NC HealthConnex
Powering Health Care Outcomes

NORTH CAROLINA HEALTH INFORMATION EXCHANGE AUTHORITY

Advisory Board Meeting

June 7, 2023

NCDIT
NORTH CAROLINA DEPARTMENT OF INFORMATION TECHNOLOGY

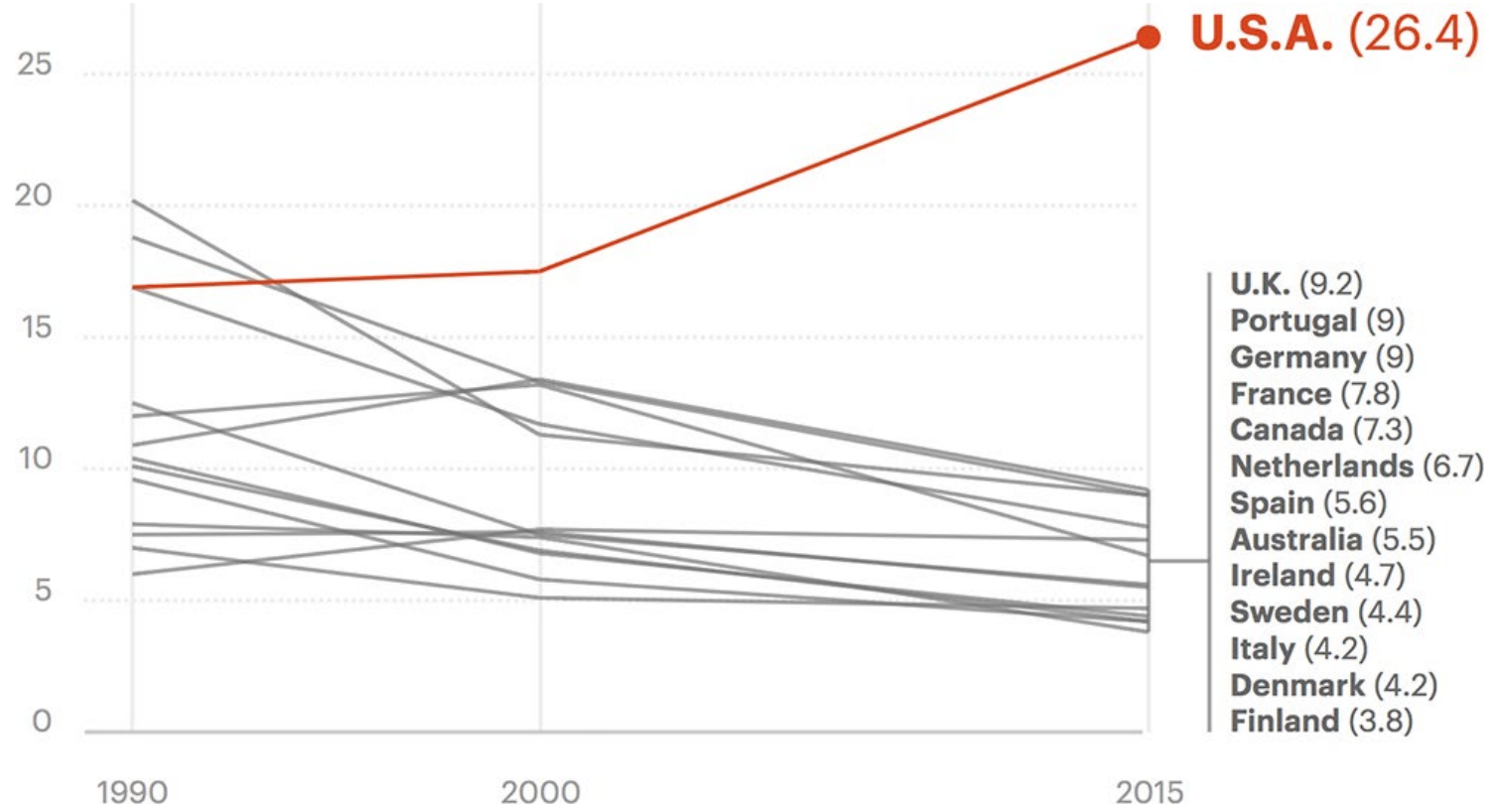
ACURE4Moms Study

(Accountability for Care through Undoing Racism & Equity for Moms)

UNC SCHOOL OF MEDICINE
Obstetrics and Gynecology

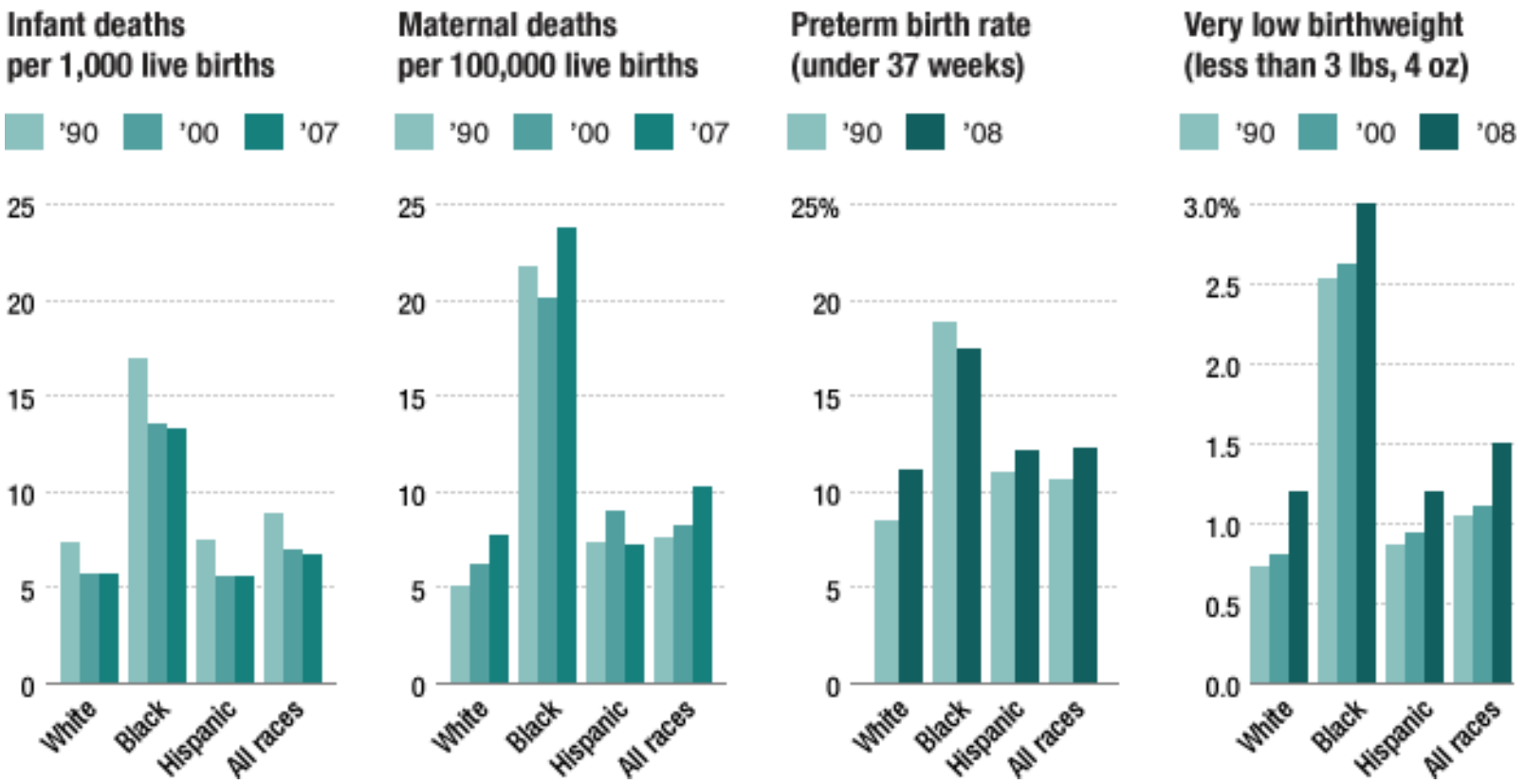
ACURE4Moms
Accountability for Care through Undoing Racism & Equity

Maternal Mortality in the United States



"Global, regional, and national levels of maternal mortality, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015," *The Lancet*. Only data for 1990, 2000 and 2015 was made available in the journal.

Racial Disparities in Birth Outcomes



Notes

The World Health Organization defines "maternal death" as "the death of a woman while pregnant or within 42 days of termination of pregnancy."

Source: Centers for Disease Control and Prevention

Credit: Alyson Hurt/NPR


WE LIFT UP BLACK MOTHERS AND CALL ON PUBLIC OFFICIALS TO ADDRESS BLACK MATERNAL HEALTH DISPARITIES.
IN OUR OWN voice
National Black Women's Reproductive Justice Agenda
BLACK MATERNAL HEALTH WEEK

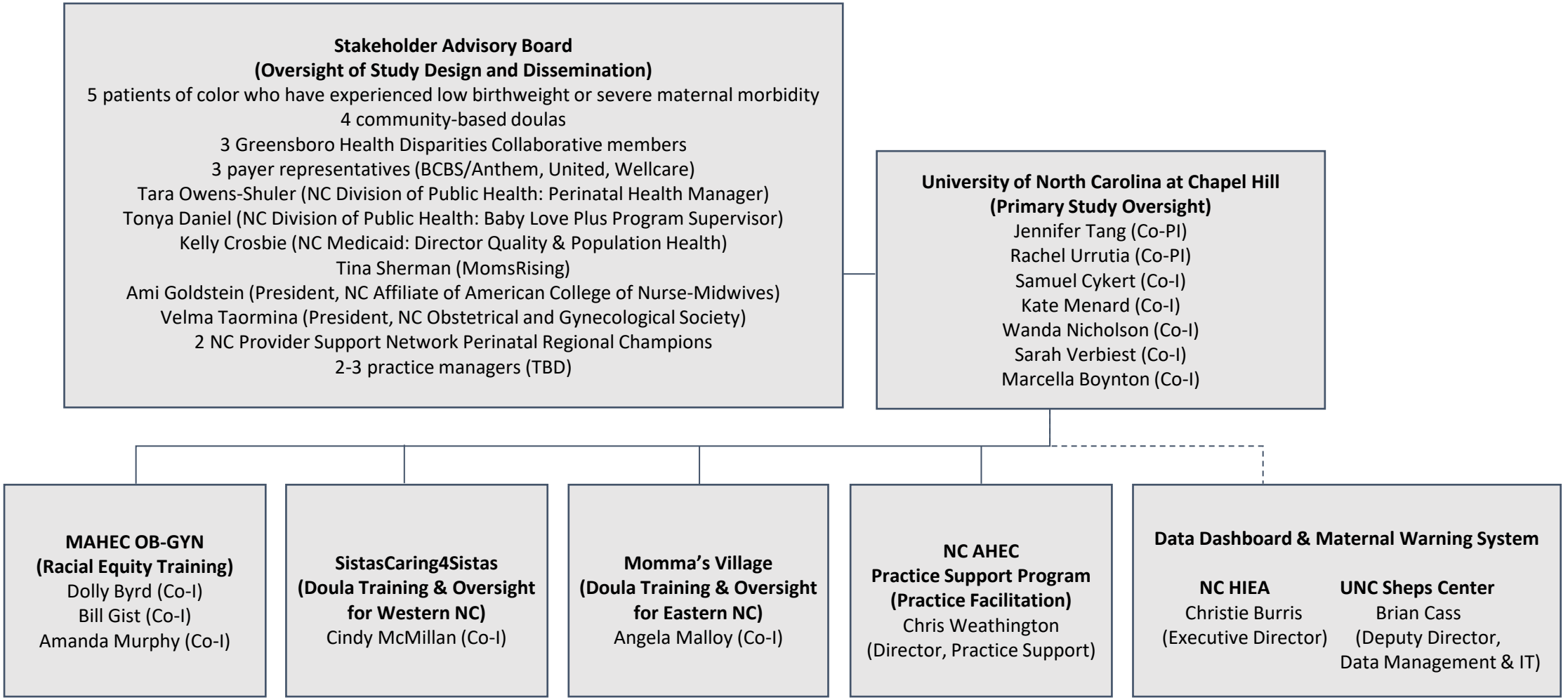
How to decrease maternal health disparities?

- Lack of proven interventions to decrease Black-White disparities in maternal health.
  - Data Accountability and Transparency
    - ACCURE* study eliminated lung & breast cancer disparities
    - Heart Health Now study reduced Cardiovascular Risk Disparities
      - Quarterly presentation of race-stratified **Data Dashboard**
      - Quarterly **Racial Equity Training**
      - **Early Warning System**
      - **Active quality improvement**
  - Community-Based Doula support
    - Reduces Cesarean section, pain medication and improves satisfaction with birth
    - Associated with ↓LBW in Greensboro

*ACCURE=Accountability for Cancer Care through Undoing Racism and Equity

Cykert, et al. J Natl Med Assoc 2019

PCORI and Duke Endowment-funded ACURE4Moms Study Partners



The University of North Carolina at Chapel Hill

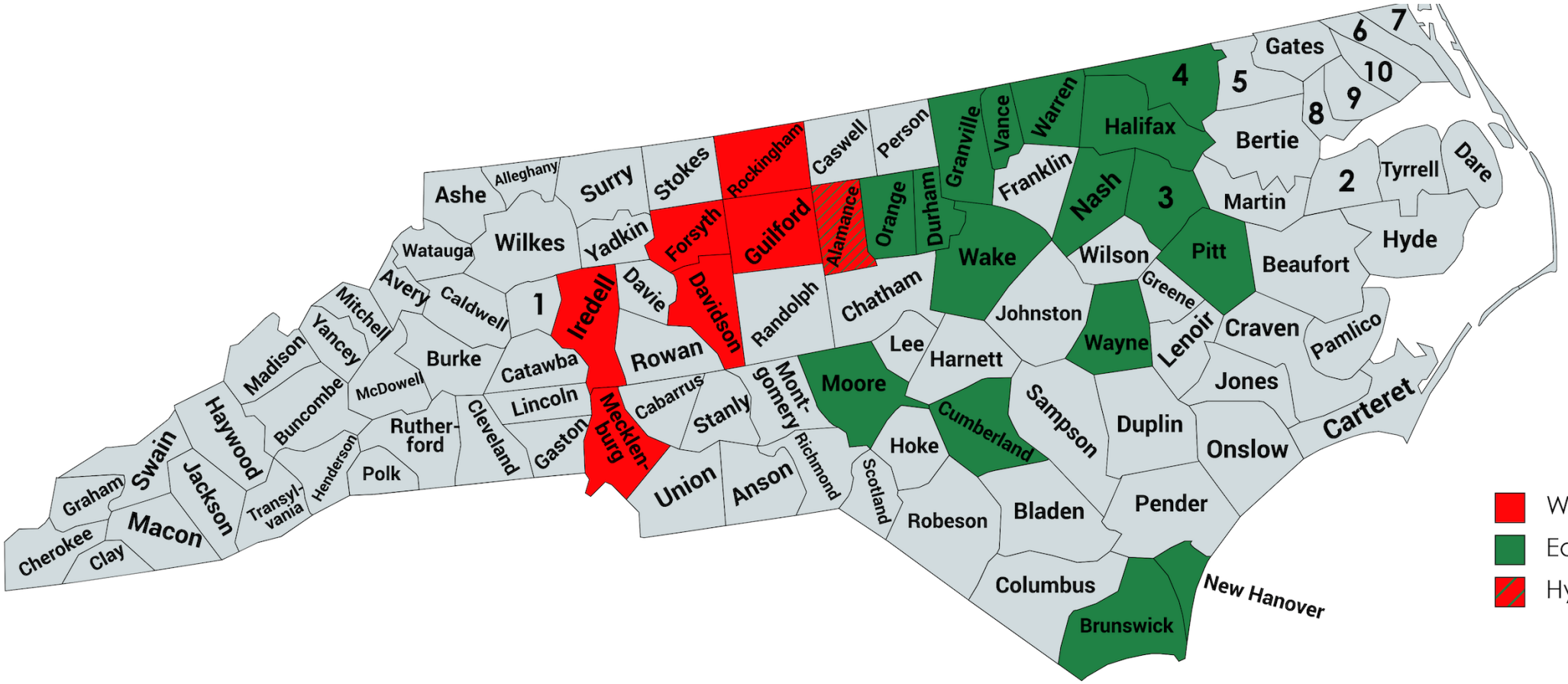
ACURE4Moms Study Design

- Four arm cluster RCT of 40 practices:
  - 1) Standard Care Management (**Control Arm**)→ 10 practices
  - 2) Data Interventions-Only (**Data Arm**)→ 10 practices
  - 3) Community-Based Doula Support-Only (**Doula Arm**)→ 10 practices
  - 4) Data Interventions + Doula Support (**Data+Doula Arm)→** 10 practices

Practice Recruitment Map

ACURE4Moms
Accountability for Care through Undoing Racism & Equity

pcori



ACURE4Moms Study Aims & Outcomes

- Aim 1: Compare proportion of Black women who deliver a **low birthweight** baby between Arms (**Primary Outcome).**
  - Secondary: **Maternal Morbidity and Mortality**

- Aim 2: Compare **# ED visits and hospitalizations** during pregnancy and up to 1 year after delivery between Arms.

