North Carolina Healthcare Association

NCHF Presentation

NC Critical Access Hospital Network Regional Meeting

May 22, 2019

Sue Collier, MSN, RN, FABC

Vice President, Innovation and Clinical Excellence

Uniting hospitals, health systems and care providers for healthier communities

National Rural Health Association Conference

A2Rural (AHA Rural Advisory Group)

Quality Measures and Reports

Data Reminders

May 15, 2019

- CMS Outpatient Web-based Measures:

  Includes measure OP-22: Patient Left Without Being Seen – full calendar year 2018

  CMS Hospital Outpatient Reporting Specifications Manual version 11.0b

  Entered via the Secure Portal on Quality Net

May 15, 2019

- CMS Inpatient Measures:

  Patients seen Q4 2018 (October, November, December)

  CMS Hospital Inpatient Reporting Specifications Manual version 5.4a

  Submitted to the QualityNet warehouse via CART or by vendor

  CART version – 4.22

May 15, 2019

- Healthcare Personnel Influenza Vaccination – HCP/IMM-3 (formerly OP-27)

  For data October 1, 2018 – March 31, 2019

  Submitted through the National Healthcare Safety Network (NHSN)

Report Run Date: 03/01/2019

Telligen

MBQIP Care Transitions Quality Report: Improving Care Through Emergency Department Transfer Communication (EDTC)

Reporting Period: First Quarter 2018 through Fourth Quarter 2018 Discharges

State: NC

MBQIP Quality Measures		Your State Performance by Quarter 1Q18	2Q18	3Q18	4Q18	Your State Performance Aggregate for All Four Quarters	State Current Quarter Average Current Quarter	# CAHs with MBQIP MOU Submitting Data	90th Percentile**	National Current Quarter Average Current Quarter	# CAHs with MBQIP MOU Submitting Data	90th Percentile**
Total Medical Records Reviewed		N = 775	N = 807	N = 864	N = 864	N = 3310	N = 864			N = 49812		
EDTC-1	Administrative Communication	100% (n=773)	100% (n=803)	99% (n=857)	99% (n=857)	99%	99%	18	100%	97%	1226	100%
EDTC-2	Patient Information	100% (n=774)	99% (n=801)	91% (n=789)	91% (n=789)	95%	91%	18	100%	96%	1226	100%
EDTC-3	Vital Signs	100% (n=773)	99% (n=802)	95% (n=824)	95% (n=824)	97%	95%	18	100%	96%	1226	100%
EDTC-4	Medication Information	99% (n=771)	99% (n=799)	95% (n=818)	95% (n=818)	97%	95%	18	100%	95%	1226	100%
EDTC-5	Practitioner Information	100% (n=775)	99% (n=801)	93% (n=800)	93% (n=800)	96%	93%	18	100%	95%	1226	100%
EDTC-6	Nurse Information	97% (n=754)	97% (n=786)	93% (n=806)	93% (n=806)	95%	93%	18	100%	91%	1226	100%
EDTC-7	Procedures and Tests	100% (n=772)	100% (n=803)	96% (n=831)	96% (n=831)	98%	96%	18	100%	97%	1226	100%
All EDTC	Composite*	97% (n=748)	97% (n=782)	87% (n=755)	87% (n=755)	92%	87%	18	100%	84%	1226	100%

N = denominator
n = numerator
N/A = the provider did not submit any data
D/E = the provider reported 0 records reviewed

* The state and national roll-up for the All-EDTC sub-measure is not inclusive of every reporting CAH, as some CAHs did not report t
** The 90th percentile is the level of performance needed to be in the top 10% of CAHs for a given measure (i.e. 10% of CAHs perfor

Please direct questions regarding your MBQIP data reports to the Flex Coordinator in your State. You can find contact information fo

EDTC

HCAHPS

Report Run Date: 02/22/2019

Telligen

MBQIP Patient Engagement Quality Report: Improving Care Through Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey

State: NC

HCAHPS Survey Completion and Response Rate

HCAHPS Composites and Individual Items

HCAHPS Composites		Your State's Data: Reporting Period 4Q16 - 3Q17			Reporting Period 1Q17 - 4Q17			Reporting Period 2Q17 - 1Q18			Reporting Period 3Q17 - 2Q18			State Average			National Average		
		Number of Completed Surveys		N/A	Number of Completed Surveys		N/A	Number of Completed Surveys		N/A	Number of Completed Surveys		2724						
		Survey Response Rate		N/A	Survey Response Rate		N/A	Survey Response Rate		N/A	Survey Response Rate		19						
		% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Composite 1 (Q1 to Q3)	Communication with Nurses	4	15	81	4	15	81	4	15	81	4	15	81	4	15	81	4	16	80
Composite 2 (Q5 to Q7)	Communication with Doctors	4	13	83	5	13	82	5	13	82	5	13	82	5	13	82	5	14	81
Composite 3 (Q4 & Q11)	Responsiveness of Hospital Staff	9	23	68	9	23	68	10	21	69	10	21	69	10	21	69	9	21	70
Composite 4 (Q13 & Q14)	Pain Management	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Composite 5 (Q16 & Q17)	Communication about Medicines	17	17	66	17	17	66	17	17	66	17	17	66	17	17	66	17	17	66
Hospital Environment Items		% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Q8	Cleanliness of Hospital Environment	9	18	73	9	18	73	9	18	73	9	18	73	9	18	73	7	18	75
Q9	Quietness of Hospital Environment	9	27	64	9	28	63	10	27	63	10	27	63	10	27	63	10	28	62
Discharge Information Composite		% Yes		% No	% Yes		% No	% Yes		% No	% Yes		% No	% Yes		% No	% Yes		% No
Composite 6 (Q19 & Q20)	Discharge Information	88		12	88		12	88		12	87		13	87		13	87		13
Care Transition Composite		% Disgree to Strongly Disagree	% Agree	% Strongly Agree	% Disgree to Strongly Disagree	% Agree	% Strongly Agree	% Disgree to Strongly Disagree	% Agree	% Strongly Agree	% Disgree to Strongly Disagree	% Agree	% Strongly Agree	% Disgree to Strongly Disagree	% Agree	% Strongly Agree	% Disgree to Strongly Disagree	% Agree	% Strongly Agree
Composite 7 (Q23 to Q25)	Care Transition	5	42	53	5	42	53	5	42	53	5	42	53	5	42	53	5	42	53

