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
© 2018 NCHA | All rights reserved
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)
### State: NC

#### HCAHPS

<table>
<thead>
<tr>
<th>Year</th>
<th>Average HEC</th>
<th>Average Score</th>
<th>Median HEC</th>
<th>Median Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>80</td>
<td>80%</td>
<td>81</td>
<td>81%</td>
</tr>
<tr>
<td>2018</td>
<td>82</td>
<td>82%</td>
<td>83</td>
<td>83%</td>
</tr>
</tbody>
</table>

#### EDTC

<table>
<thead>
<tr>
<th>EDTC Quality Measures</th>
<th>Total Median Performance</th>
<th>National Median Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>82%</td>
<td>82%</td>
</tr>
<tr>
<td>Physical Therapy, Med</td>
<td>81%</td>
<td>81%</td>
</tr>
</tbody>
</table>

#### Inpatient/Outpatient Data

<table>
<thead>
<tr>
<th>Measure</th>
<th>Total Median Performance</th>
<th>National Median Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>30-day Mortality</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

---

**NORTH CAROLINA HEALTHCARE ASSOCIATION**

Report Run Date: 03/13/2019

Report Run Date: 05/30/19
Upcoming Events

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

Innovation Center

Uniting hospitals, health systems and care providers for healthier communities

© 2018 NCHA | All rights reserved
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)

Community Health (HPHC, AccessHealth)

Clinical Care Delivery (FLEX/SHIP, PSO, etc.)
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
Designing an Innovation Center

- **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.

- 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
Behavioral Health Update + Resources

- Helpful tools + information for patient care

CAH Regional Meeting
Sue Collier, MSN, RN, FABC
May 22, 2019
S.B. 630 – Changes to the Involuntary Commitment Process (IVC)

**UNDERSTANDING CHANGES TO THE INVOLUNTARY COMMITMENT PROCESS**

**New Law**

Revisions to North Carolina’s Involuntary Commitment Laws

*Senate Bill 630: Revise Involuntary Commitment (IVC) Laws to Improve Behavioral Health* became law June 22, 2018. With overwhelming bipartisan support, SB 630 provides a comprehensive update to be in line with best practices for involuntary commitment, voluntary treatment, and outpatient commitment.

What do these changes mean for you and your patients? Click below to learn more.

- Voluntary Admission
- Involuntary Commitment
- Outpatient Commitment

**NCHA STAFF CONTACT**

Nicholle Karim, MSW, LC WAL
Director of Behavioral Health
NC Healthcare Foundation
919-677-4105
nkarim@ncha.org

- Law goes into effect on October 1, 2019
- Interactive educational tool on the NCHA website geared towards healthcare professionals: [https://www.ncha.org/ivcbill/](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.

**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.

**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.

- 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

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

Slides (PDF)
Recording (YouTube)
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

North Carolina Networks of Care for Low Income, Uninsured

1. Albermarle Project Access
2. Burke Health Network
3. Cape Fear HealthNet
4. CapitalCare Collaborative
5. Care Ring/Physicians Reach Out
6. Carolina HealthNet
7. Cumberland HealthNet
8. Greater Hickory Cooperative Christian Ministry
9. Guilford Adult Health (Guilford Community Care Network)
10. HealthCare Access
11. HealthCare Connection/Wilkes HealthNet
12. HealthNet Gaston
13. Hertford Health Access & Roanoke Chowan Community Health Center
14. Project Access of Durham County
15. Project Access of Johnston & Harnett County
16. Rockingham County Healthcare Alliance
17. The Free Clinics
18. Western Carolina Medical Society - Project Access
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

Cohort 1 Coalitions:
- Live Well Catawba
- Chatham Health Alliance
- Granville Working on Wellness
- Montgomery/Richmond 2020 Taskforce
- Wilkes Health Action Team

Cohort 2 Coalitions:
- Brunswick Wellness Coalition
- Henderson Partnership for Health
- Pitt Partnership for Health
- Healthy Robeson
- Healthy Rowan
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
Telehealth Policy Update (Parity)
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.
Borrowing from NC’s neighbors, here are the key components of NCHA’s 2019 draft proposal

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Definition of Telemedicine</th>
<th>Provider definition</th>
<th>Exclusions</th>
<th>Intent of legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina (propose coverage and payment parity)</td>
<td>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)</td>
<td>Interactive audio, video or other electronic media, store-and-forward, remote patient monitoring (use MS)</td>
<td>Healthcare provider licensed in North Carolina</td>
<td>To mitigate workforce shortages and to improve health care access for North Carolinians regardless of where they live</td>
</tr>
</tbody>
</table>
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.
For more information:

Sue Collier, MSN, RN – VP Innovation and Clinical Excellence
scollier@ncha.org
(919) 677-4121
Virginia and Georgia have defined coverage parity in their laws, but do not have payment parity

<table>
<thead>
<tr>
<th></th>
<th>Coverage</th>
<th>Definition of Telemedicine</th>
<th>Provider definition</th>
<th>Exclusions</th>
<th>Intent of legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Virginia</strong></td>
<td>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</td>
<td>Use of electronic technology or media for the purpose of diagnosing or treating a patient or consulting with other health care providers</td>
<td>Health care provider</td>
<td>Audio-only telephone, email, facsimile or online questionnaire</td>
<td>Insurers cannot treat telemedicine services different than in-person services for lifetime maximums, copays and deductibles</td>
</tr>
<tr>
<td><strong>Georgia</strong></td>
<td>Policy includes payment for services</td>
<td>Audio, video or data communications used during visit or to transfer medical data obtained during visit</td>
<td>Duly licensed physician or other health care provider</td>
<td>Standard telephone, facsimile, unsecured email</td>
<td>To mitigate geographic discrimination in delivery of health care</td>
</tr>
</tbody>
</table>

(coverage, but no payment parity)
Mississippi has coverage and payment parity in their laws, but has spent 5 years fighting over the law’s enforcement

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Definition of Telemedicine</th>
<th>Provider definition</th>
<th>Exclusions</th>
<th>Intent of legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mississippi (Payment parity, but insurers and providers are still fighting over enforcement of law)</td>
<td>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</td>
<td>Interactive audio, video or other electronic media, store-and-forward, remote patient monitoring (with limitations)</td>
<td>Health care provider, but RPM limited to in-state provider</td>
<td>Audio-only, email or facsimile</td>
</tr>
</tbody>
</table>
Tennessee and Kentucky have coverage and payment parity in their laws

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Definition of Telemedicine</th>
<th>Provider definition</th>
<th>Exclusions</th>
<th>Intent of legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tennessee (coverage and payment parity)</td>
<td>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</td>
<td>Real-time, interactive audio, video or electronic tech or store-and-forward</td>
<td>Healthcare provider</td>
<td>Audio-only, email, and facsimile</td>
</tr>
<tr>
<td>Kentucky (coverage and payment parity)</td>
<td>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</td>
<td>Real-time interactive audio and video, store-and-forward</td>
<td>Health care provider licensed in Kentucky</td>
<td>Audio-only, text chat, email or facsimile</td>
</tr>
</tbody>
</table>