
North Carolina Healthcare Quality Initiative:

Building Connectivity Beginning with Medication Management

*Improving Healthcare in North Carolina by Accelerating the
Adoption of Information Technology*

Emerging Models for Connected Communities

“Connected Communities”

- Connected Community (RHIO or RHIN)
 - A collaborative, consumer-centric collaboration or organization focused on facilitating the coordination of existing and proposed e-health initiatives within a region, state, or other designated local area.
 - Goal is for Connected Communities to adopt and implement standards-based solutions that eventually will link into the envisioned National Health Information Network (**NHIN**).

Types of Connected Communities

- **Federations**

- Large, “self-sufficient” enterprises that agree to network and share access to information they maintain on peer to peer basis

- **Co-ops**

- Mostly smaller enterprises; agree to pool resources, create combined, common data repository

- **Hybrids**

- Combination of Federations and Co-ops; allows aggregation across large areas (statewide or regional)

Organizational Structures for RHIOs

- **501(c)(3) Nonprofit**
- **Option #1: Organize and operate “utility”**
 - Centralized database
 - Patient information exchange and locator
 - Clearinghouse
- **Option #2: Neutral, convener, facilitator**
 - Bring together competitive enterprises
 - Bridge multiple RHIOs in geographic location
 - Open-standards approach – non vendor specific

Challenges to RHIO Formation

- **Business Issues**
- **Policy Issues**
- **Political Issues**
- **Technical Issues**
- **Security Issues**

Key Allies for a RHIO Include:

- **Governor's Office**
- **State HHS Department**
- **Medical Society**
- **Hospital Association**
- **Nurses Association**
- **Health Information Management Assn.**
- **Medical Group Managers Association**
- **Healthcare Financial Management Association**
- **Association of Local Health Directors**
- **Association of Pharmacists**
- **Long-term Care Association**
- **Association of Health Plans**
- **QIOs**
- **Pharmaceutical Industry**
- **Vendors / Consultants / Law Firms / etc.**
- **Etc., Etc.**

On the Drawing Board for NC: NCHICA Initiatives

NCHICA Background

- Established in 1994 by Executive Order of Governor
- 501(c)(3) nonprofit - research & education
- **Mission: *Improve healthcare in NC by accelerating the adoption of information technology***
- 240+ members including:
 - Providers
 - Health Plans
 - Clearinghouses
 - State & Federal Government Agencies
 - Professional Associations and Societies
 - Research Organizations
 - Vendors and Consultants

Past NCHICA Initiatives

- **1994-1996** **Statewide Patient Information Locator Project**
- **1995-1999** **Model Privacy Legislation**
- **1998-2005** **HIPAA Work Groups**
- **1998-2005** **PAiRS Immunization Initiative**
- **1998-2000** **Y2K**
- **1999-2005** **NCEDD ED Data Initiative**

NC Healthcare Quality Initiative

- Phase I – Medications Management
 - Medication history compiled from multiple sources
 - Automate refills
 - Access to formularies
 - e-Rx
- Phase II
 - Laboratory orders and results
 - Radiology orders and results
- Phase III
 - Electronic Health Records