Report Run Date: 03/13/2019

MBQIP Patient Safety and Inpatient/Outpatient Care Quality Report: Improving Care Through Patient Safety and Inpatient/Outpatient Measures

Reporting Period: Fourth Quarter 2017 through Third Quarter 2018 Discharges

State: NC

MBQIP Quality Measures		Your State's Performance by Quarter 4Q17	1Q18	2Q18	3Q18	CAH State Current Quarter Median Time/Overall Rate	# CAHs with MBQIP MOU Submitting Data	90th Percentile**	CAH National Current Quarter Median Time/Overall Rate	# CAHs with MBQIP MOU Submitting Data	90th Percentile**	ALL National Current Quarter Median Time/Overall Rate
AMI Cardiac Care												
OP-2	Fibrinolytic Therapy Received Within 30 Min. of ED Arrival	75% of 12 patients	88% of 8 patients	45% of 11 patients	60% of 5 patients	60%	16	100%	52%	957	100%	59%
OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention	53 Min. based on 16 patients	70 Min. based on 9 patients	60 Min. based on 11 patients	54 Min. based on 13 patients	54 Min.	16	39 Min.	70 Min.	957	34 Min.	61 Min.
OP-5	Median Time to ECG	8 Min. based on 374 patients	8 Min. based on 332 patients	7 Min. based on 414 patients	8 Min. based on 440 patients	8 Min.	16	1 Min.	7 Min.	1004	3 Min.	7 Min.
Immunization												
IMM-2	Influenza Immunization	92% of 1,749 patients	97% of 1,771 patients	D/E	D/E	D/E	13	D/E	D/E	880	D/E	D/E

Inpatient/Outpatient Data

NCHA

Upcoming Events

- May 28, 2-3pm: CAH Open Office Hour Call
- August 21-23: CAH Regional Meeting, Winston Salem

North Carolina Healthcare Association

North Carolina Healthcare Foundation

Innovation Center

Uniting hospitals, health systems and care providers for healthier communities

MISSION

To foster & accelerate the collective impact of hospitals, health systems & community partners to improve the health of North Carolinians

VISION

A North Carolina where high quality healthcare is equitable and accessible for all


Increasing
ACCESS to
Healthcare
Influencing
EQUITABLE
Care Delivery
Improving
Health
OUTCOMES

Behavioral Health (IVC reform, ED Peer Support, Coalition for Model Opioid Practices)

Clinical Care Delivery (FLEX/SHIP, PSO, etc.)

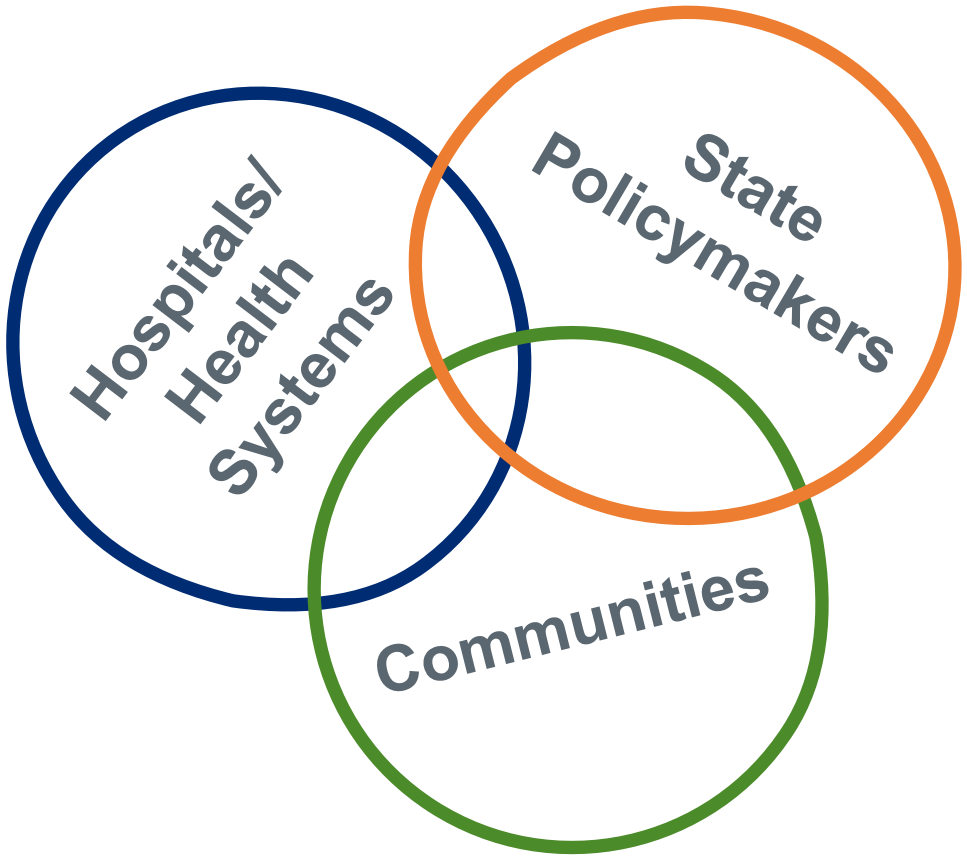
Community Health (HPHC, AccessHealth)