- Aim 3: Explore trends in **self-reported racism** during pregnancy and up to 4 months after delivery between Arms through patient surveys.

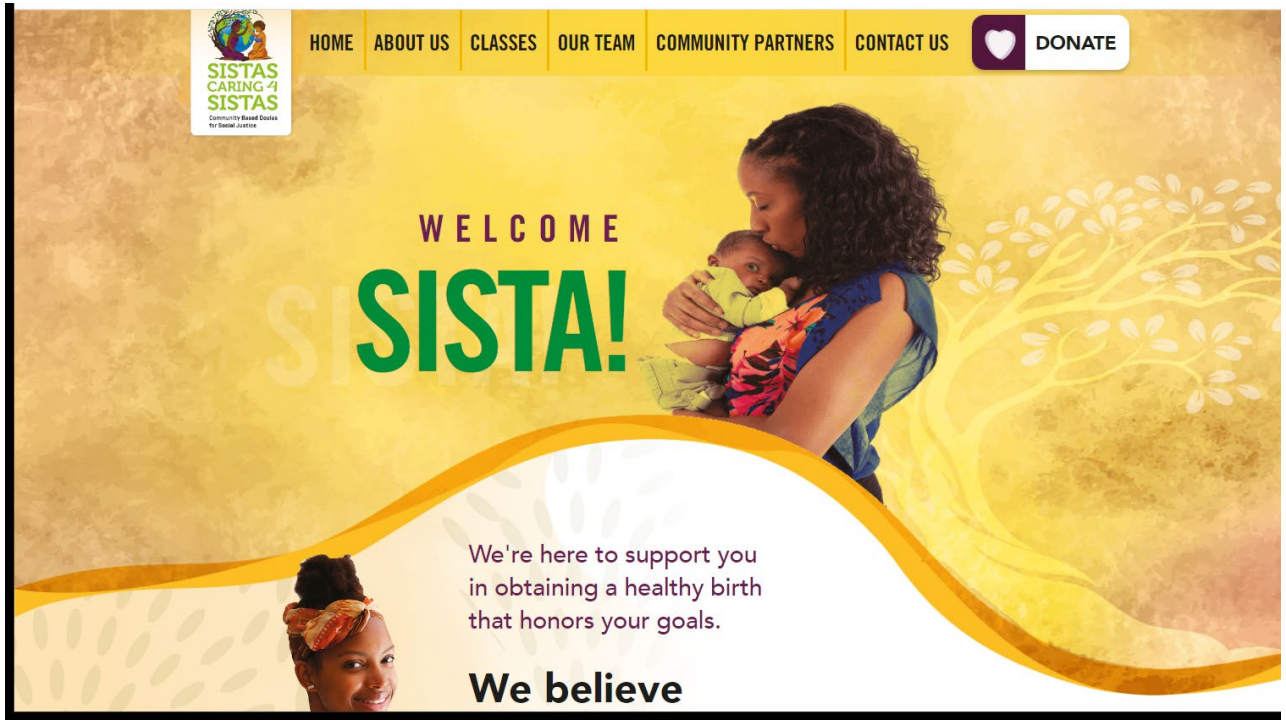
Standard Care Arm (1)

- Participate in Medicaid Care Management for High-Risk Pregnancies as usual
- Participate in any current pay per performance or QI processes that are already in place
- Patients work with doulas on an ad hoc basis

Community-Based Doula Arms (3 and 4)

- Linkage between the practice and 2 community-based doulas→Quarterly meetings together
- Practices refer patients at high risk for Low birth weight for doula support
- Doulas support 6 births per month x 2 years
  - Prenatal support
  - Birth Support
  - Postpartum support

Doula Organizations



Data Accountability and Transparency Arms (2 and 4)

- Modified from the ACCURE and HHN studies
- Race equity dashboards for key maternal health and quality of care indicators
- Quarterly meetings to present data to practice and to undergo race equity training
- Maternal Early Warning System: flags patients who are missing key preventive services
- Practice facilitators from AHEC to help with Quality Improvement on Key Indicators

Practice Criteria

- Be willing to be randomized to 1 of the 4 Arms
- Be in (or close to) 1 of the Targeted Counties
- Have at least 7-8 deliveries of Black women per month
  - Currently Share Data with the HIEA

NC HIEA Deliverables

- Data Extraction for 40 practices for analysis of outcomes
- Maternal Early Warning Alerts for 20 practices (same 20 as above) through NC*Notify
  - Elevated Blood Pressure
  - Missed Prenatal and Postpartum Visits
  - Aspirin Needed to Prevent Preeclampsia
  - ???? Others
- Health Disparities Dashboard for 20 practices: Low birth weight; Preterm birth; Cesarean Section rate; ED visits during pregnancy and postpartum; Hospitalizations during pregnancy and postpartum; Severe Maternal Morbidity (ICD-10-CM/CPT codes); Postpartum visit attendance; Contraceptive use; Number of Alerts; Time to respond to Alerts

Alignment with Current Medicaid Priorities for HIEA

- Phase 1 priorities are mostly all included as key elements in our data request

HIEA Priority Data Elements	Category
A1c Values (diabetics)	Clinical Values
Blood Pressure	Clinical Values
Name/DOB	Member Demographics
Depression Screening (adolescents and adults)-positive score	Screenings/Exams
Screening for Depression and Follow-up	Current Treatment
Depression screening (maternal)-positive screening	Screenings/Exams
Medications (Contraceptive. Antidepressant/Anxiolytic, Opioids, Antipsychotics	Current Treatment
Labs (Blood glucose testing)	Current Treatment

The Value-Added of HIEA

- Data collection regardless of where care was received
- Data Dashboard and Maternal Early Warning Alerts will be state utilities that other practices could easily use
- Build results-based accountability structure within HIEA for maternal health that can be used by payers, public health programming, health systems, etc.
- Working with Medicaid and other stakeholders for collaboration and synergy
  - HRSA grant
  - Wake Forest project

Timeline

- Apr 1, 2022: award started
- November 2022: randomized practices
- May 2023-December 2023: onboarding practices
  - 20 will have data accountability and transparency elements
  - Phase 1 alerts available mid June 2023
  - Dashboard available last quarter 2023
- June-December 2025: 10 Arm 1 sites begin implementation of desired interventions, including Data Accountability and Transparency
- Mar 2027: award ends

Proposed HIEA Use Case

- HIEA extracts data for all sites and shares with our secure research database (Sheps)
- HIEA builds data dashboard and early warning system for practices randomized to data accountability and transparency
  - 20 practices randomized to data accountability and transparency 2022-23
  - 10 practices randomized to standard care, if desired, 2025
- Maternal Early Warning System and Race Equity Dashboards become state utilities that other practices can use to improve quality of care and disparities in maternal health care

Conclusions

- The goal for ACCURE4Moms is to see improved outcomes and reduced disparities for mothers and infants
- The cross site and multiple EHR-data sources and ability to scale up any data accountability tools makes HIEA an ideal partner

Questions?

- Rachel Peragallo Urrutia: rachel_peragallo@med.unc.edu
- Jennifer Tang: jennifer_tang@med.unc.edu
- Angela Malloy: angela@mommasvillage.org
- Cindy McMillan: cindy@sistascaring4sistas.org

ACURE4Moms

Accountability for Care through Undoing Racism & Equity

THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

North Carolina State Transformation Collaborative: Critical Role for the NC HIEA

Presentation to the NC HIEA Advisory Board
June 7, 2023

Rebecca Whitaker, PhD, MSPH

Research Director, Duke-Margolis Center for Health Policy

Presentation Overview

- Review the status of Health Care Transformation in North Carolina
- Describe the role for multi-stakeholder alignment in advancing reforms
- Describe the State Transformation Collaborative opportunity and progress to date
- Highlight synergistic policy reforms at the national level
- Identify opportunities for the NC HIEA to engage in the NC State Transformation Collaborative

Status of Health Care Transformation in NC

Steps toward supporting better population health – **primary care payment reforms, availability of telehealth, social services data sharing, public health/health care collaboration** – helped NC achieve relatively good results relative to other states in terms of limiting deaths and disparities in the pandemic

NC DHHS, Medicare, and other health insurers remain committed to the **transformation goals of improving equity, outcomes, and affordability** – while recognizing complications caused by COVID-19 and economic disruptions

Variety of steps taken to encourage payment and delivery system reforms, but these changes are occurring in pockets and not directionally aligned across payers, limiting participation and uptake

Health care systems are stressed with **staffing shortages and rising costs** – need to focus on steps that can reduce the workforce burdens and inefficiencies in care delivery

Multi-stakeholder Alignment Can Help Advance Health Reform Efforts

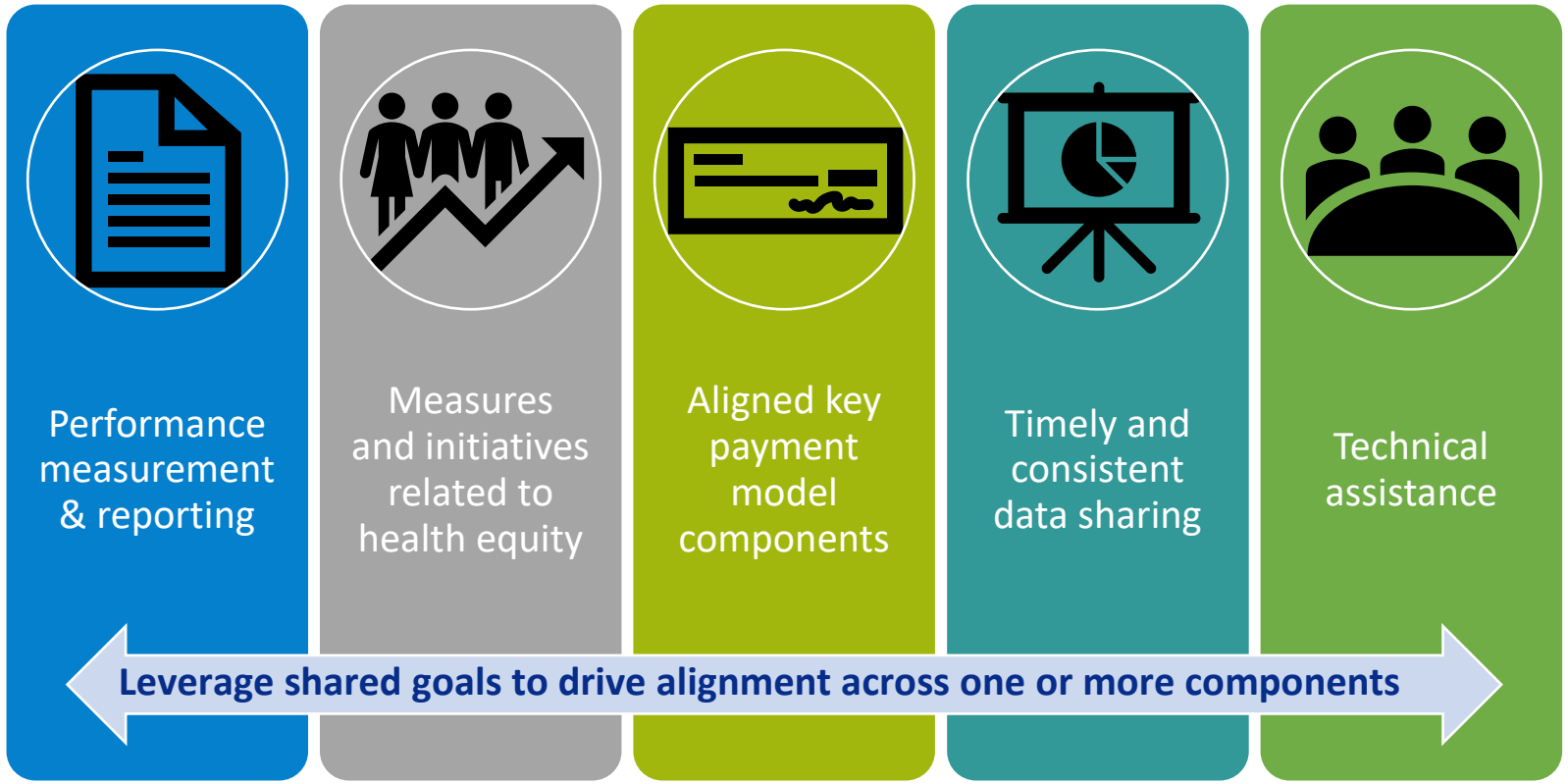
Accelerate participation in new payment and delivery models and improve provider performance.

Reduce variability and administrative burden by creating a single set of expectations that helps providers pursue the same goals for all patients, regardless of which payer or program insures them.

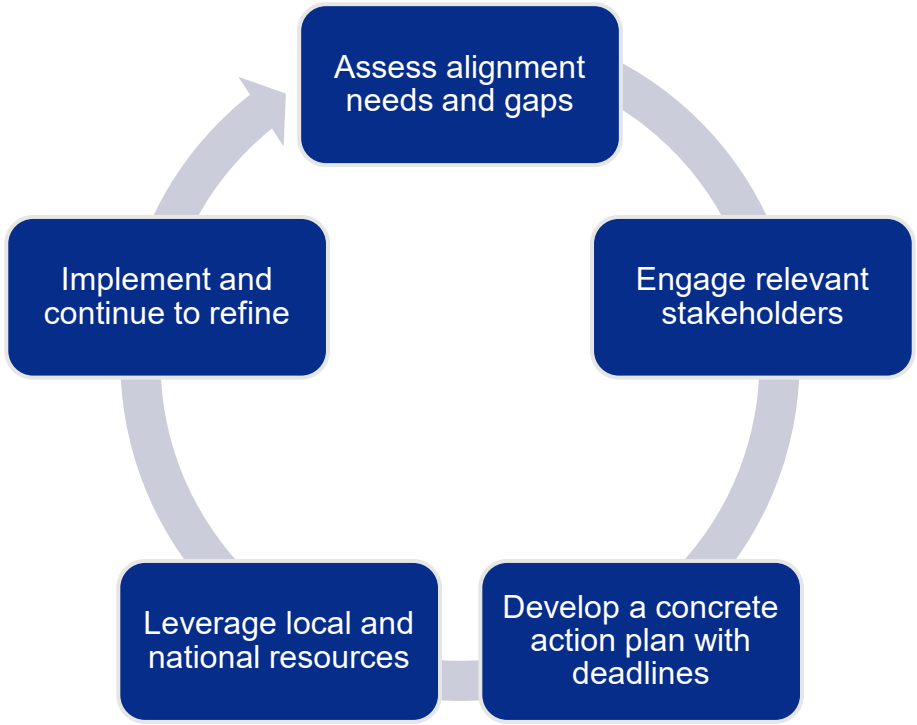
Improve health system capabilities, including addressing rising costs and disparities, identifying and tracking data that can improve provider performance, building technical infrastructure, and sharing best practices.

Multipayer Alignment Framework with Iterative Steps to Achieve Progress toward Shared Goals

Foundational Elements of Alignment



Iterative Alignment Pathway



Opportunity to Synergize with Centers for Medicare & Medicaid Services Strategy

Source: Innovation At The Centers For Medicare And Medicaid Services: A Vision For The Next 10 Years

Public-Private Collaboration to Advance Payment and Care Reform

HCPLAN
Health Care Payment Learning & Action Network

"The Health Care Payment Learning & Action Network (HCPLAN or LAN) is an active group of public and private health care leaders dedicated to providing thought leadership, strategic direction, and ongoing support to accelerate our care system's adoption of alternative payment models (APMs)."