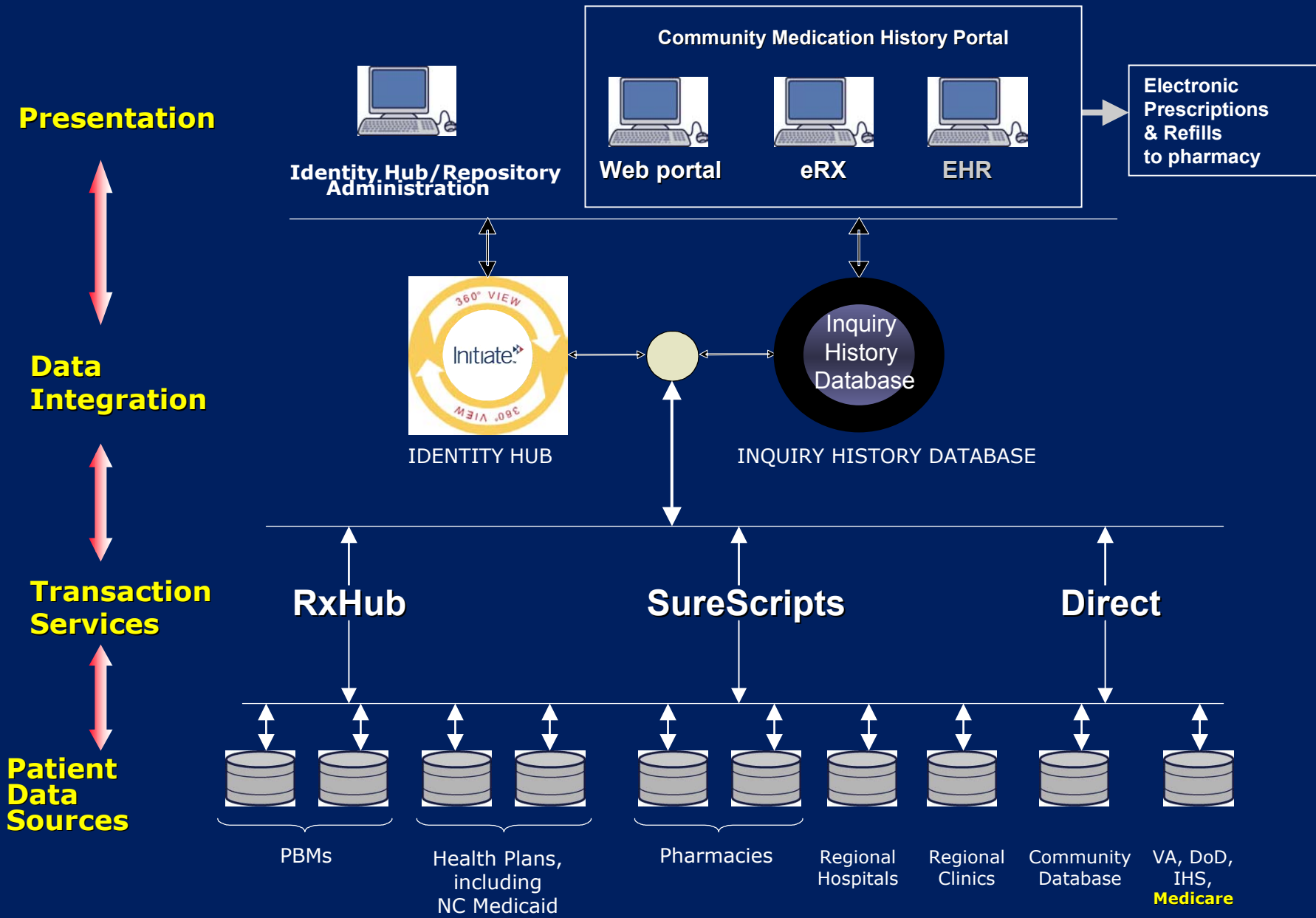
Medications Management Project

- **2003** - NCHICA Board embraces improving safety, quality, effectiveness, and efficiency by making medication history / prescription information available, under appropriate procedural authority, to providers of care and those directly involved in care management.
- **2005** - *IBM, CIGNA, and NCHICA discuss efforts to improve care for IBM covered lives, and begin process to build business case for initiative; initial thrust in Triangle area with expansion statewide*
- **2005** - *CIGNA licenses Bridges to Excellence for NC*
- **2005** – *ONCHIT-3 RFP for NHIN Prototypes*