Health Innovation Institute

@ the NC Healthcare Foundation

Accelerating Discovery

Realizing Impact



Connection point for **hospitals, communities & state policymakers**

to improve **access, equity & outcomes**

through **innovation, capacity building & systems change**

INNOVATION

Pilot initiatives that advance performance; scale, evaluate & inform the field

CAPACITY BUILDING

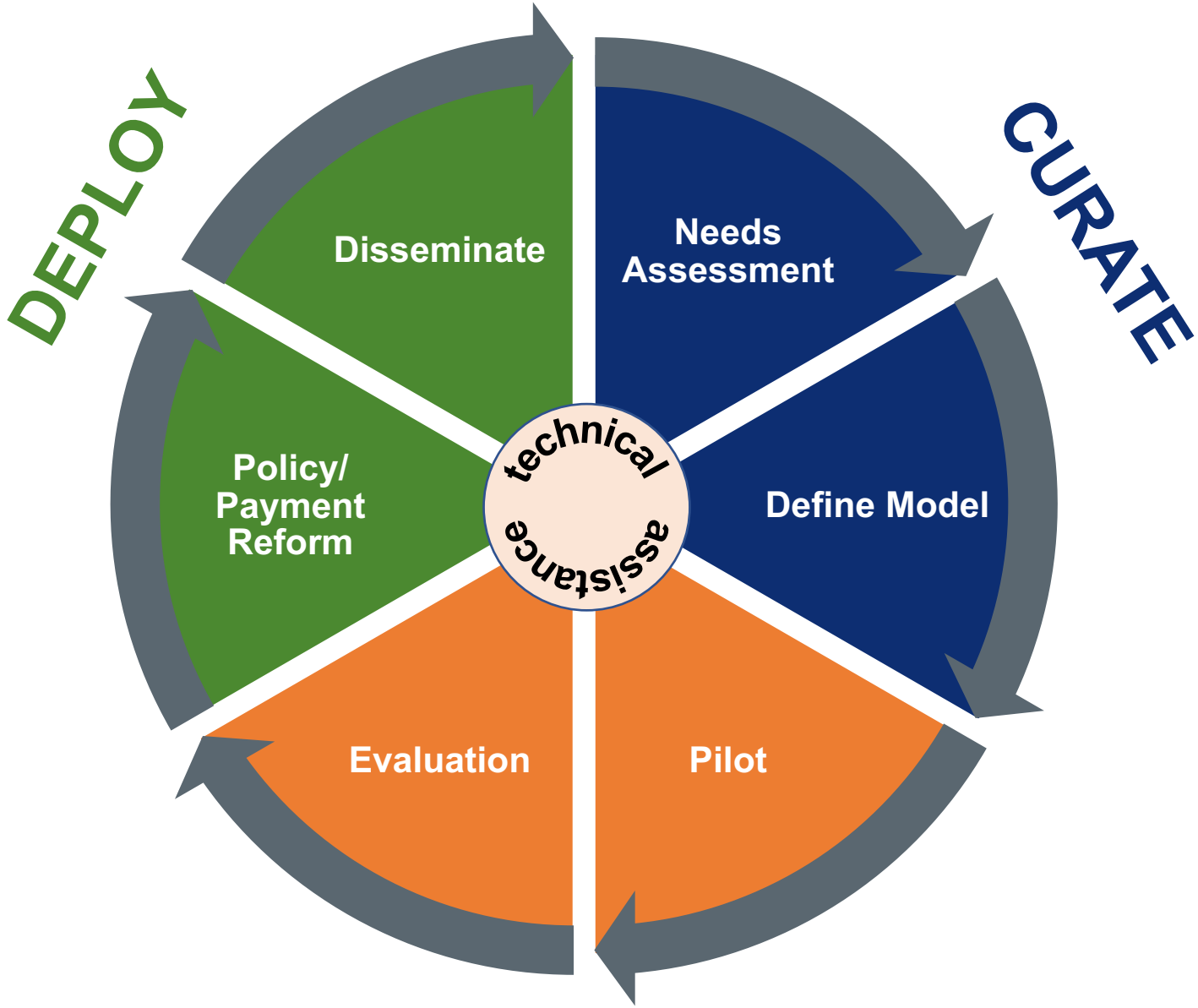
Equip leaders for meaningful community engagement; data-informed technical assistance

SYSTEMS CHANGE

Translate discoveries into sustainable statewide improvements

Health Innovation Institute

@ the NC Healthcare Foundation



- **CHALLENGES** help us understand the context of each area.
- **PARTNERS** so we can engage the right stakeholders in the work.
- **DREAMS and PRIORITIES** to help us begin to focus our efforts on the best ideas.