- Focus on specific actions to support advanced, accountable care that achieves improvements in outcomes, spending, and equity
- Goal of advancing synergistic payment and care reforms by engaging communities and states

https://hcp-lan.org/about-us/

State Transformation Collaboratives

A private-public and state-federal partnership to continue to shift the economic drivers away from fee-for-service to a value-based, person-centered approach to health through ***Medicaid****,* ***Medicare,*** *and* ***commercial*** *collaboration and partnership.*

Comprised of payers, purchasers, providers, health systems, purchasers, patient advocates, and community organizations

Identifying commonalities in locally-driven approaches to enable cross-state learning and implementation of alternative health care payments

Four distinct working groups:

North Carolina

Arkansas

Colorado

California

Identifying and Exploring Priority Areas for Action

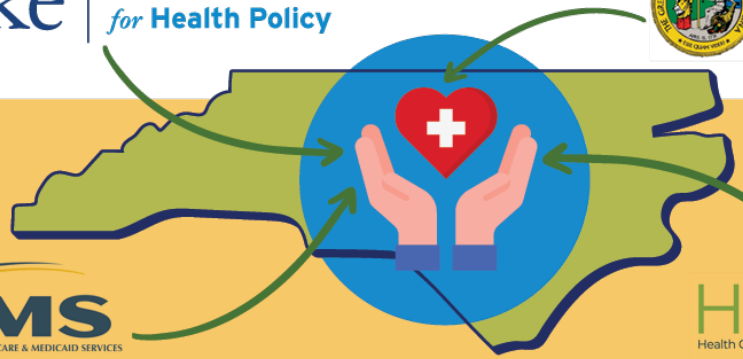
At the request of the NC Division of Health Benefits, Duke-Margolis is serving as the convener for the State Transformation Collaborative. The image below describes the roadmap for early activities.

1. Interview interested stakeholders to identify priority areas for alignment in payment and delivery reforms that would apply across payer and purchaser organizations

2. Aggregate themes from the learning calls to identify potential priorities for the State Transformation Collaborative

3. Convene multi-stakeholder groups to focus on alignment on a few priority areas identified via the stakeholder interviews

State Transformation Collaborative



Our Goals

- Improve Population Health
- Advance Health Equity
- Enhance Patient Experience
- Relieve Provider Burden
- Reduce Cost

Our Strategies

- Strengthen Primary Care
- Align Quality Measures
- Enhance Health Equity Data
- Improve Data Infrastructure

Our Vision

An innovative North Carolina health care delivery system that rewards better health outcomes, integrates physical and behavioral health, and invests in non-medical interventions aimed at reducing costs and improving the health of North Carolinians.

STC ROLE

Securing and implementing an agreed path forward for alignment and action.

Sign up on our website to receive regular updates about this initiative: https://healthpolicy.duke.edu/ncstc

Proposed Next Steps for the NC State Transformation Collaborative

- Identify a small set of high-priority primary care performance measures where we know persistent disparities exist for voluntary adoption across payers and lines of business


Maternity Care


Cardiovascular Disease


Behavioral Health

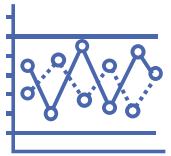

Patient-Reported Measures


Child Immunizations

- Streamline the measurement process across payers to reduce burden on providers and give them more time for patient care
- Develop a consistent approach for measuring and identifying disparities
- Build data infrastructure to support improvements on performance measures and health disparities

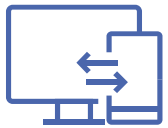
Longer-term goal: Leverage these streamlined, multi-stakeholder approaches to encourage adoption of advanced, coordinated primary care models that can improve health and health equity for patients.

Timely & Synergistic National Policy Reforms



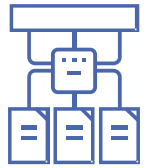
Transition to dQMs

- CMS strategic roadmap & transition to digital quality measures (dQMs)
- NCQA producing dQMs



Bulk FHIR Data Sharing

- Through 21st Century Cures Act, ONC added criteria for APIs for Bulk FHIR starting in 2023
- Coalition including ONC, VA, and leading academic health systems to participate in wider Bulk FHIR use
- NCQA-led coalition to evaluate quality of FHIR data for use as supplemental data in HEDIS reporting
- Anticipated pilot by CMMI for Bulk FHIR for demographic and SDOH data (ACO REACH)



Health Equity Measurement in Payment Models

- ACO REACH requires participants to implement health equity plans and reduce disparities
- Commercial payers and Medicaid agencies are implementing value-based contracts and incentive payments to encourage the identification of health inequities and reductions in health disparities
- NCQA Health Equity Accreditation Plus for plans and providers to collect social needs data and build community partnerships

National Efforts to Improve Health Equity Data

- Proposed revision to OMB Race & Ethnicity Standards
- Health plan requirements to screen for social needs

NC HIEA Engagement in the NC STC

Opportunity to leverage this multi-stakeholder initiative to improve data quality and data flows between payer and provider organizations

- Collaborating on the performance measurement process to identify opportunities to minimize administrative burden associated with collecting, reporting, validating performance data
- Facilitating bulk FHIR data sharing on key hybrid performance measures where clinical data standards are well-established (e.g., blood pressure and hypertension)
- Informing a multi-payer strategy to improve data quality
- Assisting with data quality checks for health equity data (e.g., race, ethnicity, language, sexual orientation, gender identify, disability, social drivers of health); help establish a “source of truth”

Thank You

Contact Us

100 Fuqua Drive, Box 90120, Durham, NC 27708

1201 Pennsylvania Avenue, NW, Suite 500
Washington, DC 20004

healthpolicy.duke.edu

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dukemargolis@duke.edu

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NC Medicaid and HIEA: Partnering to Improve Quality and Population Health

June 7, 2023

Agenda

1. Background and Goals
2. Proposal to Leverage NC HealthConnex for:
   a. Quality Measurement
   b. Exchange of Social Drivers of Health data
   c. Exchange of data to support Care Management
3. Overview of Workplan

The Vision

The Context: NC Medicaid's Transition to Managed Care

- In 2021, NC Medicaid began transitioning to a managed care structure
  - Under this new structure, private Prepaid Health Plans (PHPs) carry out processes and programs on behalf of NC Medicaid
  - Currently: 5 Standard Plans
  - Launching in Fall 2023: 6 Tailored Plans (focused on those with significant behavioral health needs, intellectual/developmental disabilities, or traumatic brain injury)

- Under managed care, beneficiaries are assigned to a medical home that takes responsibility for their care
  - A beneficiary's PHP or medical home may serve as their care management entity

The Challenge

1. Key data elements used for NC Medicaid programs is currently incomplete, non-standardized, and duplicative across multiple sources
2. Exchange of data between health plans and providers is often decentralized and requires many different interfaces
3. Practices face increasing administrative burden related to paperwork, documentation, and data sharing

How can we provide actionable data to support care management and quality improvement, while also reducing provider burden related to data exchange?

Key Goals

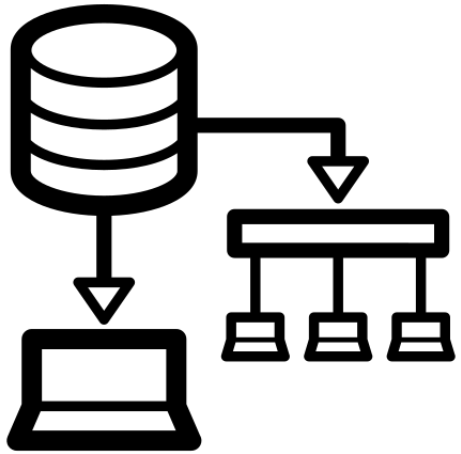
1. Improve near-real-time exchange of key quality measure data elements between entities
2. Improve accuracy, completeness, and timeliness of DHB's quality measurement
3. Reduce administrative burden
4. Support care managers with complete, timely, and accurate data to inform their clinical decision-making and outreach
5. Develop a solution that can be supported by federal matching funds

NC Medicaid's Solution: NC HealthConnex

Challenges with Our Current Process		Potential Future Using NC HealthConnex
1. Administrative burden	→	1. Reduces burden associated with sending data and reporting to multiple sources
2. Siloed patient health information	→	2. Real-time access to patient health information from multiple sources at the point of care
3. Lag in data availability and variability in care gap reports	→	3. Near-real-time care management and quality measure data, decreased variability in care gap reports
4. Operational complexity and lack of cross-system communication	→	4. Standardized, accurate, and timely data pulled in from multiple sources with minimal human interaction

Priority Use Cases

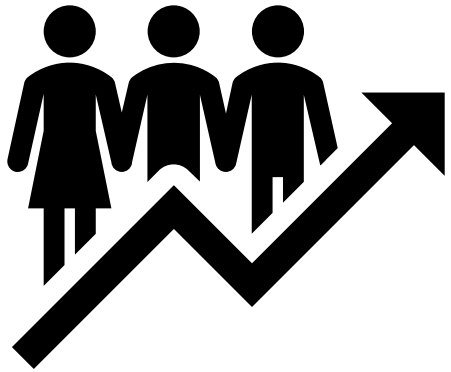
1. Quality Measurement
2. Exchange of Social Drivers of Health data
3. Exchange of data to support Care Management



#1: Improving Quality Measurement

Overview of Quality Measurement

Quality Measures: Tools that allow us to measure processes, outcomes, structures, and patient perceptions that are associated with the provision of high-quality healthcare



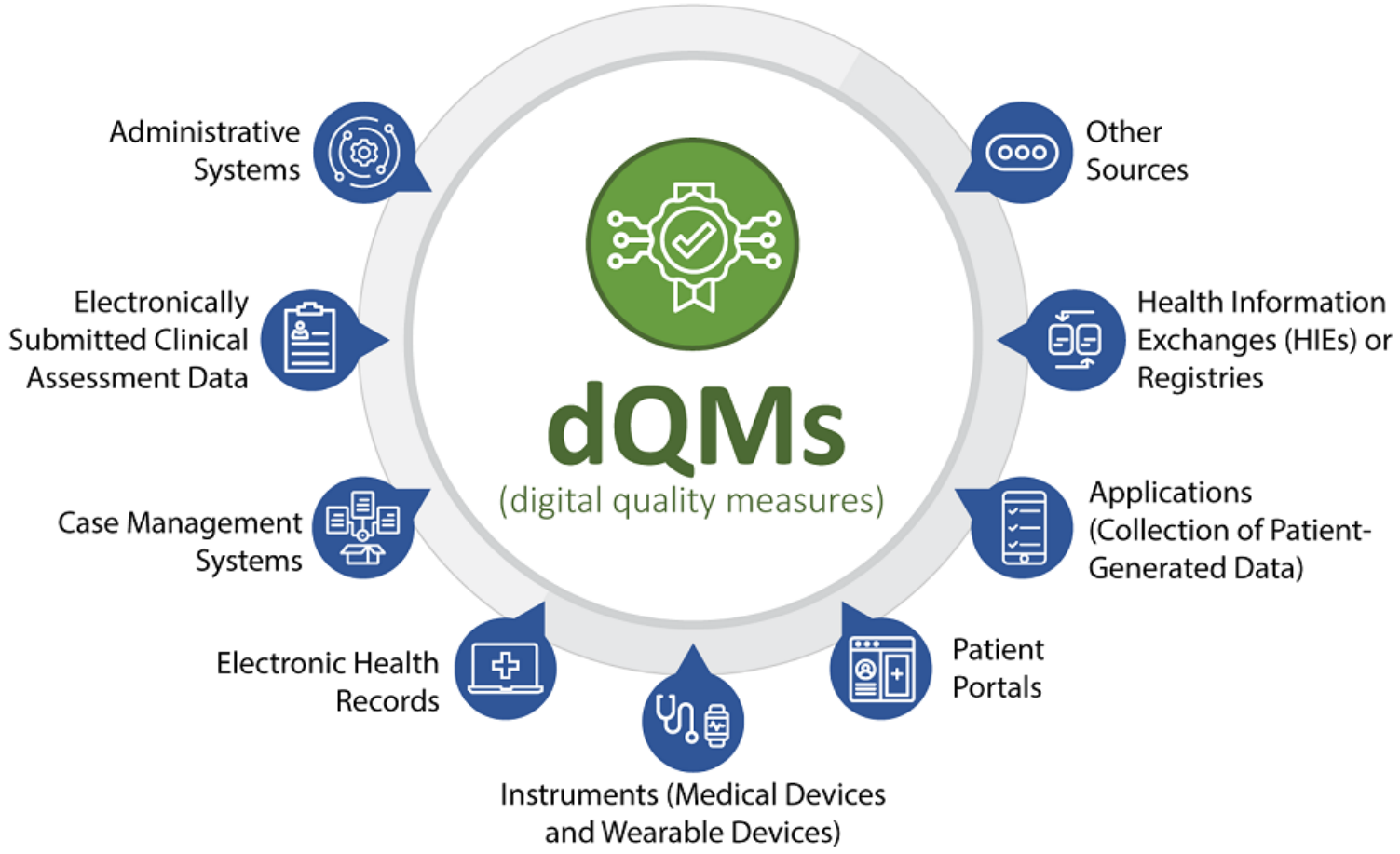
NC Medicaid and our PHPs use quality measures to:

1. Understand the type of care provided to our beneficiaries
2. Monitor and improve health outcomes
3. Evaluate the success of new programs and policies
4. Transform service delivery (e.g., value-based payment arrangements)

Alignment with CMS Objectives

The CMS draft definition of Digital Quality Measures (dQMs) are:

"Quality measures, organized as self-contained measure specifications and code packages, that use one or more sources of health information that is captured and can be transmitted electronically via interoperable systems"



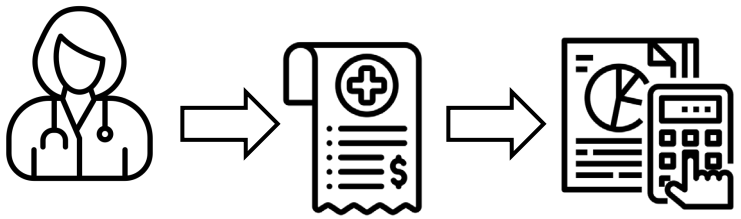
Example: Controlling High Blood Pressure (CBP)

The 2020 national average for Medicaid HMOs for Controlling High Blood Pressure was 55.9%.

Traditional → Hybrid → dQMs

Traditional Method

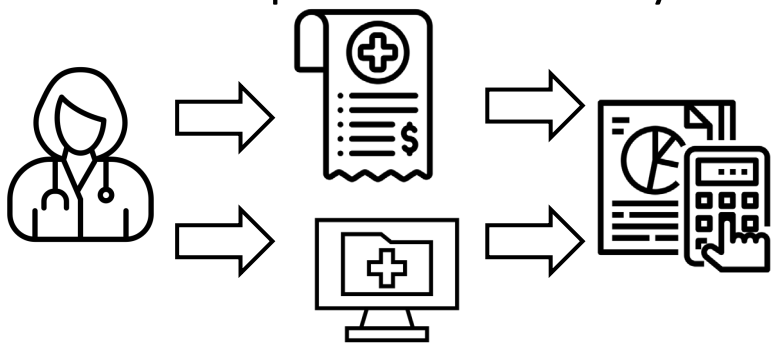
- Only claims and encounter data are used for quality measurement
- Results are produced annually



2020 CBP Rate: 4.58%

Hybrid Method

- Claims/encounter data is combined with electronic clinical data via NC HealthConnex (as available)
- Results are produced annually

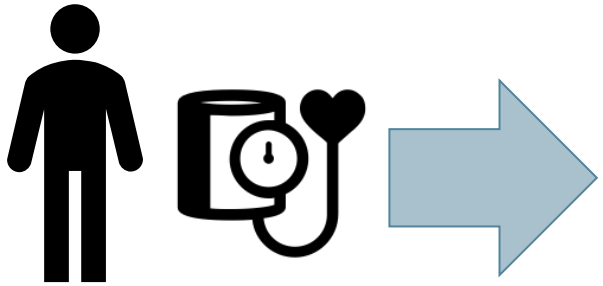


2020 CBP Rate: 20%

Digital Quality Measures (dQMs)

- NC HealthConnex pulls in data from a multitude of sources
- Results are available in near-real-time

Example #1: Data Quality (Problem)



John has his blood pressure taken by a specialist

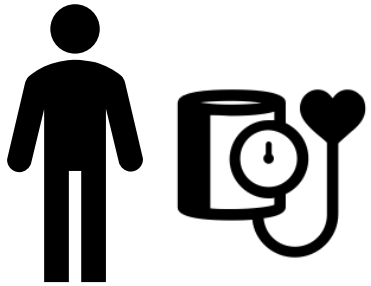
The provider records John's blood pressure (120/80) in the EHR using in-house standards that are incompatible with NC HealthConnex, causing only the systolic value (120) to be sent

NC Health Connex

Some providers may access this information, but its meaning may not be clear without the full blood pressure reading

Data cannot be used for bulk analytics or quality measurement due to lack of standardization and units of measurement

Example #1: Data Quality (Solution)



