

Health Reform: New Models of Care Workgroup
Thursday, August 4, 2011
North Carolina Institute of Medicine, Morrisville
1:00pm-4:00pm
Meeting Summary

Attendees:

Workgroup Members: Allen Dobson (co-chair), Craigan Gray (co-chair), Don Bradley, Peter Chauncey, Steve Cline, Chris Collins, Beth Lovette, Lloyd Michener, Gina Upchurch, Neil Williams

Steering Committee Members: Allen Feezor

NCIOM Staff: Thalia Fuller, Arijit Paul, Pam Silberman, Rachel Williams

Other Interested Persons: Annette DuBard, Corye Dunn, Markita Keaton, Andy Landes, Catherine Moore, Jacob Parrish, Sheila Platts, Chris Skowronek, Andrew Weniger, Rebecca Whitaker

Welcome and Introductions

Allen Dobson, MD, FAAFP
Vice President, Clinical Practice Development
Carolinas HealthCare System
Co-chair

Craigan Gray, MD, MBA, JD
Director, Division of Medical Assistance
NC Department of Health and Human Services
Co-chair

Dr. Gray welcomed everyone to the meeting.

Review of Past Discussion and Potential Recommendations

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

Dr. Silberman briefly reviewed suggestions of needed infrastructure to support new models of care discussed at the May 18th meeting. Topics included a centralized depository for

dissemination of current efforts, evaluation standards of new models, data needed to support new models, and other barriers to new models of care.

A copy of this presentation and the next two presentations can be found here: [Infrastructure Needed to Implement New Models](#).

Data Consortium Informal Workgroup

Steve Cline, DDS, MPH

Assistant Secretary for Health Information Technology

NC Department of Health and Human Services

Dr. Cline discussed an upcoming Data Consortium. The consortium will focus on what health information technology (HIT) infrastructure is available. Systems that exist and what types of data they collect will also be discussed. Once an inventory of HIT is made, the consortium will begin looking for funding avenues to begin integrating needed systems and building needed infrastructure. Other future steps include creating a governance structure, a data model, and any legislation needed.

Review of Other States' All Payer Data Systems

Arijit Paul

Intern

North Carolina Institute of Medicine

Mr. Paul summarized a chart of what other states' all payer data systems (APDS) look like. Currently there are 11 states with active APDSs and six states in the process of implementing APDSs. For each of the 17 states, the chart includes the name of the system, the administering agency, the types of data collected, and the costs associated with sustaining the APDS. The data is being used by states to compare utilization patterns, identify cost saving strategies, disease surveillance, evaluation of programs, etc. Note: the information contained in the chart was obtained through a review of state legislation, and other summaries of existing APDS. The NCIOM did not contact states directly to find out how their APDS operated. A copy of the chart can be found here: [All Payer Data Systems](#).

Selected questions and comments:

- Q: How many states are reporting mandatorily versus voluntarily? A: If there is a penalty for not reporting in the "Penalties for Non-Compliance" column, then reporting is required by the state. Currently, Maine, Tennessee, Utah, Vermont, Massachusetts, and Oregon require reporting.
- Q: Who is paying for the upkeep, not just the development, of these repositories? A: The "Investment" column shows what states are investing in the repositories. We currently

do not have all the information on where money for these depositories comes from. However, Utah, for example, uses both General Fund and Medicaid money to maintain their system.

- There is the potential to get federal funding up to \$500,000 to create a medical reimbursement data center. It is not ongoing money, however and does not provide guidance on how to maintain the system.

CCNC Informatics Center

C. Annette DuBard, MD, MPH

Director of Informatics, Quality and Evaluation

NC Community Care Networks, Inc.

Dr. DuBard gave an overview of Community Care of North Carolina's (CCNC) Informatics Center (IC). The IC allows CCNC network providers to review medical histories of their patients and allows CCNC to analyze the Medicaid population. In addition, certain networks include, or will include, dual eligibles (Medicaid and Medicare), the uninsured (HealthNet data), and third party payer data (seven county multi-payer demonstration with Blue Cross Blue Shield and the State Employees Health Plan).