Designing an Innovation Center

- Access: Right care, right time, right place to achieve the best health outcomes
- Equity: Everyone has a fair and just opportunity to be as healthy as possible
- Value: A balance of patient outcomes, experience, and costs of care
- Infrastructure/functions: curate, accelerate, deploy

North Carolina Healthcare Association

Behavioral Health Update + Resources

Helpful tools + information for patient care

CAH Regional Meeting

Sue Collier, MSN, RN, FABC

May 22, 2019

Uniting hospitals, health systems and care providers for healthier communities

S.B. 630 – Changes to the Involuntary Commitment Process (IVC)

- Law goes into effect on October 1, 2019
- Interactive educational tool on the NCHA website geared towards healthcare professionals: https://www.ncha.org/ivcbill/
- Questions? Contact Nicholle Karim, Director of Behavioral Health, at nkarim@ncha.org or 919-677-4105

Initiatives to Curb the Opioid Epidemic

OPIOID DIVERSION TOOLKIT

The Coalition for Model Opioid Practices in Health Systems has created a Healthcare Worker Diversion Toolkit with information and best practices to prevent and respond to a healthcare worker experiencing a substance use disorder.

LEARN MORE

HEALTH SYSTEM RESPONSE

Emergency Departments act as a safety net for many of society's challenges, including the growing opioid epidemic. The Health System Response working group is creating strategies and best practices to shift the culture and behavior of clinicians within EDs to prevent and treat opioid use disorders.

Learn More

PATIENT EDUCATION & PREVENTION

Upstream approaches to prevent addiction is a cornerstone of NCHA's opioid response strategy. Patient education about prescribed opioids and safe pain management strategies for prescribers is a vital first step.

Learn More

Newly designed NCHA opioid webpage for easily accessible tools + information

Three workgroups with hospitals and community partners creating the opioid tools

Work is funded through the Division of Public Health – Injury and Violence Prevention Branch

Healthcare Worker Diversion Prevention Toolkit

HEALTHCARE WORKER DIVERSION PREVENTION TOOLKIT

Healthcare professionals are not exempt from experiencing a mental health challenge or substance use disorder. In fact, working in a fast-paced, intense environment coupled with responding to traumatic events may increase the likelihood of developing mental health challenges. In some situations, healthcare professionals may have access to controlled substances on the job, creating a situation in which diversion of drugs is a **risk**.

The **Coalition for Model Opioid Practices in Health Systems**, a project of the **North Carolina Healthcare Association**, has created a toolkit with information and **best practices** to prevent and respond to healthcare worker diversion of controlled substances.

An Introduction to the *Coalition for Model Opioid Practices in Health Systems'* Diversion Prevention Toolkit: Webinar – Nov 7, 2018

Slides (PDF)

Recording (YouTube)

NCHA STAFF CONTACT

Madison Ward Willis, MPA

Performance Improvement Specialist, Behavioral and Community Health

NC Healthcare Foundation

919-677-4136

mward@ncha.org

- Collaborative effort between multiple stakeholders, including hospitals, government agencies, and community partners
- Best practices for how to prevent opioid diversion within your hospital along with how to respond when diversion occurs
- Questions? Contact Madison Ward Willis at mward@ncha.org or 919-677-4136

