's to-do list right now. Is there any way of having a central reminder system to tell organizations six months in advance that a requirement is going into effect?
 - As the need arises for practices to be educated about new requirements going into effect, such as the new IC10, practices tend to request information. A lot of educational pieces are rolled out due to demand from the field.
 - Announcements and small educational pieces can be put into things that are already out there (i.e. the DMA bulletin). But things which take more education, such as a workshop or training, have to be done via demand. A prompt would be helpful, but that doesn't necessarily prompt big seminars to take place either. There are different levels of education that can occur.
 - Q: Who would do the prompting? A: Maybe the most this committee can recommend is that the gap analysis be cleaned up to include educational pieces and due dates. Then it can be sent out to organizations and included in the NCIOM report.
- Medicaid adult quality reporting could be done two different ways. The state's HIE proposal has hospitals and providers running their own quality data and then using the HIE to transport the data to another entity. The other option is to combine raw provider data that is sent into the HIE and have the HIE run the numbers.
 - One problem with hospitals and providers doing their own quality statistics is that there would not be one methodology.
 - Both models could be combined. Providers tend to trust their own data over data from outside sources. However, the HIE could provide a back-up report for the physician compare web site.
- Q: Should safe harbor legislation be recommended from this workgroup? A: The legal committee said that no legislation should be done at this time since no legislation would be immediately responsive to the ACA, which was our mandate.

Co-Chair Wrap-Up

Workgroup members will send in comments on the recommendations via email. If there is a lot of discrepancy among the comments, then the workgroup will meet again to discuss them. Otherwise, the rest of the workgroup's agenda will be carried out electronically. The co-chairs thanked everyone for their participation in the workgroup.

Public Comments

No further public comments were given.