John has his blood pressure taken by a specialist

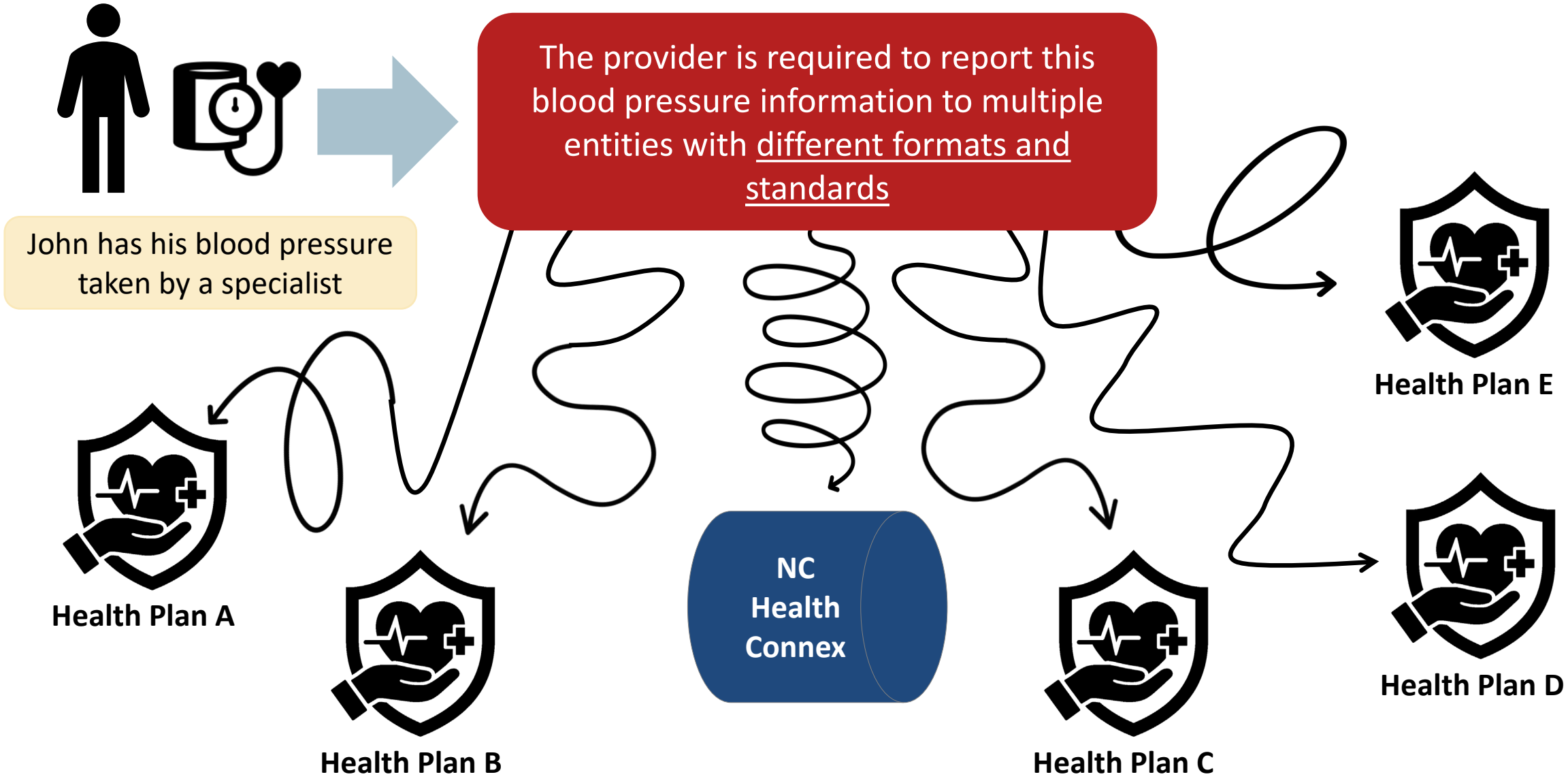
The provider records John's blood pressure (120/80) in the EHR in a complete and standardized format to ensure operability with NC HealthConnex

NC Health Connex

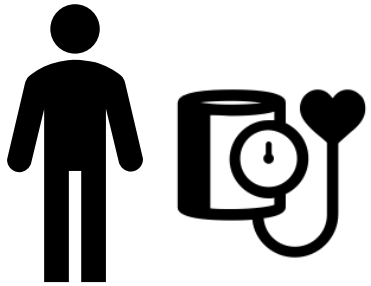
Providers from various health systems can access this information at the point of care and understand its meaning

NC Medicaid can use these data for quality measurement

Example #2: Reporting Burden (Problem)



Example #2: Reporting Burden (Solution)



John has his blood pressure taken by a specialist

The provider is ONLY required to report this blood pressure information to NC HealthConnex with a single format and standard

NC Health Connex

DHB will also receive the same standardized clinical data as the health plans

Health Plan A

Health Plan B

Health Plan C

Health Plan D

Health Plan E

Workplan: High Level Overview (Quality Measurement)

	2023	2024	2025	2026
	Exploration	Design & Implementation	Transformation	
Quality Measurement	1. Internal Exploratory analysis of NC HealthConnex data 2. Data Aggregator Validation Program (NCQA) 3. EQRO validation of NC HealthConnex data for Medicaid quality measurement	1. Convene stakeholder workgroup: propose & test solutions, develop guidance/policy 2. Design provider incentives: documentation and EHR updates 3. Implement tech updates, provider incentives, and AHEC provider coaching	1. Operationalize dQMs 2. Provide real-time gap reports and facilitate data exchange between permissioned entities	

#2: Improving Exchange of Social Drivers of Health (SDOH) Data

SDOH: A Key Priority for NC Medicaid

Understanding and addressing SDOH--like food, housing, and transportation needs--is a key focus for NC Medicaid under managed care

Good data on members' SDOH needs can:

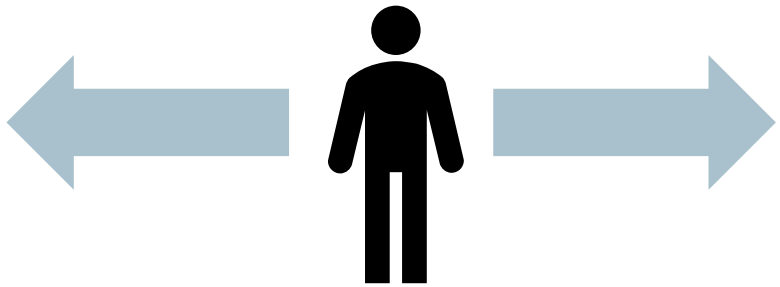
1. Help members get the support they need
2. Improve clinical decision-making
3. Evaluate the effectiveness of programs and policies focused on SDOH

NC Medicaid currently collects SDOH screening information from many sources, all of which have their own limitations

- We do not currently have a great way to collect data from SDOH screens at the provider level

Use Case #1: SDOH Screening Data Exchange (Problem)

PHP attempts to screen John for unmet resources needs but can't reach him.



John's AMH conducts an SDOH screen and finds John is struggling with food insecurity and housing instability. John's AMH provides him with some helpful resources.

PHP records that the screen is incomplete

John's AMH records his unmet resource needs and the referrals provided in the EHR

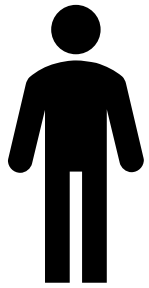
Medicaid, John's PHP, and John's care manager at his PHP do have any information on unmet resource needs

Information is only seen by providers in the same health system

Use Case #1: SDOH Screening Data Exchange (Solution)

PHP attempts to screen John for unmet resources needs but can't reach him.

John's AMH conducts an SDOH screen and finds John is struggling with food insecurity and housing instability. John's AMH provides him with some helpful resources.



PHP records that the screen is incomplete

NC Health Connex

John's AMH records his unmet resource needs and the referrals provided in the EHR

Linked screening and referral information can be seen by DHB, John's PHP, John's care manager, any provider

Workplan: High Level Overview (SDOH Data)

	2023	2024	2025	2026
	Exploration	**Design & Implementation**	**Transformation**	
SDOH Screening Data	1. Launch of DHHS-led pilot with hospitals to explore/test LOINC code mapping 2. Designing a withhold arrangement with PHPs focused on SDOH data→ move toward interoperability	*Integrate w/ Quality Measurement work:* 1. Convene stakeholder workgroup: propose & test solutions, develop guidance/policy 2. Design provider incentives: documentation and EHR updates 3. Implement tech updates, provider incentives, and AHEC provider coaching	1. Facilitate data exchange between permissioned entities 2. Add information on SDOH referrals and interventions to create holistic, linked data on each member's unmet resource needs	

#3: Improving Exchange of Data for Care Management

Overview of Care Management

Care Management: A team-based, person-centered approach to managing beneficiaries' medical, social, and behavioral conditions

Successful care management relies on:

1. Understanding a member's medical history
2. Receiving information on healthcare services and medication use
3. Receiving information on members flagged as high-need

Data are currently exchanged across providers, health plans, NC Medicaid, and other entities in non-standard and duplicative ways

Example #1: Claims Data Exchange (Problem)

Providers

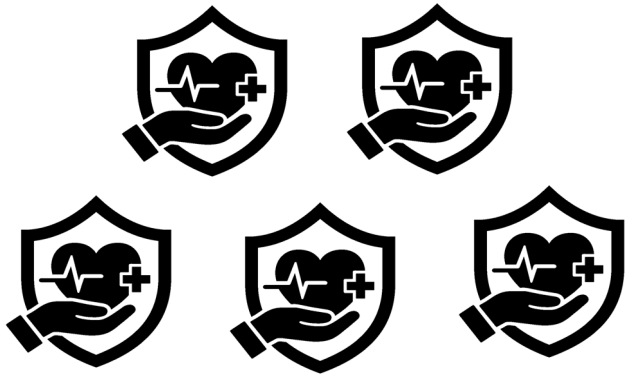
Providers submit Managed Care claims directly to Health Plans.

Managed Care Claims

Claims data to support care management programs are shared through 2,644 data interfaces between 60 entities.

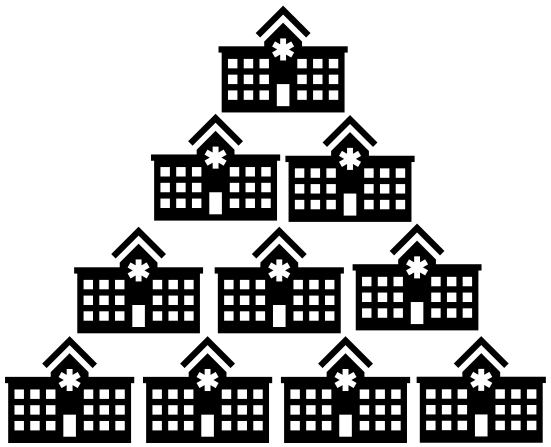
NC Tracks (Medicaid Direct Claims)

204 Data Interfaces



17 Different Health Plans

2,440 Data Interfaces



40+ Providers

Health Plans send claims to medical homes and care management providers.

Example #1: Claims Data Exchange (Solution)

Health Plans only need to submit their provider mapping to NC HealthConnex.

Claims data to support care management programs can be shared through 336 interfaces (87% reduction) between 42 entities.

Health Plans

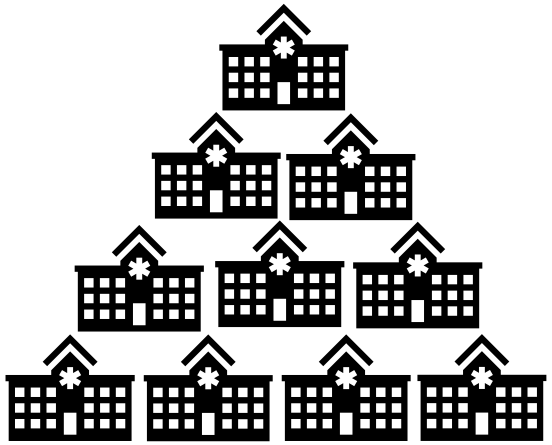
EPS (Managed Care Claims)

NC Tracks (Medicaid Direct Claims)

16 Data Interfaces

NC Health Connex

320 Data Interfaces

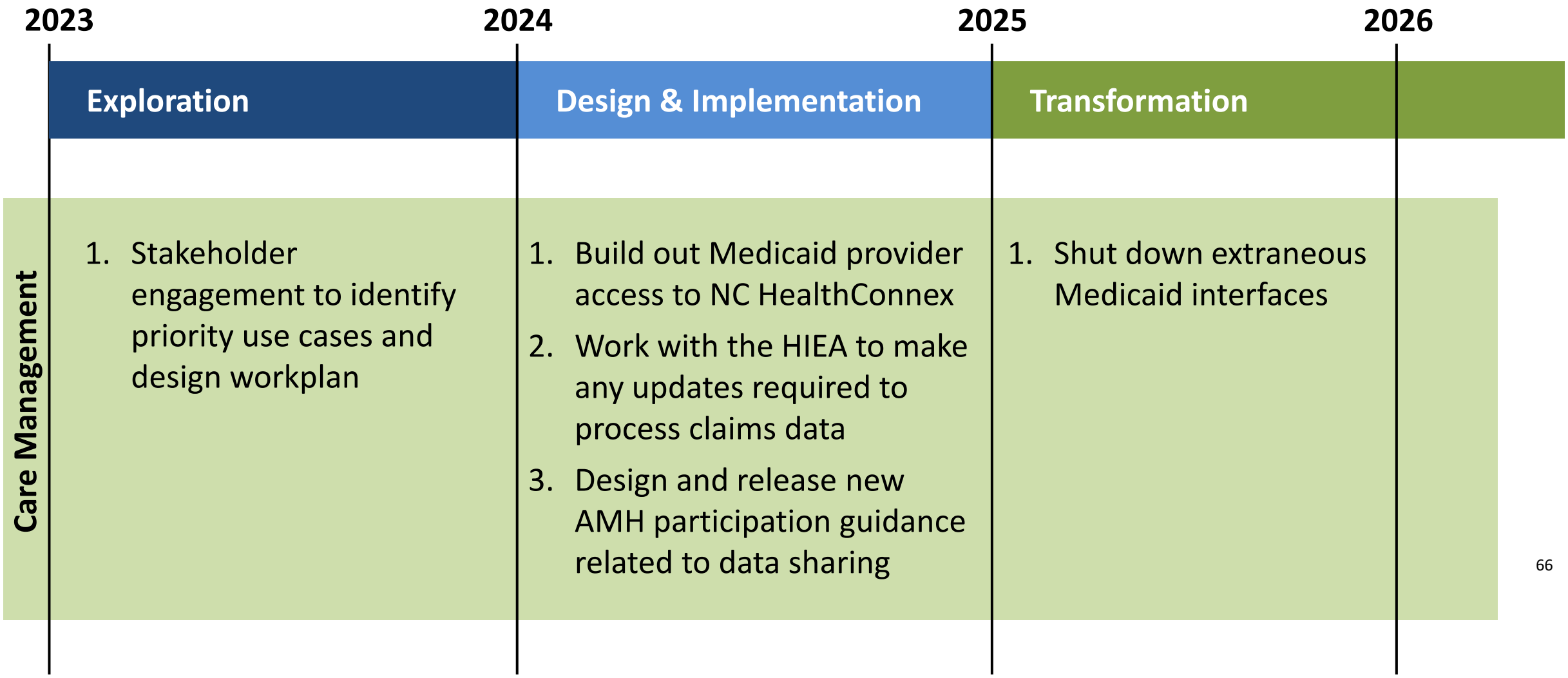


40+ Providers

Other Example Use Cases: Supporting Care Management

1. Facilitating near-real-time exchange of data on patients newly flagged as “high risk”
2. Supporting the transition of care when a member switches PHPs
3. Providing access to a beneficiary’s medical history and ongoing needs when they first enter Medicaid

Workplan: High Level Overview (Care Management)



Next Steps

Immediate Next Steps

1. Identify federal matching funds to support this work and steps to secure those funds
2. Work with HIEA to scope staffing and resource needs in more detail
3. Launch workstream with EQRO to validate data elements for key Medicaid quality measures
4. Socialize proposal with PHPs, providers, and other external partners

Thank you!