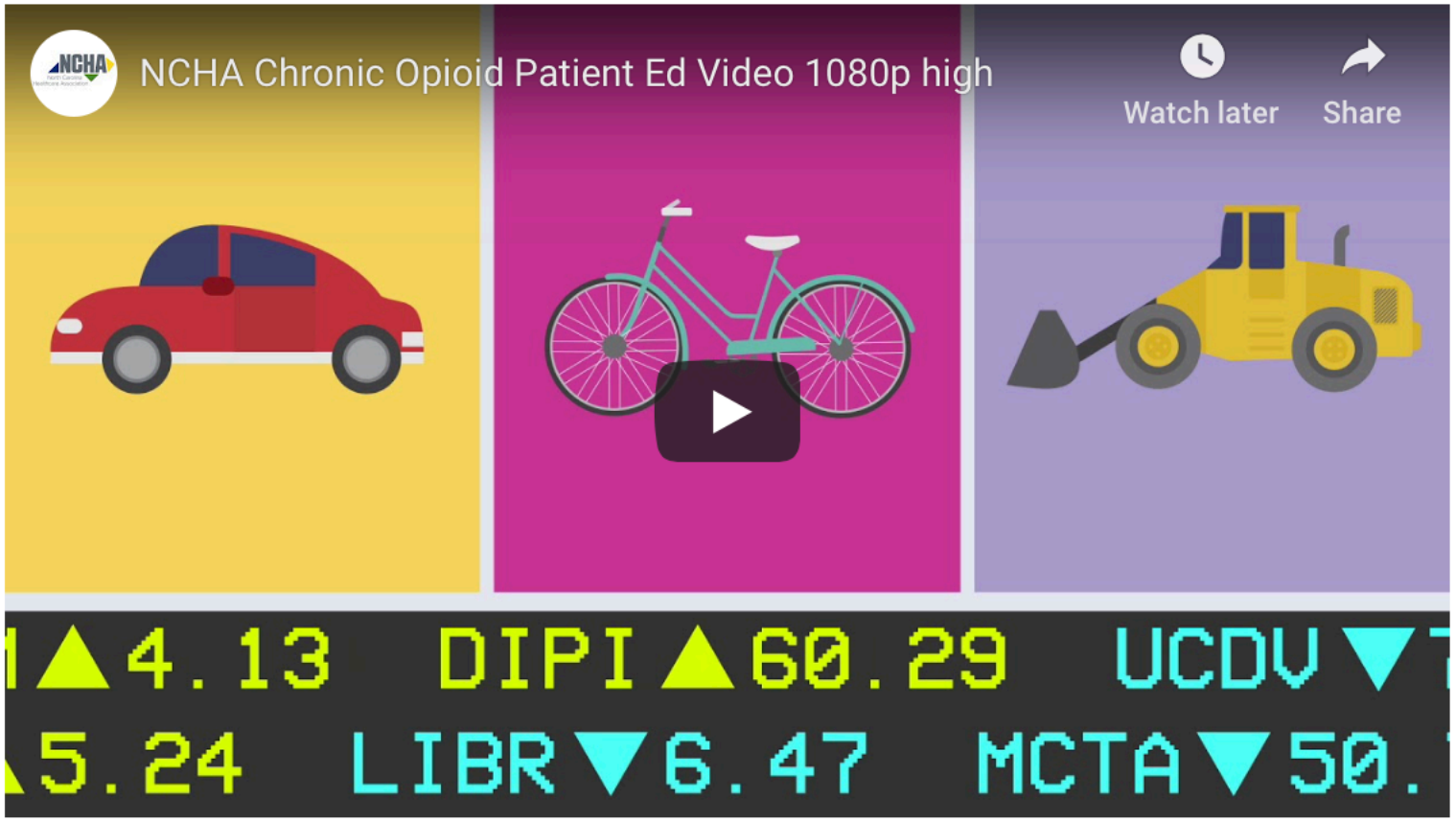
Hospital Response – ED Pathway for OUD + Safe Prescribing/Non-Opioid Therapies

- Standardized best practices for EDs to employ for the following:
  - Non-opioid therapies for pain management
  - Safe prescribing
  - Stigma elimination + culture shift
  - Responding to opioid use disorders (OUD) within the ED

- Available September 2019: https://www.ncha.org/health-system-response/

Patient Education on Opioids

NCHA OPIOID PATIENT EDUCATION VIDEO



- Patient handout on safe use of opioids free to hospitals and clinics prescribing opioids.
- Video for patient education on safely taking opioids + recognizing signs of addiction
- Free and available for hospitals to embed within patient-facing EMRs
- Want to use these resources in your hospital? Contact Madison Ward Willis at mward@ncha.org or 919-677-4136

Questions?

Nicholle Karim, Director of Behavioral Health:
nkarim@ncha.org // 919-677-4105

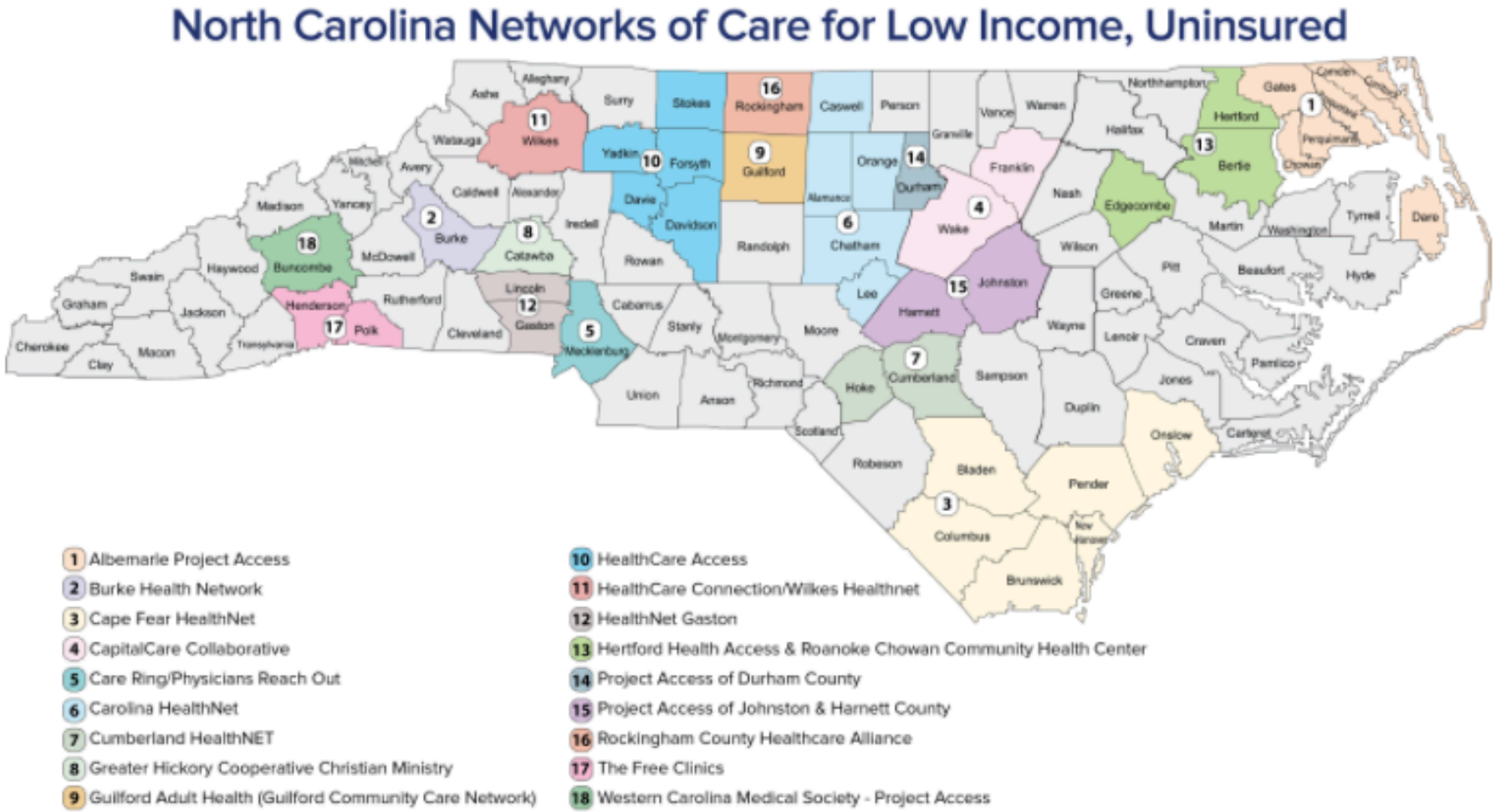
Madison Ward Willis, Performance Improvement Specialist – Community + Behavioral Health:
mward@ncha.org // 919-677- 4136