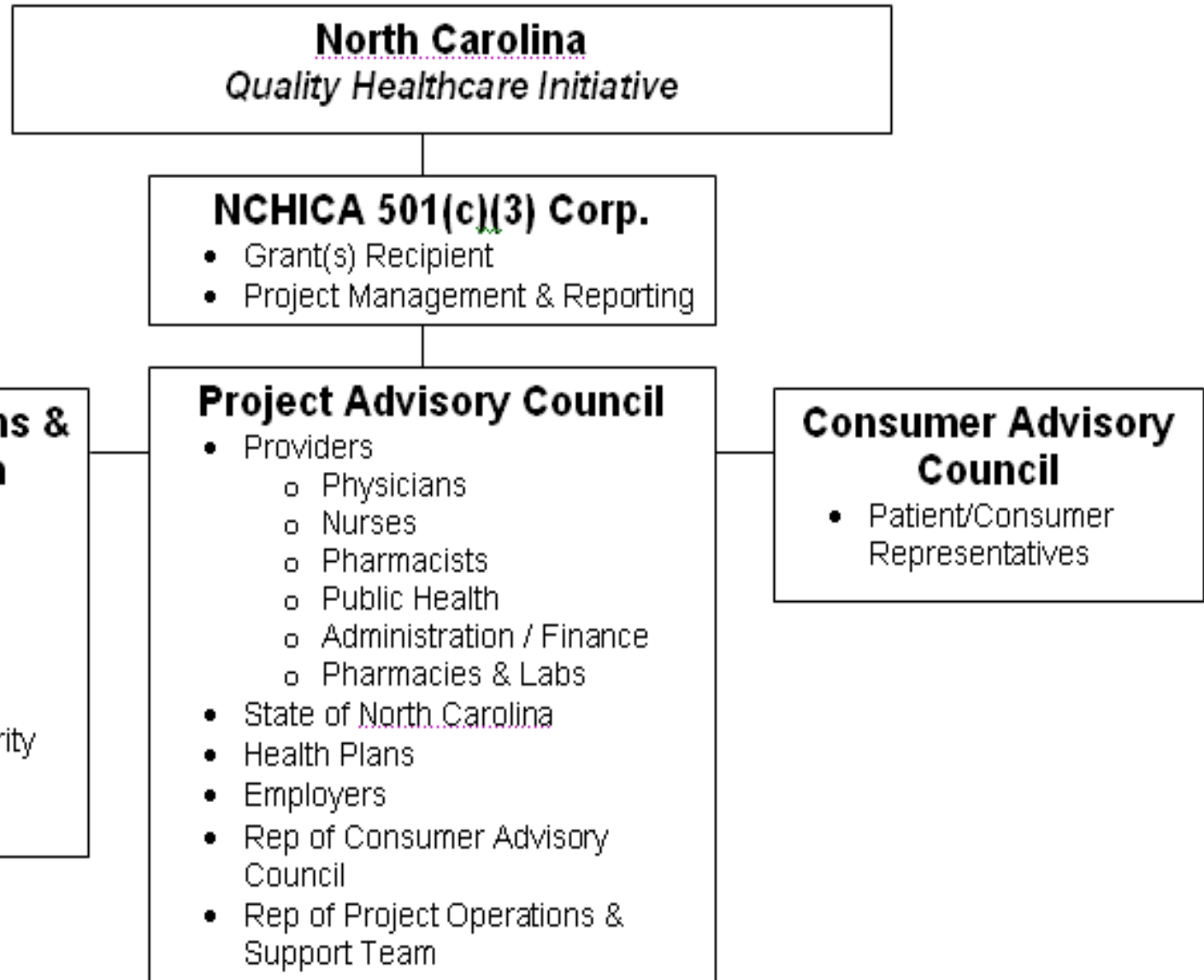
Medications Management Project

- Key Features:
 - Saves clinician's time (10%-40% of encounter)
 - Leads to automating medication refills
 - Improves patient safety
 - Leads to e-Prescribing
- Example: Medicare Population *
 - 20% have 5 or more chronic conditions
 - Chronic Care accounts for 70%-80% of expenditures
 - Those 20% see on average **13.5 different physicians** per year with average 40 office visits
 - **Potential for prescribing errors, duplication of orders, tests, etc.**

Medications Management Project



Medications Management Project - Organization



Medications Management Initiative

- **Business case payback calculations:**
 - emphasis to be placed upon short-term returns from expense reductions by stakeholders
 - rather than long-term results expected from improvements in overall patient health and employee productivity.
- **Business cases scenarios will address:**
 - advantages / disadvantages to the stakeholders
 - revenue impact
 - expense impact
 - timing
- **The initiative will have:**
 - measurable impact on accelerating technology adoption and
 - first transactions routed in early 2006

Potential Benefits to Employers and Payers Include:

- 1. Greater generic dispensing**
- 2. Fewer outbound calls to physicians**
- 3. Lower customer service call volume**
- 4. Better compliance with preferred formularies**
- 5. Increased volume of mail order prescriptions**
- 6. Lower dispensing fees**
- 7. Automated refills**

Provider Business Case

Existing IPA Infrastructure Analysis:

- **Key IPA, Raleigh, NC (Sample IPA Chosen)**
 - 43 practice groups
 - 140 physicians, entirely primary care (pediatrics, internal medicine, family medicine)
- **NOTE: (per SureScripts)**
 - 263 physicians represent 80% of prescriptions for the greater Raleigh-Durham market
 - some are Key IPA members

Provider Business Case

| | # of Practices | % of Practices | # of Physicians | % of Physicians | Avg. # of Physicians |
|--------------------|----------------|----------------|-----------------|-----------------|----------------------|
| Already There: | 11 | 25.6% | 54 | 38.6% | 4.9 |
| Going There: | 8 | 18.6% | 27 | 19.3% | 3.4 |
| Tough Sell: | 22 | 51.2% | 57 | 40.7% | 2.6 |
| Long Haul: | 2 | 4.7% | 2 | 1.4% | 1.0 |

- Already There - practices already using Electronic Medical Records (EMRs)
- Going There - practices with solid Practice Management Systems (PMS) infrastructure, and in some cases lower-level EMR systems, who are looking for an upgrade to more capable EMR
- Tough Sell - practices principally with solid PMS infrastructure but not looking to implement EMR any time soon
- Long Haul - practices with limited or no PMS infrastructure, and no interest in an EMR

Potential Benefits to Providers Include:

- 1. Decreased call volume**
- 2. Automated refills**
- 3. Electronic script & signature**
- 4. Pay for performance incentives**
- 5. Fewer errors and improved quality**

Key Challenges Include

- **Agreements among multiple partners**
 - Health Plans
 - PBMs
 - Providers
 - Consumers
- **Access to Government Sources of Data**
 - Medicare
 - Medicaid
 - Veterans Health Administration
 - Indian Health Service
 - DoD
- **Standards**
 - Authentication Across Multiple Enterprises
 - Data Interchange (NCPDP, HL7, etc.)
- **Business Case & Sustainability**
 - Competitive Position
 - Free Rider Effect
 - Market Enablement
- **Unknown Factors**

Thank You

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