NC HIEA Operations Update

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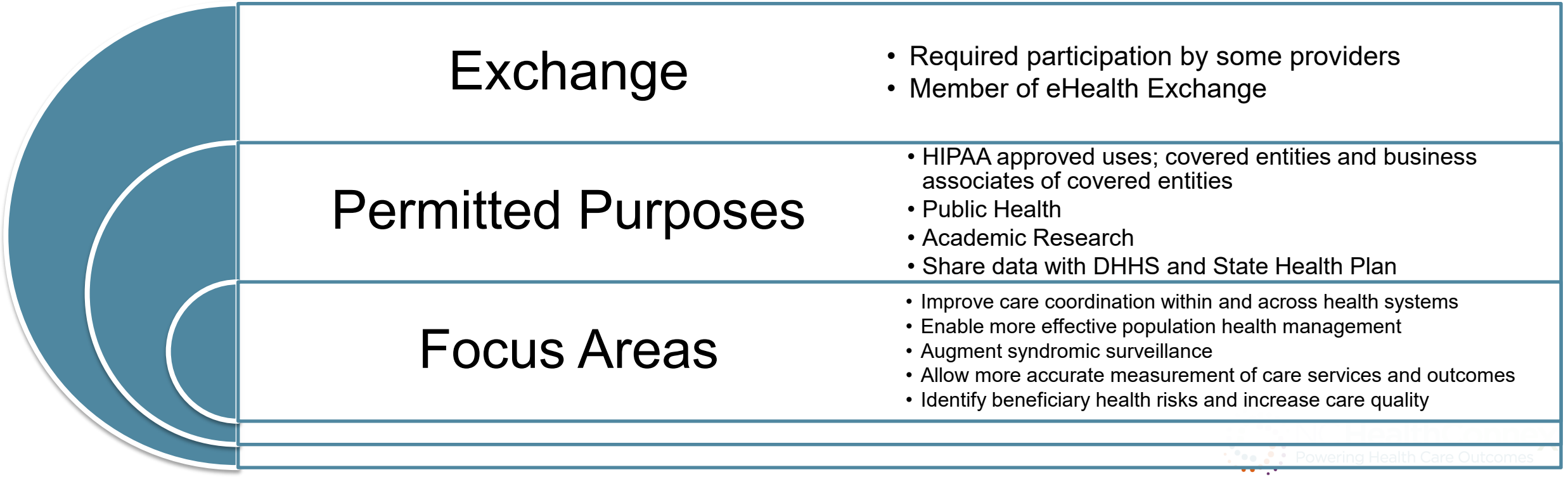
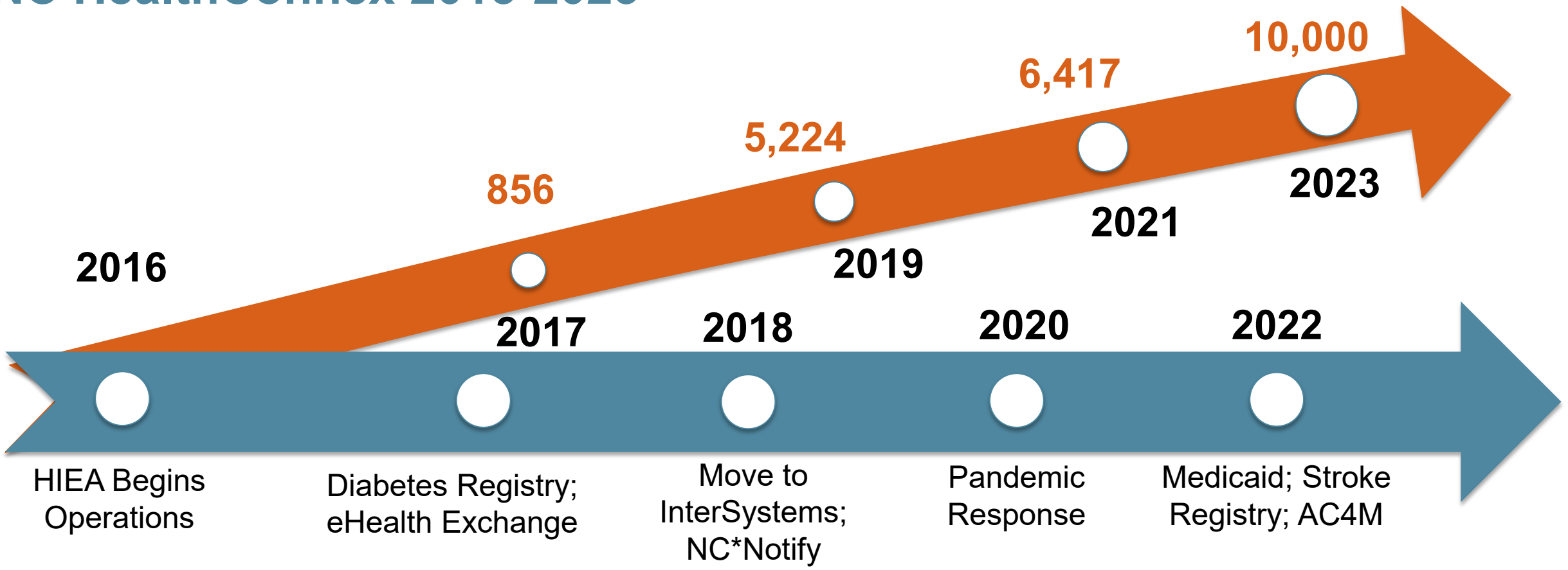
Statewide Health Information Exchange Act, Article 29B

"§ 90-414.2. Purpose.

This Article is intended to improve the quality of health care delivery within this State by facilitating and regulating the use of a voluntary, statewide health information exchange network for the secure electronic transmission of individually identifiable health information among health care providers, health plans, and health care clearinghouses in a manner that is consistent with the Health Insurance Portability and Accountability Act, Privacy Rule and Security Rule, 45 C.F.R. §§ 160, 164.



The Vision for Statewide Health Information Exchange – NC HealthConnex 2015-2023



Orange arrow = growth
Blue arrow = milestones

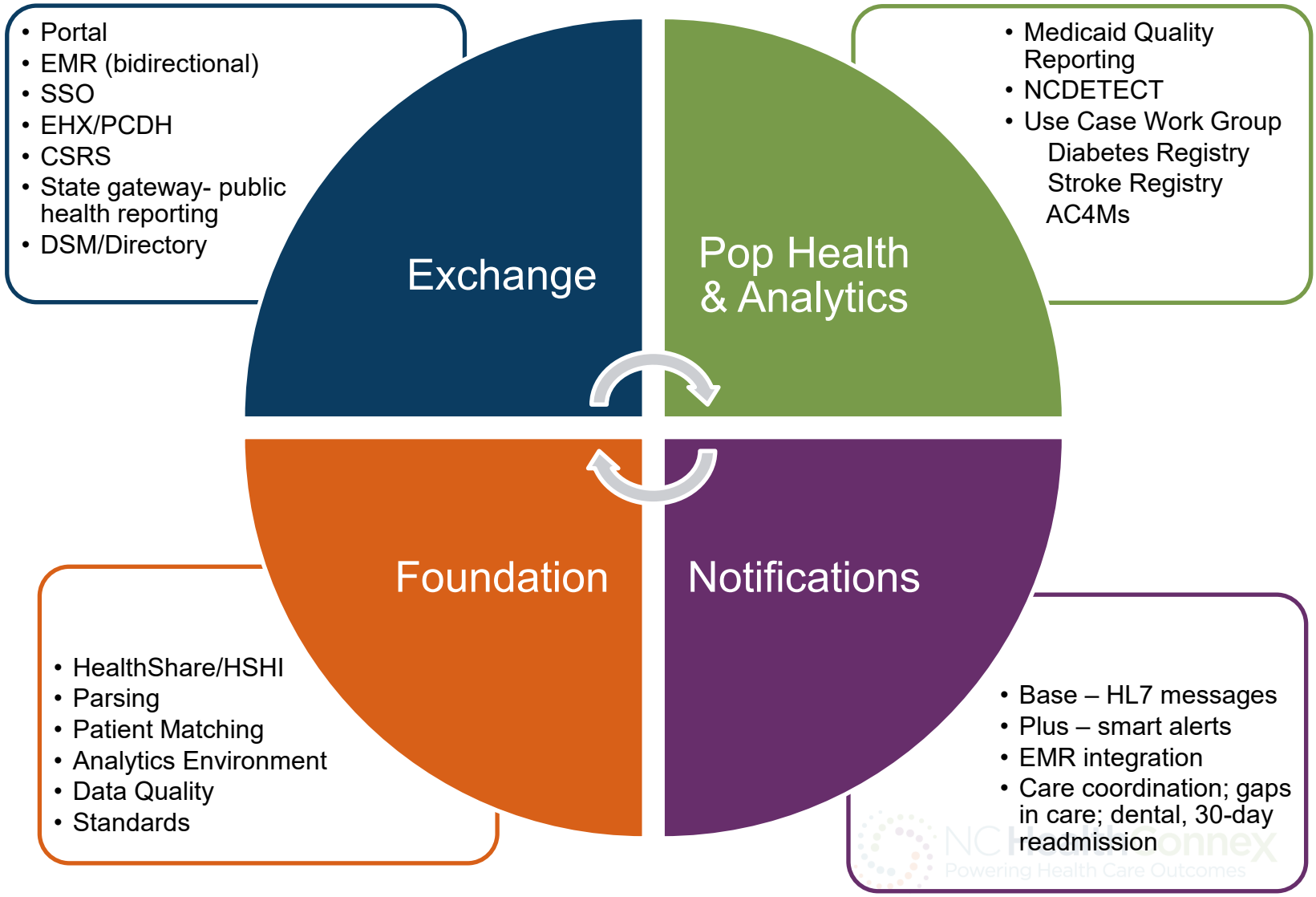
NC HealthConnex
Powering Health Care Outcomes

NC HealthConnex Services

- Initially defined in 2018, the Current Core Components and Value-Added Features on four pillars.

- Features/Services map back to core functionality and the mission of the NC HIEA:

We connect health care providers to safely and securely share health information through a trusted network to improve health care quality and outcomes for North Carolinians.



Summary of NC HIEA Priority Workstreams

Data Connections

Providers
Pharmacy Claims
Medicaid Claims
State Lab
Adult Corrections
Public Health Reporting – NCIR/ELR

Infrastructure

HealthShare/Clinical Portal upgrade; new analytic environment – Viya 4; operating system upgrades; API Manager; FHIR enablement

Provider Relations/Outreach

Continue education; focus on proactive outreach to increase adoption/utilization
Stakeholder relationships

DHHS: Medicaid, Public Health, WIC

Quality Measure Reporting
Sickle Cell
Data TAG
WIC data extracts
Stroke Registry Phase 3
State Lab Test Order/Results
SDOH

Strategy/Policy

Monitor federal initiatives – TEFCA, HDU models
Advocate state legislative changes
Oversee governance –contracting, development/oversight work groups
MES certification/APD funding
State Transformation Collaborative
HITRUST certification preparation

Data Quality

ADT Audit
Data Targets – USCDI
Normalization pilot
NCQA DAV

Operations & Maintenance Activities

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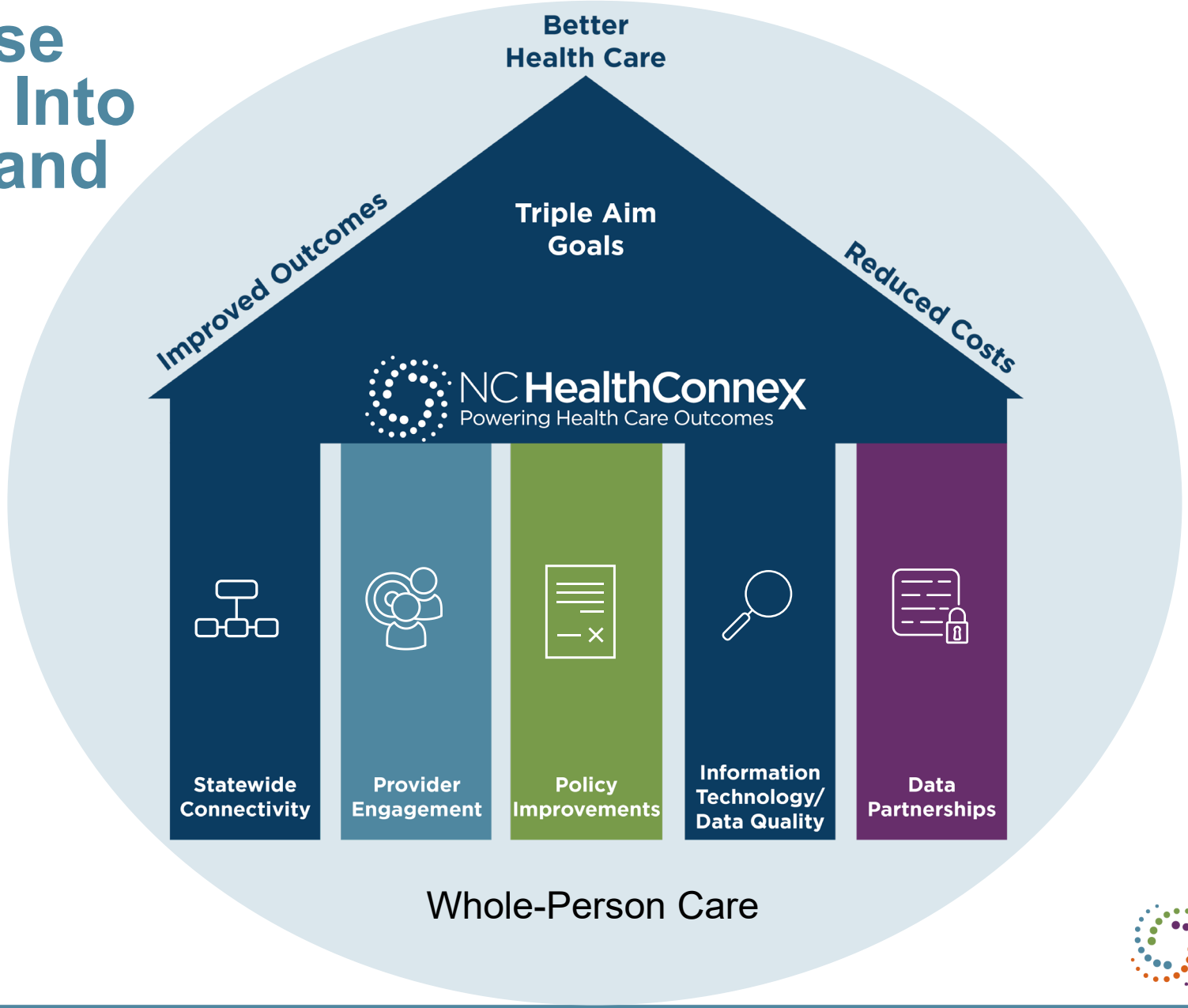
How Do These Priorities Fit Into the Mission and Vision?



NC HealthConnex
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The Vision for a National Network of Networks

NC HealthConnex
Powering Health Care Outcomes

May 1, 2023

eHealth Exchange™

Please e-mail questions or concerns to
administrator@ehealthexchange.org

TEFCA for NC HealthConnex

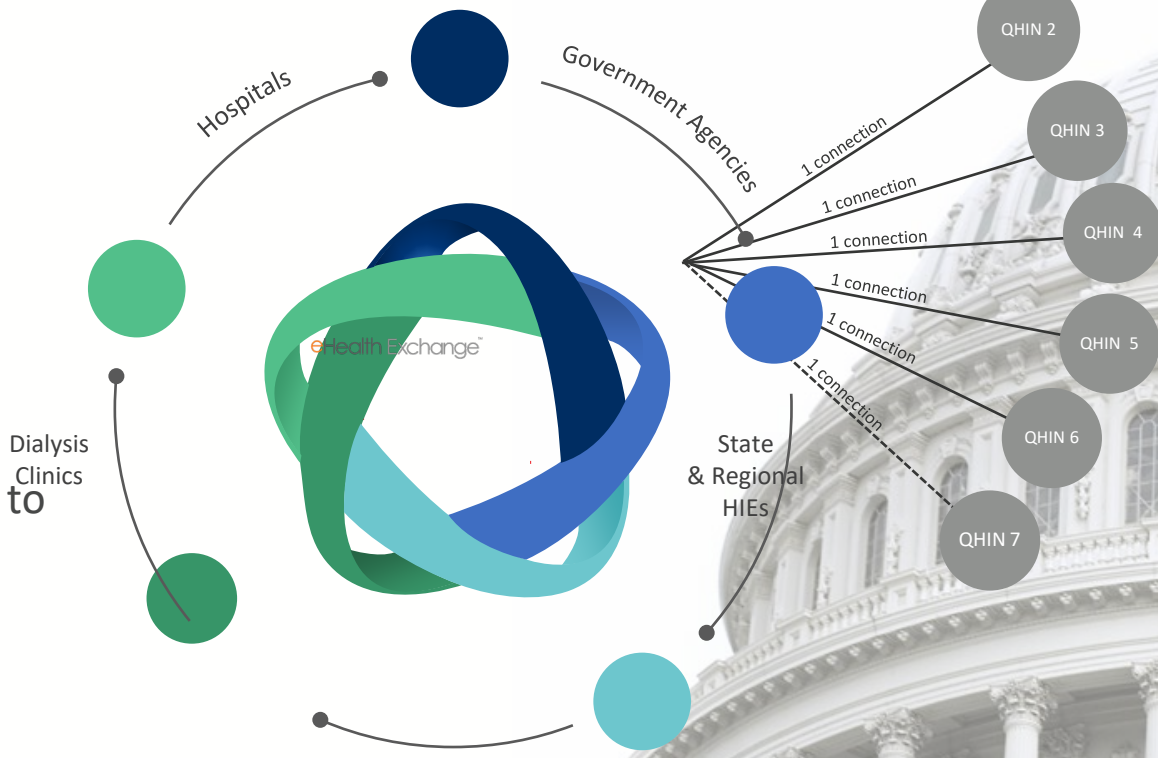
What is the Trusted Exchange Framework (TEFCA)?