The IC helps CCNC providers understand their population, identify high-risk patients for targeted services, couple performance measurement with actionable information, and enable quality improvement. Providers are able to get an overall picture of each patient's health and the overall population they serve. Data sources include claims data, LabCorp data, hospital admissions and discharges, and Surescripts pharmacy data. Future data sources will include UNC Health Systems data, Piedmont Behavioral Health encounter data, state data (i.e., from the Division of Public Health), electronic health record (EHR) data, Medicare data, some State Health Plan data and Blue Cross Blue Shield data (from the seven county multi-payer demonstration), and HealthNet data.

Dr. DuBard's presentation can be found here: [CCNC IC](#).

A chart showing how the IC works can be found here: [CCNC IC Roles and Features](#).

Selected questions and comments:

- Q: Does the IC receive prescription data from Medicare? A: In the 646 dual-eligibles demonstration there is a data feed from a dispensing pharmacy. Medicare claims are also used to find what medical homes patients belong to and compare it to other data.
- The Office of Rural Health has data on the uninsured through HealthNet, which will help the IC keep a continuous record for patients who go on and off Medicaid.
- Q: How often does Medicare data get updated in the IC? A: Usually within a couple of weeks from when a visit occurred. The longest delay time is for inpatient stays. For

Medicaid, it takes 90 days from the date of service to get about 90% of the data.

Pharmacy data is more timely. The timing issue is a problem for a single doctor visit since data is not real time; however, the system allows providers to see patient patterns.

- HealthNet data has information on uninsured patients, many of whom will be eligible for either Medicaid or the Health Benefit Exchange in 2014. This information can be used to identify the uninsured and help them enroll in appropriate coverage.
- Q: How is the IC used practically by a physician getting ready to see a patient? Is it being regularly integrated into practice? A: It is variable and usually has to do with how big of a footprint Medicaid has in their practice. A community with a lot of safety net patients, for example, utilizes this system more often than a community with more third party insured patients.

Group Discussion on Recommendations

The workgroup discussed possible recommendations related to data collection, a central tracking system, the need to evaluate new models of care, and barriers which prevent organizations from adopting new models of care. After hearing about CCNC's IC, the workgroup felt that a more comprehensive system was needed that includes all payers across the state as well as the uninsured receiving safety net services. Having data from all payers would make the system more useful to providers, especially those with more privately insured patients, and would help identify population health patterns more easily. Before deciding what data should be included, the workgroup discussed what the purpose of the data would be: to support delivery of care or to monitor population health? Ideally, the data would support both purposes. The workgroup felt that in order to decide what data should be included, there should be more stakeholders involved and a consensus needs to be reached among them. A final concern the workgroup had was sustainability; provider or payer fees should not support the data since it could discourage providers and payers from using it.

A central tracking system would catalogue what new models were occurring in the state and be able to disseminate information on how to implement these models to other entities. The system would also have an evaluation component in order to determine what models were the most effective. Most of the discussion was on what entity should maintain the tracking system. Some entities mentioned included the NCIOM, Cecil G. Sheps Center for Health Services Research, Center for Medical Excellence, NC Foundation for Advanced Health Programs, NC Health Quality Alliance, CCNC, and academic institutions. The creation of a new entity, funded by the state or by private funders, was also mentioned.

The workgroup felt that state-funded new models should be rigorously evaluated and evidence-based. Metrics would be needed to determine what models are effective. Stakeholders need to decide what evaluation metrics would be the most valuable. Instead of creating new metrics, the

workgroup felt that existing metrics should be used such as those that will be used by accountable care organizations or the federal meaningful use measures. Some workgroup members expressed concern that having metrics that were too strict would discourage promising new models. The workgroup suggested having different categories for new models such as promising practices, evidence-based, not effective, etc., to address this issue.

The group began discussing barriers, but did not have as much time to explore this issue. This topic will be addressed in more detail at a future workgroup meeting.

Public Comment Period

No further public comments were given.