Community Health

Healthcare providers & community partners united for a healthier NC

- Emily Roland, Senior Director of Community Health

AccessHealth NC



AccessHealth NC

- *Community-based networks of care across the state providing access to coordinated primary and specialty healthcare services for low-income, uninsured*
- NCHF funded by the Duke Endowment to provide technical assistance and coaching in the form of:
  - Data to reflect positive health outcomes, impact
  - Policy & advocacy support
  - Strengthening connections w/ hospitals & health systems
- NCHF team has conducted on-site visits w/ all networks; conducted organizational assessment survey to serve as a baseline; convening networks regularly to share best practices & design new TA framework/action plans related to outcome measures (reduced ED utilization, reduced hospital inpatient utilization, improved A1c levels for patients served)

Healthy People Healthy Carolinas

Healthy People Healthy Carolinas

- *A community-based approach to addressing chronic health issues, such as obesity, diabetes and heart disease by creating multi-sector partnerships and implementing evidence-based interventions (EBIs) that work to engage residents in improving health (launched in 2015)*
- NCHF funded by the Duke Endowment to provide technical assistance and coaching, working with Population Health Improvement Partners (IP)
- NCHF team has participated in coaching calls, affinity group meetings, and onsite coalition meetings to learn IP's model of TA support, identifying elements that can inform the TA model for other NCHF projects; working w/ SCHA to create a joint evaluation plan

North Carolina Healthcare Association

Telehealth Policy Update (Parity)

Uniting hospitals, health systems and care providers for healthier communities

Overview of NCHA telehealth policy working group

- Purpose: To develop policy recommendations to overcome barriers to telehealth implementation
- Membership is made up of people from 18 hospitals and health systems across the state
- Work is in four major buckets:
  - Reimbursement – parity, designated sites, technologies allowed;
  - Regulatory – credentialing, privileging, and cross-state licenses;
  - Infrastructure – connectivity and accessibility;
  - Clinical metrics – develop these metrics to use across providers.

Recommendations to date: reimbursement

1. Federal – NCHA submitted comments on 2018 CMS telehealth rule changes for Physician Fee Schedule and will work with federal lobbyist and AHA to develop a strategy to modify the Social Security Act to change the limitations relating to geography, patient setting, and type of furnishing practitioner for Medicare telehealth services - UNDERWAY
2. State – UNDERWAY
    a) Pursue parity for private insurance, Medicaid, Medicaid managed care and State Health Plan
    b) Collect data that show that hospitals are providing telehealth services in 26 areas/service lines, but are not getting reimbursed and lack of reimbursement has impacted some areas

Recommendations to date: regulatory

- Consider working with NCDHHS on their recommendation to pursue Interstate Medical Licensure Compact and develop a standardized and centralized credentialing process – ON HOLD
- Explore The Joint Commission's proposed telemedicine standards on credentialing regulation to determine if the working group wants to recommend an approach for members – ON HOLD

Recommendations to date: infrastructure

- Advocate with broadband partners to pursue payment parity for telehealth as they think that the success of telehealth will drive demand for broadband in rural areas - UNDERWAY
- NCHA shared coverage map corrections and affordability map challenges with NC Broadband Infrastructure Office. Also, NCHA regional policy councils noted that patients lack devices beyond cell phones to access telehealth services in many parts of NC - COMPLETE