It's a federally endorsed governance framework for **cross-network** exchange of healthcare records.

It's not a network, but a framework providing:

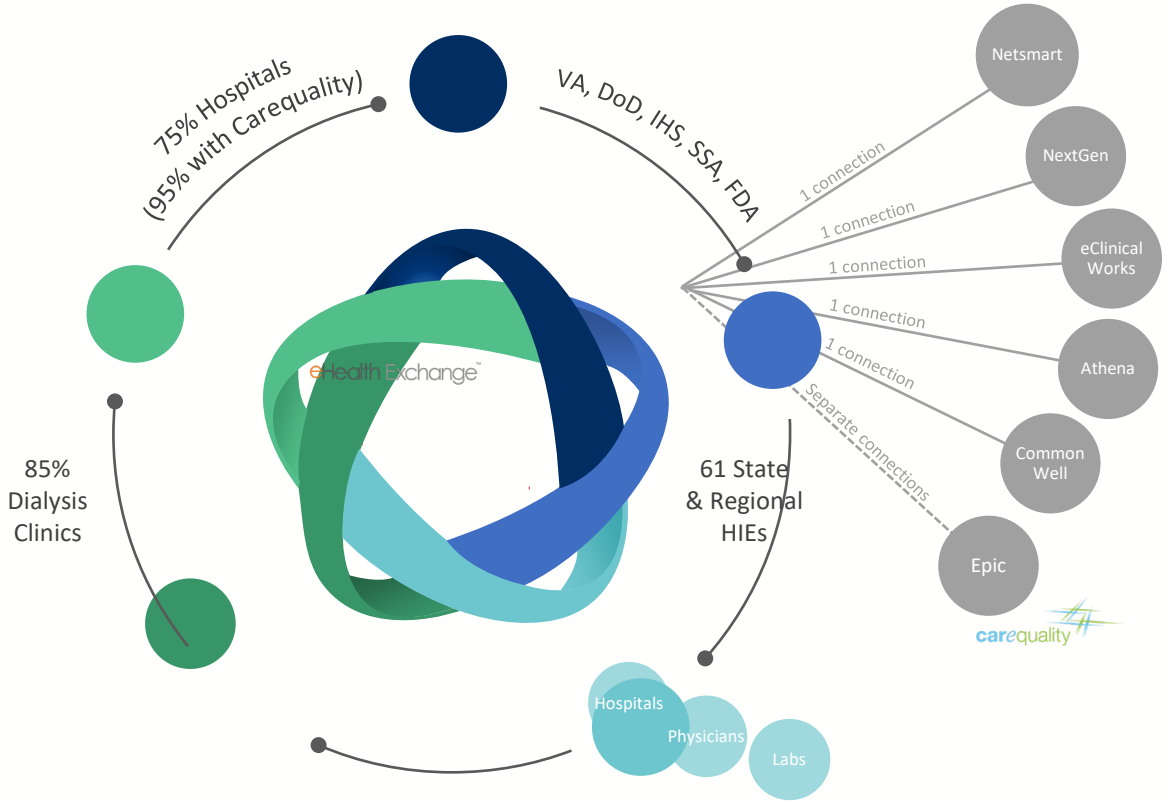
1. Technical & policy agreements
2. Governing structure
3. Federated architecture

Enables healthcare organizations connected to a TEFCA Qualified Health Information Network (QHIN) to exchange patient data with other healthcare organizations connected to other QHINs.

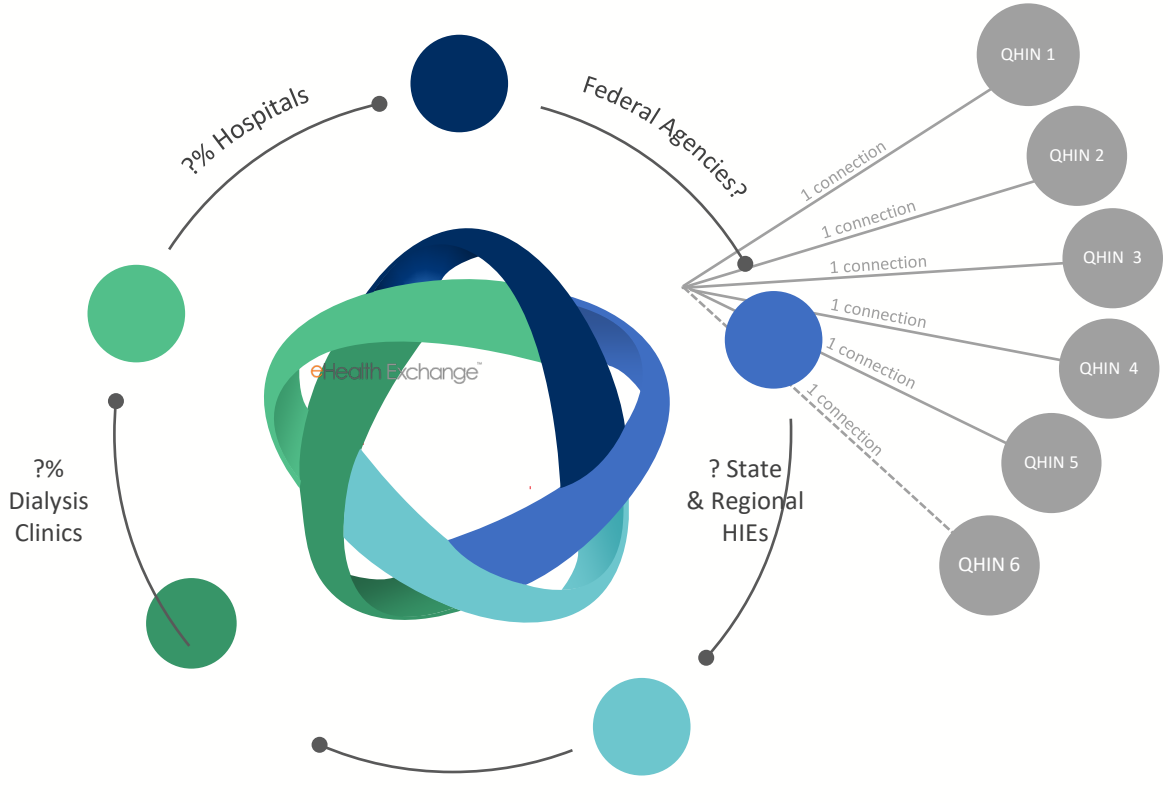


Note eHealth Exchange is only a candidate QHIN today

Carequality



TEFCA



Intent to Participate from 8 HIEs Operating in 13 States

CRISP

Indiana Health Information Exchange

SCHIO
Serving Communities Health Information Organization
Community Interoperability Since 1996

contexture℠
Creating connections. Improving lives.

CyncHealth

Manifest MEDEX

ConnectVirginia
Advancing Virginia's Health Care

Alabama One Health Record®

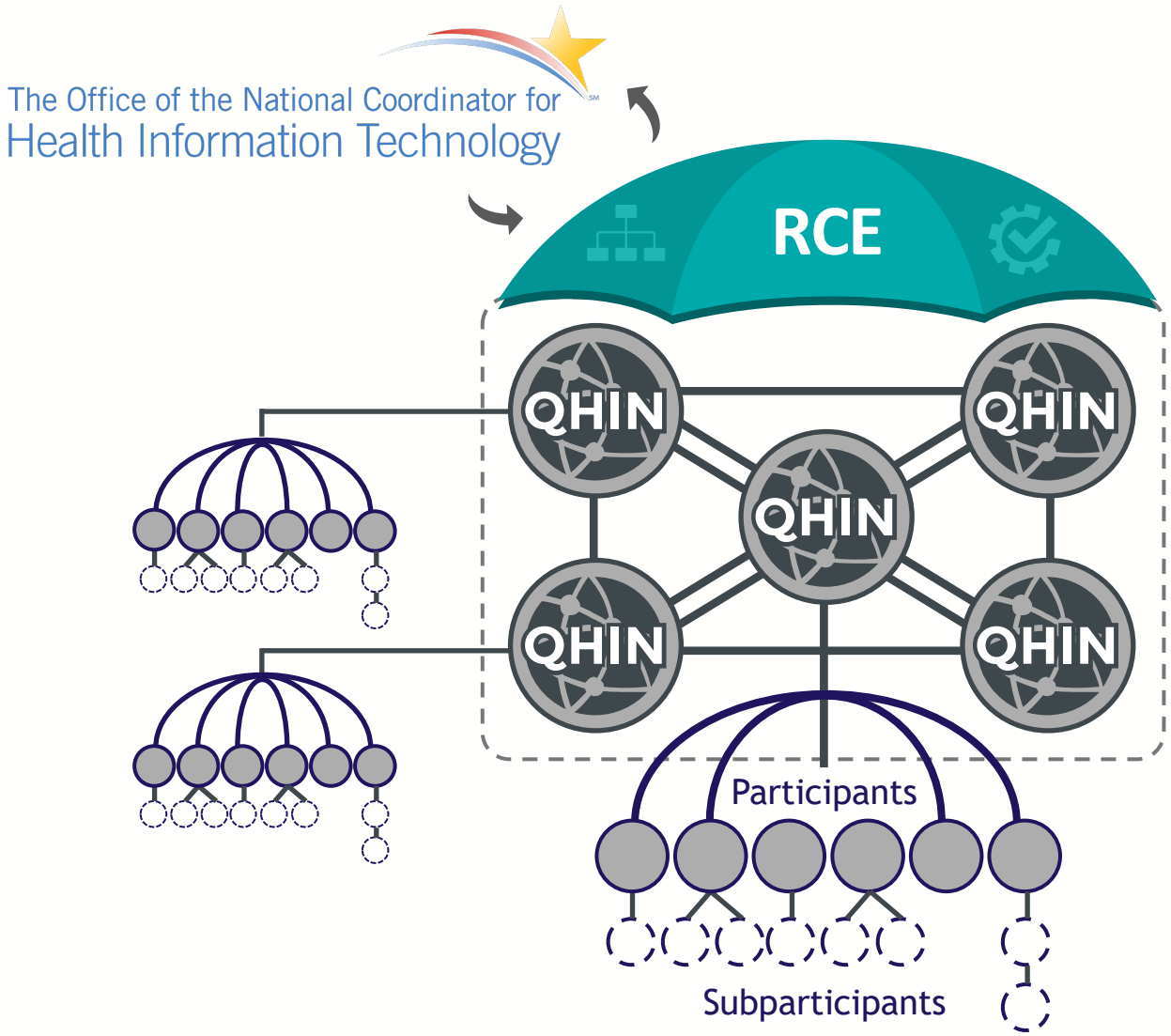
MD, DC, WV, AK, CT, VA, IN, NE, IA, CO, AZ, CA, AL

TEFCA Statutory Authority & Elements

Section 4003(b) of the 21st Century Cures Act requires the Office of the National Coordinator to "develop or support a **trusted exchange framework** for **trust policies and practices** and for a **common agreement** for exchange between health information networks," (emphasis added).

Elements:

How will TEFCA Work?



ONC defines overall policy and certain governance requirements.

RCE provides oversight and governing approach for QHINs.

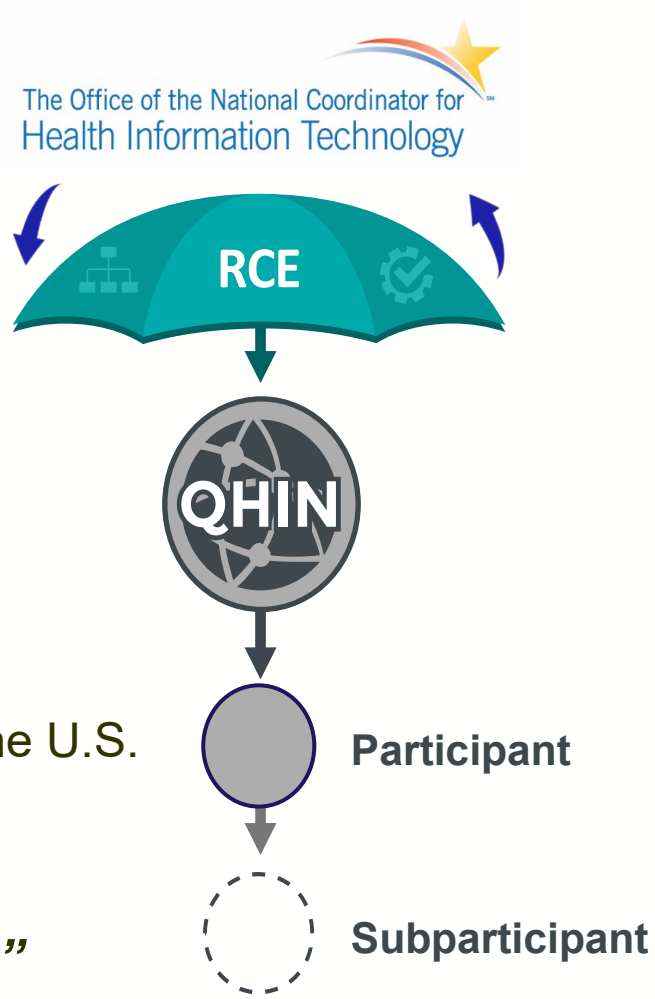
Qualified Health Information Networks (QHINs) connect directly to each other to facilitate nationwide interoperability.

Each QHIN connects Participants, which connect Subparticipants.

Framework Agreement Flow-Down Provisions

Common Agreement

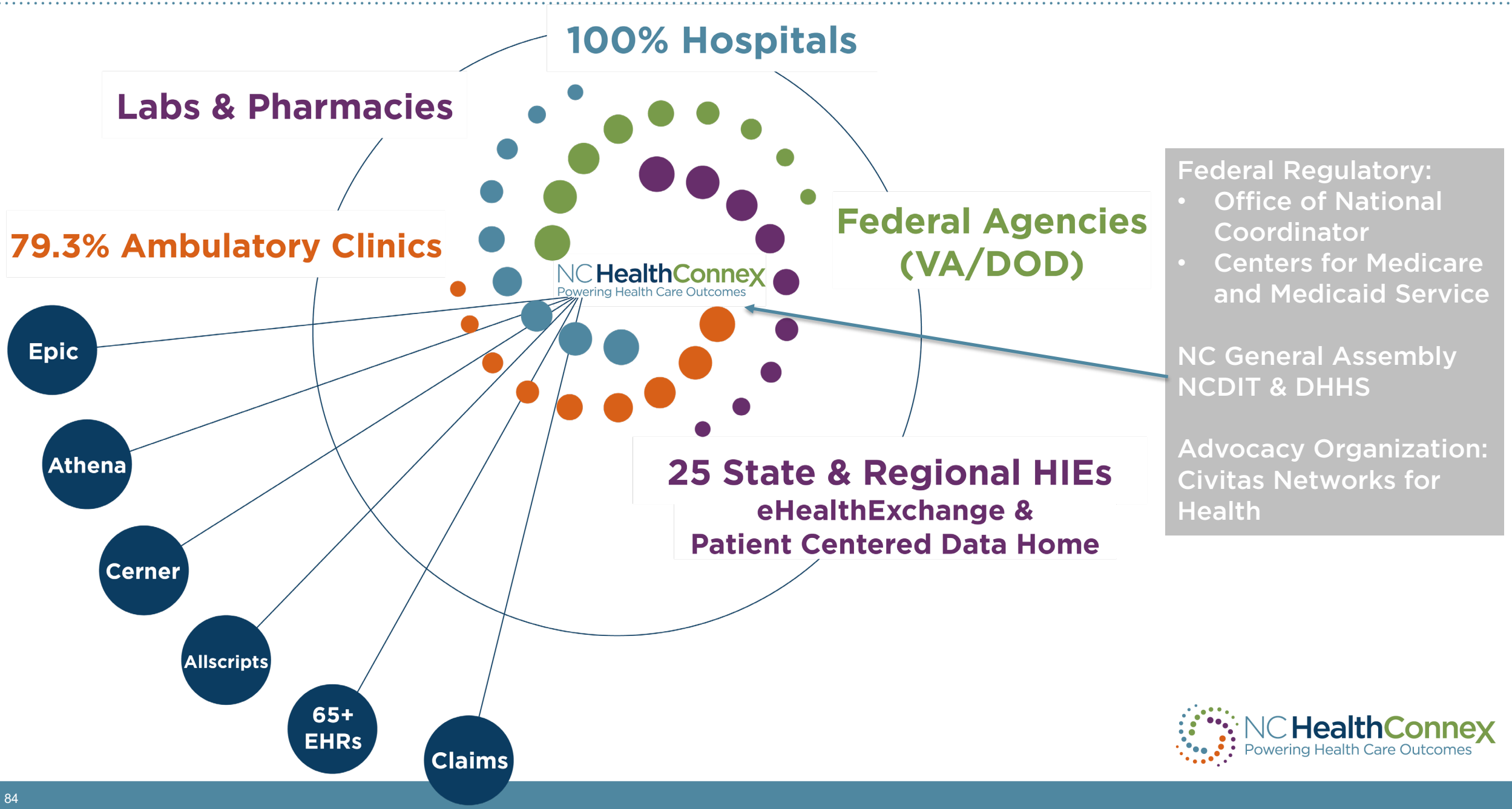
Each QHIN shall voluntarily enter into a contractual agreement with the RCE by signing the Common Agreement, making all QHINs parties to the Common Agreement. The Common Agreement includes flow-down clauses for the QHIN's agreements with its Participants and each Participant's agreements with its Subparticipants.



Required Flow-Downs Will Address:

- Cooperation and Nondiscrimination
- Confidentiality
- Utilization of the RCE Directory Service
- Uses, Disclosures, and Responses
- Individual Access Services
- Privacy
- Security
- Special Legal Requirements
- TEFCA Information Outside the U.S.
- Other General Obligations

Entities may connect into exchange at any level, but must abide by the flow-down provisions, which create common "rules of the road."



NC HealthConnex
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Metrics Update

NC HealthConnex
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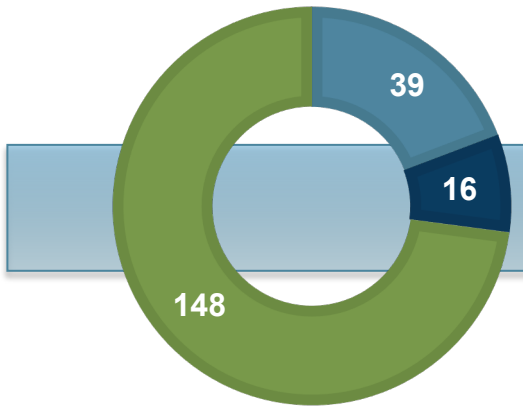
Enrollment in Services

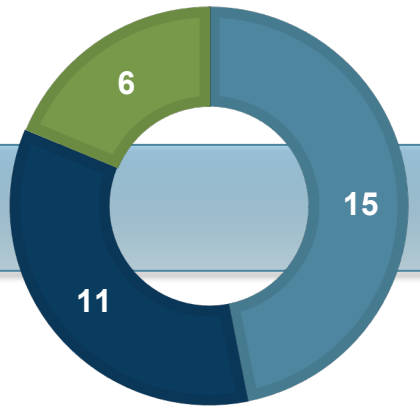
NC*NOTIFY



- 39 Integrations Enrolled
- 16 Integrations in Development
- 148 Integrations Live

143 Integrations Live represents **622 Practices**

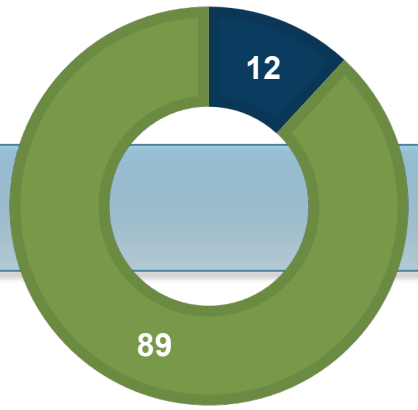
NCIR



- 15 EHRs Enrolled
- 11 EHRs in Development
- 6 EHRs Live

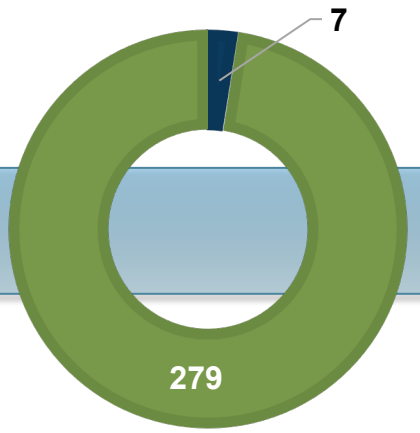
6 EHRs Live represents **436 Practices**
11 EHRs in Development represents **210 facilities**

ELR



- No Enrollments
- 12 Feeds in Development
- 89 Feeds Live

DSM



- No Enrollments
- 7 Participants in Development
- 279 Domains Live

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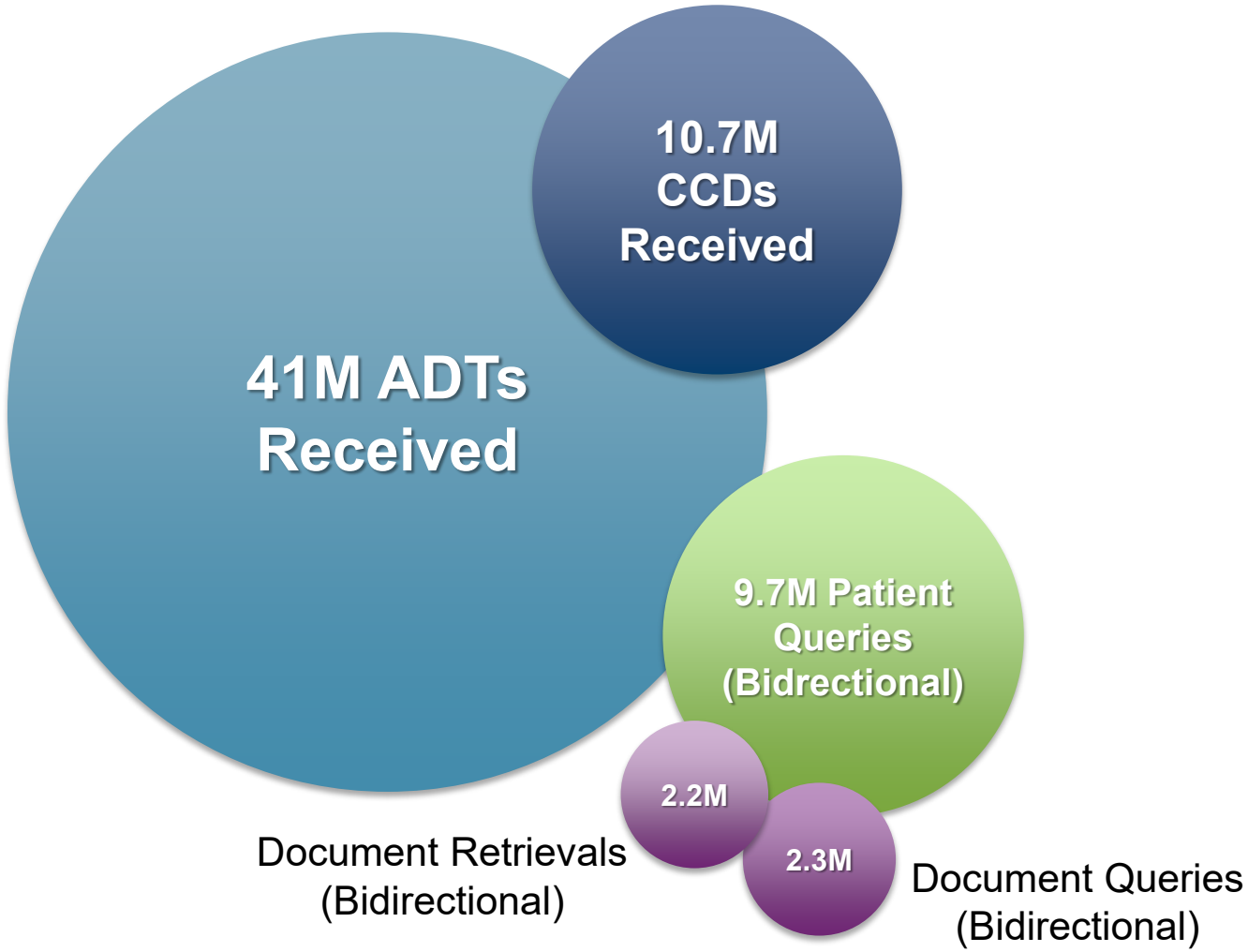
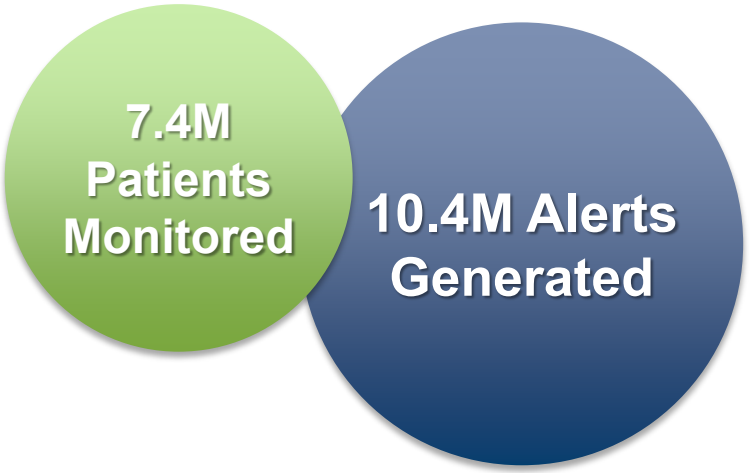
Key Metrics:

Data Exchange – April 30, 2023: 8,876 Portal Accounts



NC*Notify – April 30, 2023:



Data Connections – April 30, 2023:

Net New YTD (82 Facilities)

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Legislative Update

NC HealthConnex
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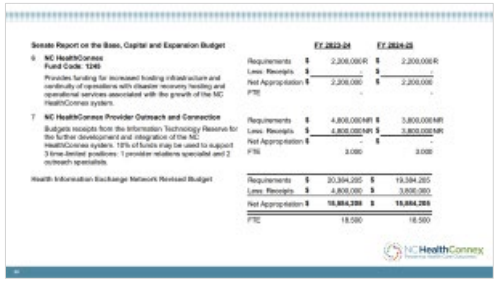
Legislative Update

H259 2023 Appropriations Act

- H76 Access to Healthcare Options – Medicaid expansion (SL 2023-7) is a budget provision and will not take effect until budget is passed
- Sec 7.49 Study that would explore other methods to allow for Medicaid reimbursement for additional services like transportation
- Sec. 9E.28 Primary Care Payment Reform Task Force with NC HIEA director serving as a member
- Referred to Senate Appropriations
- Current proposed budget:



- Tentative final votes will be late June

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Senate Report on the Base, Capital and Expansion Budget

6 NC HealthConnex
Fund Code: 1245

Provides funding for increased hosting infrastructure and continuity of operations with disaster recovery hosting and operational services associated with the growth of the NC HealthConnex system.

	FY 2023-24	FY 2024-25
Requirements	$ 2,200,000R	$ 2,200,000R
Less: Receipts	$ -	$ -
Net Appropriation	$ 2,200,000	$ 2,200,000
FTE	-	-

7 NC HealthConnex Provider Outreach and Connection

Budgets receipts from the Information Technology Reserve for the further development and integration of the NC HealthConnex system. 10% of funds may be used to support 3 time-limited positions: 1 provider relations specialist and 2 outreach specialists.

Requirements	$ 4,800,000NR	$ 3,800,000NR
Less: Receipts	$ 4,800,000NR	$ 3,800,000NR
Net Appropriation	$ -	$ -
FTE	3.000	3.000

Health Information Exchange Network Revised Budget

Requirements	$ 20,384,205	$ 19,384,205
Less: Receipts	$ 4,800,000	$ 3,800,000
Net Appropriation	$ **15,584,205**	$ **15,584,205**
FTE	18.500	18.500

NC HealthConnex
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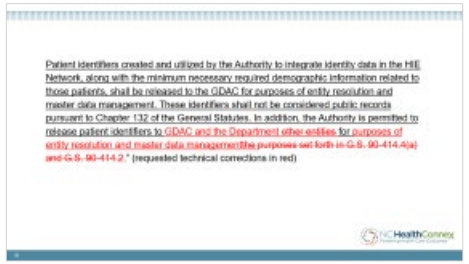
Legislative Update

H600 Regulatory Reform Act of 2023

- Sec 19.1 HIE network participation → Dental and Chiropractors will be added to the voluntary list
- Sec 19.2 HIE Advisory Board membership → two additional members
- § 90-414.6. State ownership of HIE Network data → Patient identifiers language

SECTION 19.3. G.S. 90-414.6 reads as rewritten:



"§ 90-414.6. State ownership of HIE Network data.

- Referred Senate Rules Committee

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Patient identifiers created and utilized by the Authority to integrate identity data in the HIE Network, along with the minimum necessary required demographic information related to those patients, shall be released to the GDAC for purposes of entity resolution and master data management. These identifiers shall not be considered public records pursuant to Chapter 132 of the General Statutes. In addition, the Authority is permitted to release patient identifiers to GDAC and the Department ~~other entities~~ for purposes of entity resolution and master data management~~the purposes set forth in G.S. 90-414.4(a) and G.S. 90-414.2~~." (requested technical corrections in red)

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Legislative Update

S3 NC Compassionate Care Act

- Intent of the bill is to allow the sale of cannabis and cannabis-infused products to qualified patients with a debilitating medical condition
- Sec. 1 requires the physician to maintain an electronic registry that is to be updated within 48 hours of any changes to the original certification
- Referred to House Rules Committee

H484 Mental Health Confidential Info. Disclosure | Referred to the Senate Rules Committee

- The bill modifies the law relating to the release of confidential information by mental health providers to conform to federal regulations.

S156 Medicaid Children & Families Specialty Plan | Referred to the House Rules Committee

- Requires DHHS to issue an initial request for proposals to procure a single statewide children and families specialty plan contract with services to begin no later than December 1, 2024.

S425 Medicaid Agency Omnibus | Referred to the House Rules Committee

- Updates laws relating to Medicaid and behavioral health.

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Upcoming Dates

- Advisory Board Meeting, Quarter 3 – September 11, 2023
- Advisory Board Meeting, Quarter 4 – December 7, 2023
- Behavioral Health Work Group – June 30, 2023
- Use Case Work Group – July 11, 2023
- Clinical Data User Group – July 2023

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Questions?