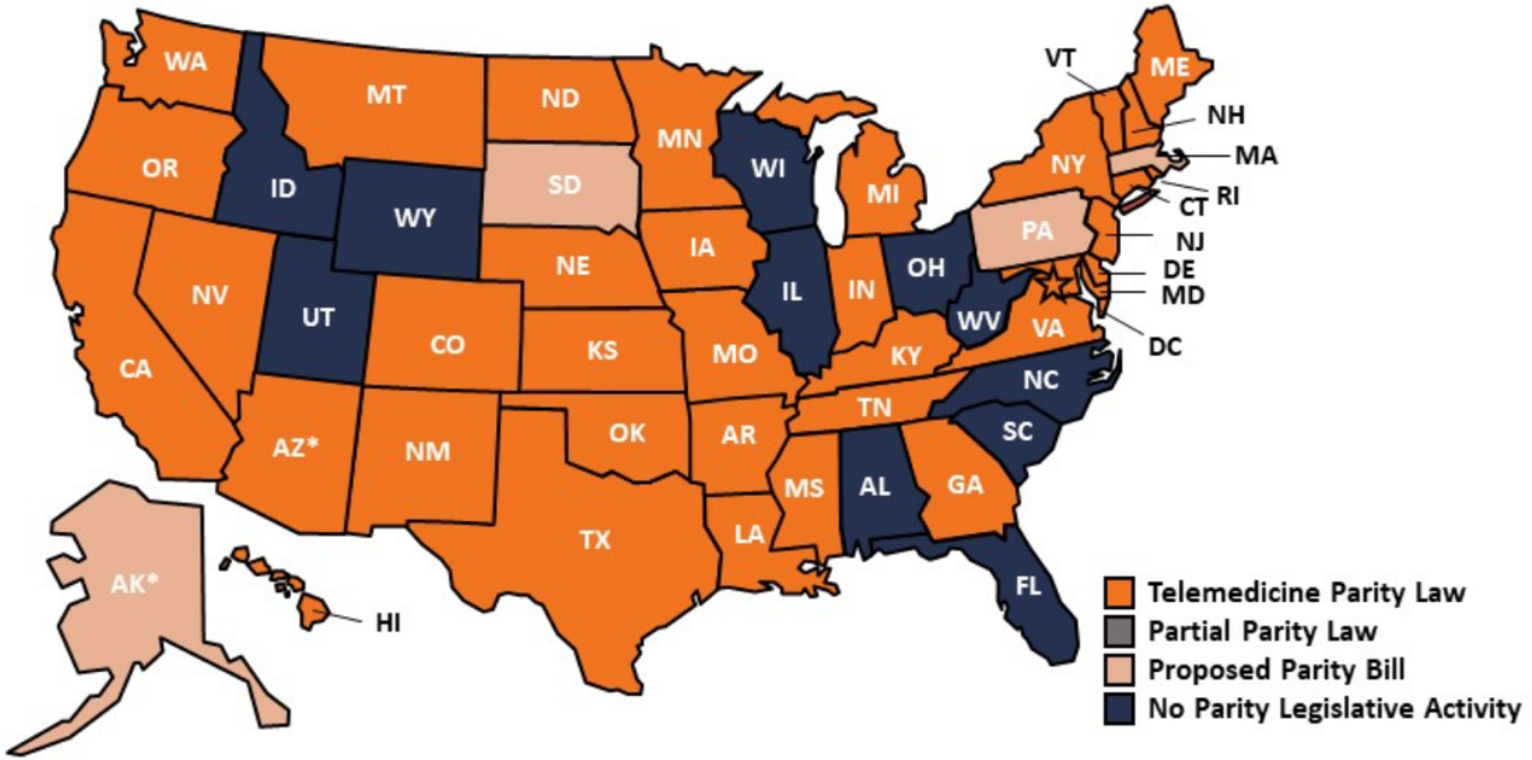
Recommendations to date: clinical metrics

- Assemble a small group of quality experts to evaluate the National Quality Forum's August 2017 report on telehealth framework and develop metrics for NCHA members – ON HOLD
- Recommend metrics to NCHA's Policy Development Committee – ON HOLD

Definition of telehealth in NC bill

- The term “telehealth” means the delivery of health care-related services by a health care provider who is licensed in this State to a patient or client through
  - (i) an encounter conducted through real time interactive audio and video technology,
  - (ii) store and forward services that are provided by asynchronous technologies as the standard practice of care where medical information is sent to a provider for evaluation, or
  - (iii) an asynchronous communication in which the provider has access to the recipient’s medical history prior to the telehealth encounter.
- The requirement for a face to face encounter shall be satisfied with the use of asynchronous telecommunications technologies in which the health care provider has access to the recipient’s medical history prior to the telehealth encounter.
- Telehealth shall not include the delivery of services solely through electronic mail, text chat, or audio-communication unless either (i) additional medical history and clinical information is communicated electronically between the provider and patient or (ii) the services delivered are behavioral health services.

States with Parity Laws for Private Insurance Coverage of Telemedicine (2018)



States with the year of enactment: Alaska (2016)*, Arizona (2013)*, Arkansas (2015), California (1996), Colorado (2001), Connecticut (2015), Delaware (2015), Georgia (2006), Hawaii (1999), Indiana (2015), **Iowa (2018),** Kentucky (2000), Louisiana (1995), Maine (2009), Maryland (2012), Michigan (2012), Minnesota (2015), Mississippi (2013), Missouri (2013), Montana (2013), **Nebraska (2017),** Nevada (2015), New Hampshire (2009), **New Jersey (2017),** New Mexico (2013), New York (2014), **North Dakota (2017),** Oklahoma (1997), Oregon (2009), Rhode Island (2016), Tennessee (2014), Texas (1997), Vermont (2012), Virginia (2010), Washington (2015) and the District of Columbia (2013)

States with proposed legislation: In 2018, Alaska, Massachusetts, Pennsylvania, and South Dakota

**Coverage applies to certain health services.*

AMERICAN TELEMEDICINE ASSOCIATION

NCHA

Borrowing from NC's neighbors, here are the key components of NCHA's 2019 draft proposal

	Coverage	Definition of Telemedicine	Provider definition	Exclusions	Intent of legislation
North Carolina (propose coverage and payment parity)	Requires insurer, Medicaid, Medicaid Managed Care and the State Health Plan to provide coverage consistent with in-person encounters (use KY); Cover additional telehealth-based services, such as remote patient monitoring and mHealth apps even if they are not covered in the in-person setting (use MS)	Interactive audio, video or other electronic media, store-and-forward, remote patient monitoring (use MS)	Healthcare provider licensed in North Carolina	Audio-only (except for behavioral health), text chat, email or facsimile	To mitigate workforce shortages and to improve health care access for North Carolinians regardless of where they live

Parity requirement

- Coverage and payment parity would be applied to Medicaid, Medicaid managed care, the State Health Plan, and commercial insurers
- “Every health benefit plan offered by an insurer in this State shall reimburse for covered services provided to an insured through telehealth. Telehealth coverage and reimbursement shall be equivalent to the coverage and reimbursement for the same service provided in person.”

Actions

- Coordinated efforts with NC Rural Center, NC Broadband Infrastructure Office, other broadband partners, and other key allies
- Proposed legislation that included provider and patient stories from regional policy councils
- Emphasized importance of telehealth to rural hospitals and in keeping patients and their care close to home

Status of HB 721

- Note: The original bill developed by workgroup would have provided a framework for telehealth services through both Medicaid and private insurance with payment parity for services provided through telehealth.
- Unfortunately, the health insurance companies (including BCBSNC) objected to those provisions.
- In order to keep the bill eligible for the session and move it to the Senate, NCHA agreed to substitute the language with that similar to Texas.
- Once in the Senate, staff will begin working to restore the original language. The bill passed the House 113-4.
- The Medicaid and SHP provisions stayed the same, but the private insurance payment parity has been removed.

North Carolina Healthcare Association

For more information:

Sue Collier, MSN, RN – VP Innovation and Clinical Excellence

scollier@ncha.org

(919) 677-4121

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Virginia and Georgia have defined coverage parity in their laws, but do not have payment parity

	Coverage	Definition of Telemedicine	Provider definition	Exclusions	Intent of legislation
Virginia (coverage, but no payment parity)	Policy includes coverage for the cost of health care services provided through telemedicine; insurers cannot exclude a service solely because it is provided through telemedicine	Use of electronic technology or media for the purpose of diagnosing or treating a patient or consulting with other health care providers	Health care provider	Audio-only telephone, email, facsimile or online questionnaire	Insurers cannot treat telemedicine services different than in-person services for lifetime maximums, copays and deductibles
Georgia (coverage, but no payment parity)	Policy includes payment for services	Audio, video or data communications used during visit or to transfer medical data obtained during visit	Duly licensed physician or other health care provider	Standard telephone, facsimile, unsecured email	To mitigate geographic discrimination in delivery of health care

Mississippi has coverage and payment parity in their laws, but has spent 5 years fighting over the law's enforcement

	Coverage	Definition of Telemedicine	Provider definition	Exclusions	Intent of legislation
Mississippi (Payment parity, but insurers and providers are still fighting over enforcement of law)	Requires insurer to cover telemedicine to the same extent that the services would be covered if they were provided through in-person consultation; RPM minimum of $10 per day each month and $16 per day with meds plus $50 training fee per patient; originating site is eligible for facility fee for RPM	Interactive audio, video or other electronic media, store-and-forward, remote patient monitoring (with limitations)	Health care provider, but RPM limited to in-state provider	Audio-only, email or facsimile	Not specified

Tennessee and Kentucky have coverage and payment parity in their laws

	Coverage	Definition of Telemedicine	Provider definition	Exclusions	Intent of legislation
Tennessee (coverage and payment parity)	Requires insurer to provide coverage consistent with in-person encounters for the same service, but does not require insurer to pay total reimbursement in amount greater than in-person encounter	Real-time, interactive audio, video or electronic tech or store-and-forward	Healthcare provider	Audio-only, email, and facsimile	Not specified, but does limit originating sites to provider office, hospital, clinic, but lets insurers add other locations
Kentucky (coverage and payment parity)	Insurers shall not exclude a service from coverage solely because the service is provided through telehealth and not provided through a face-to-face consultation	Real-time interactive audio and video, store-and-forward	Health care provider licensed in Kentucky	Audio-only, text chat, email or facsimile	Replaces previous law that required provider to be a part of Kentucky-run telehealth network; help providers care for patients, no matter where they live