Thank You For Joining Us

For more information, visit

www.nchealthconnex.gov

Tel: 919-754-6912

E-mail: hiea@nc.gov

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Appendix

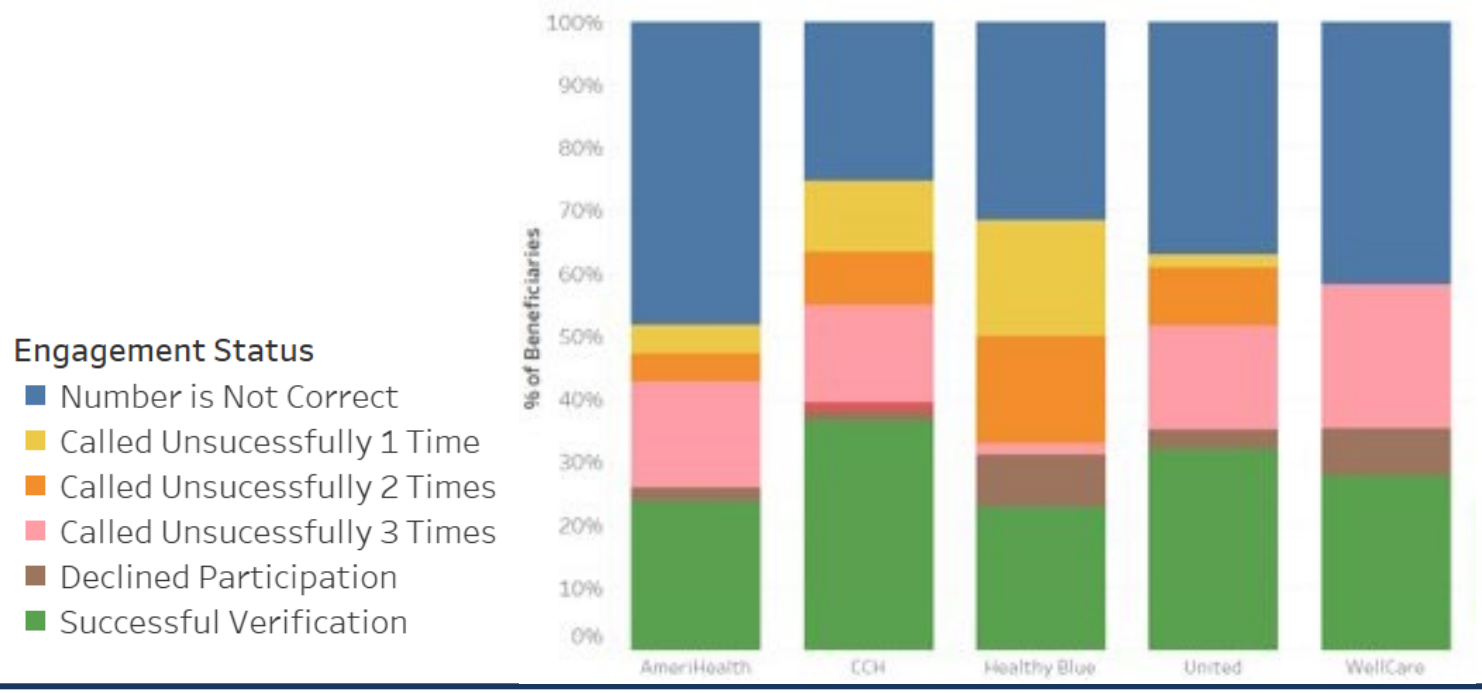
Additional Challenge with the Current System: 834 Term Dates

- Issues with how North Carolina's enrollment data interacts with health plan's HEDIS engines is also pushing us towards dQMs
- The Electronic Data Interchange (EDI) 834 has a spot for member start and end dates – normally the end date looks super high (ex: 12/31/9999), but in North Carolina the presumptive end of eligibility is much nearer term.
  - This is because counties have until the end of any given month to recertify a beneficiary.
- When this information is fed into the health plan's HEDIS engines, the system says the patient will not make continuous enrollment and, therefore, they are not included on the subsequent gap report.
  - This keeps providers from being able to receive incentives for closing that gap.
- The magnitude of this issue is substantial, impacting hundreds to thousands of beneficiaries.

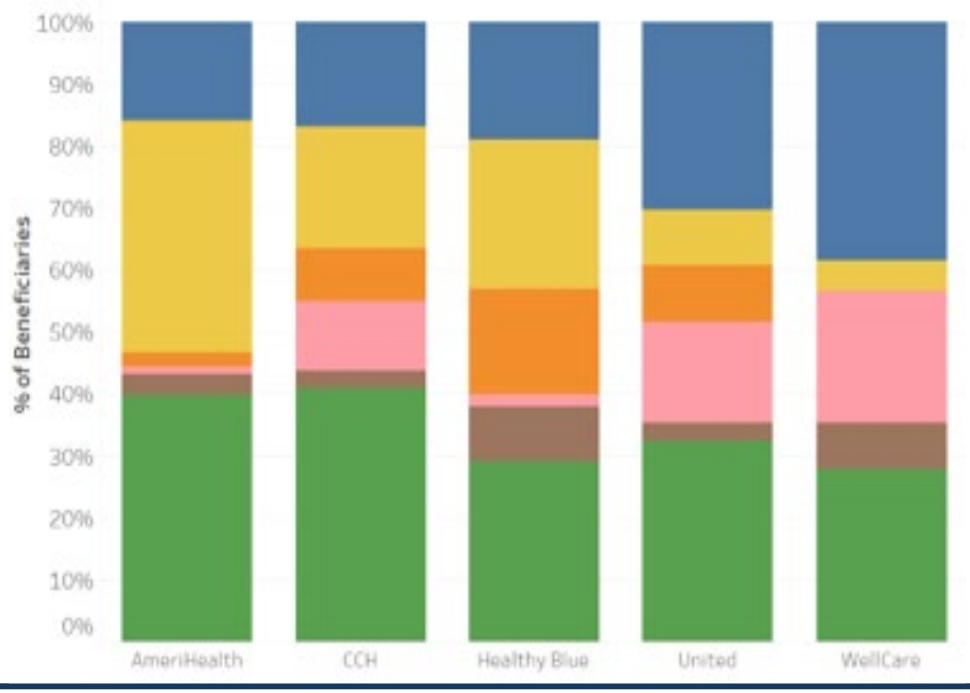
The Impact of NC HealthConnex Data

- Phone numbers provided by NC HealthConnex *significantly* increased successful beneficiary verification during the "Transition of Care High-Needs Member Survey"
  - 37 new beneficiaries were successfully verified using NC HealthConnex data
  - The success rate doubled from 16% using in-house numbers to 33%

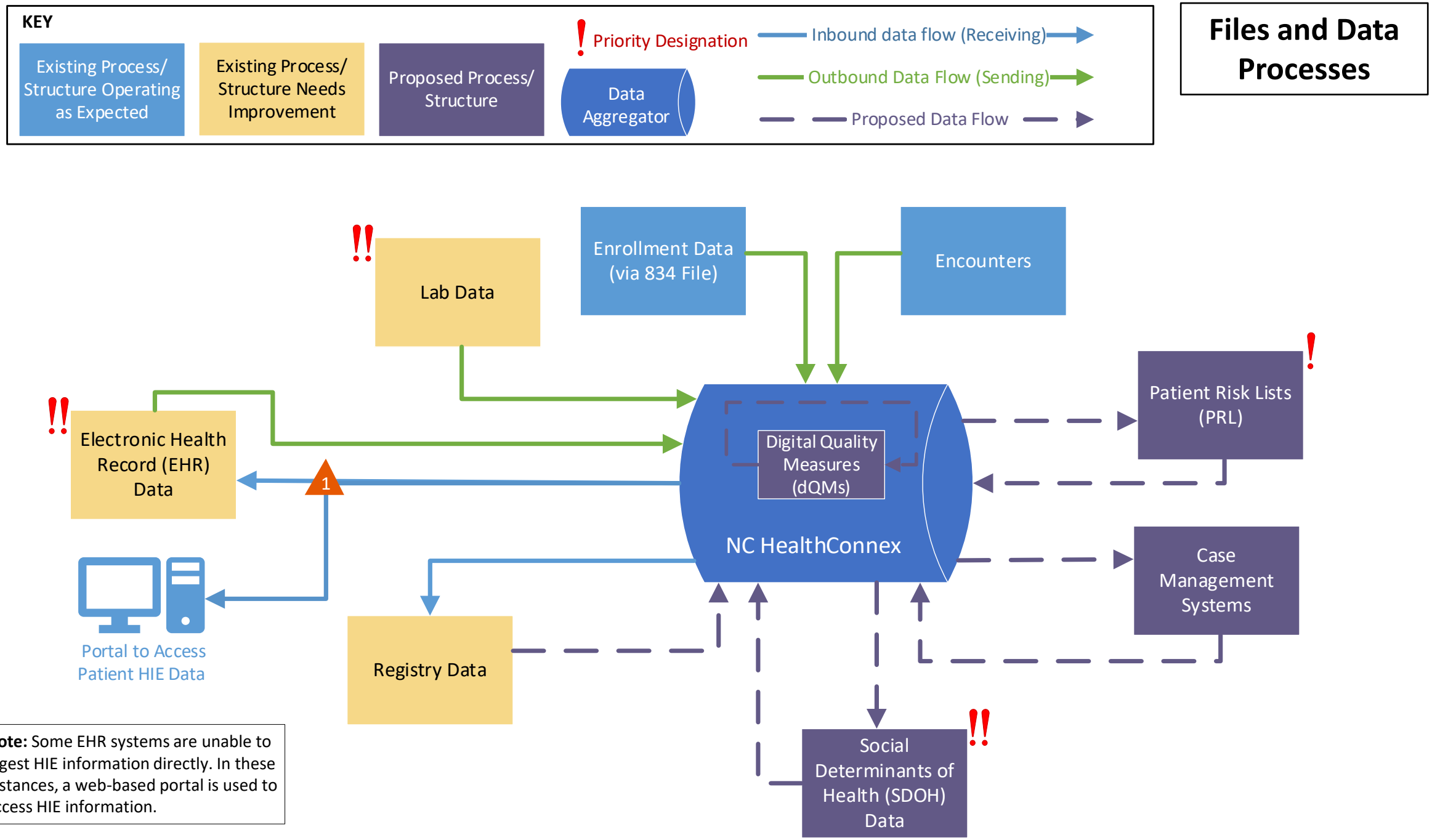
BEFORE incorporating NC HealthConnex Numbers



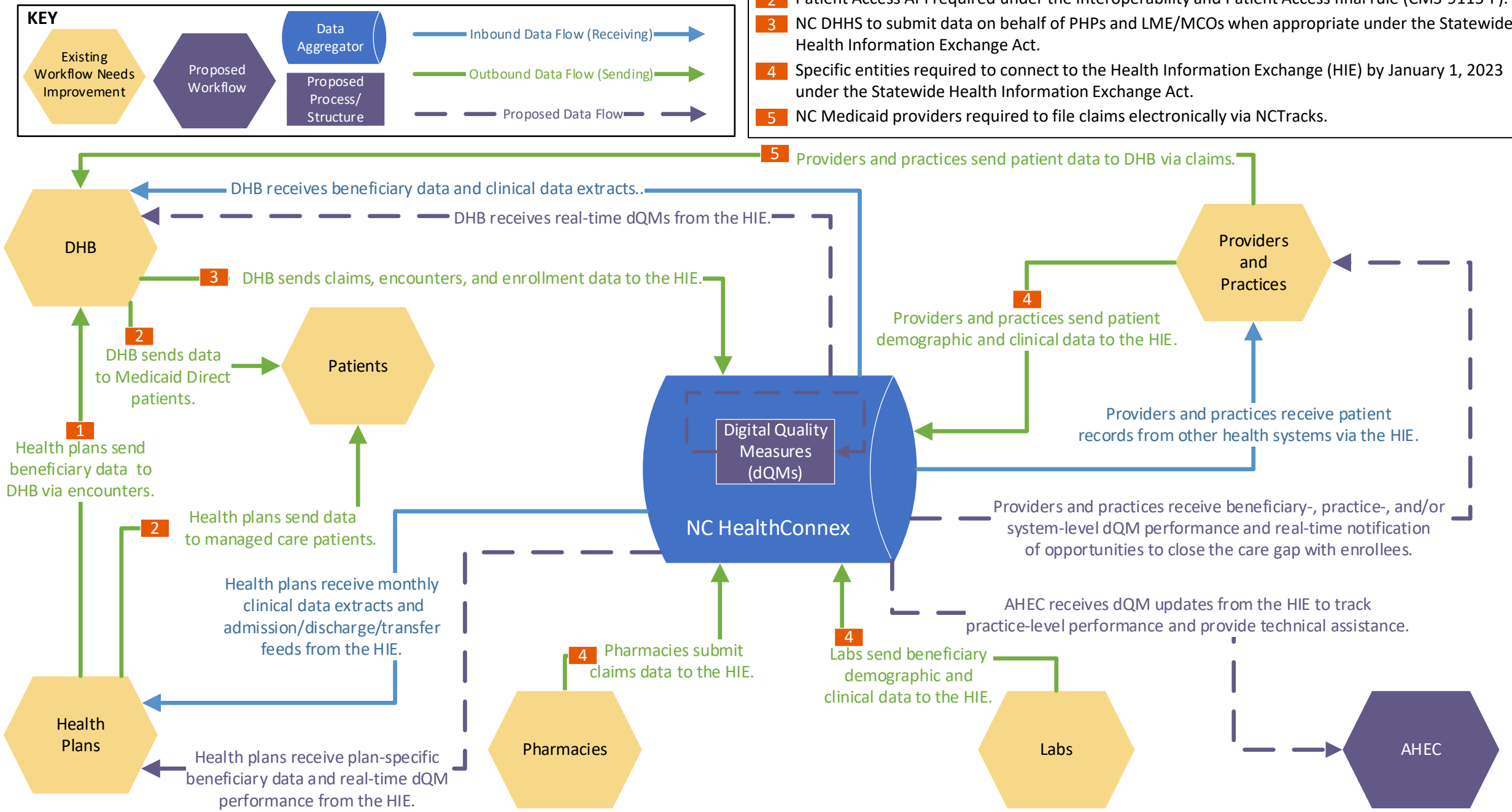
AFTER incorporating NC HealthConnex Numbers



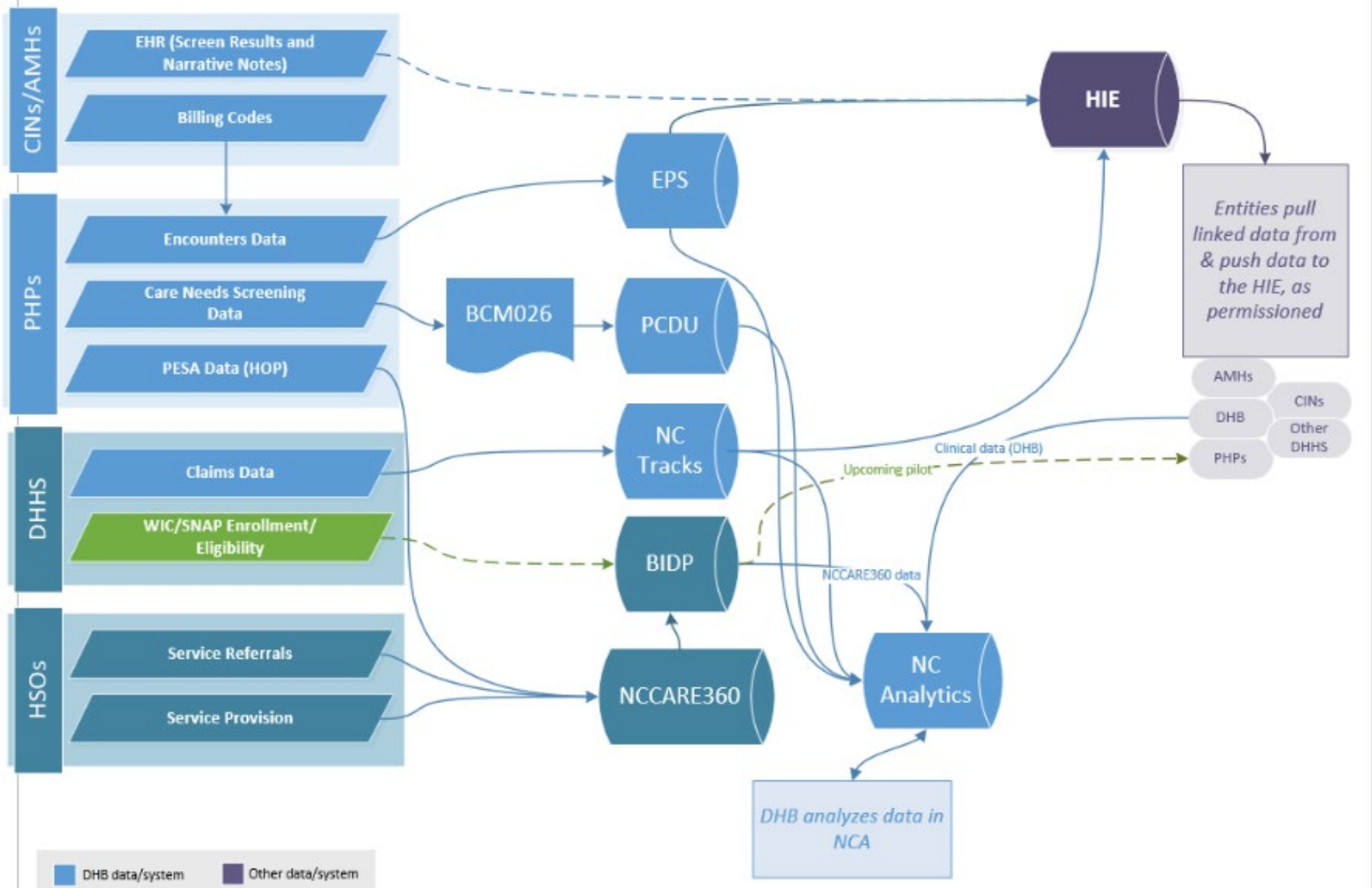
Files and Data Processes



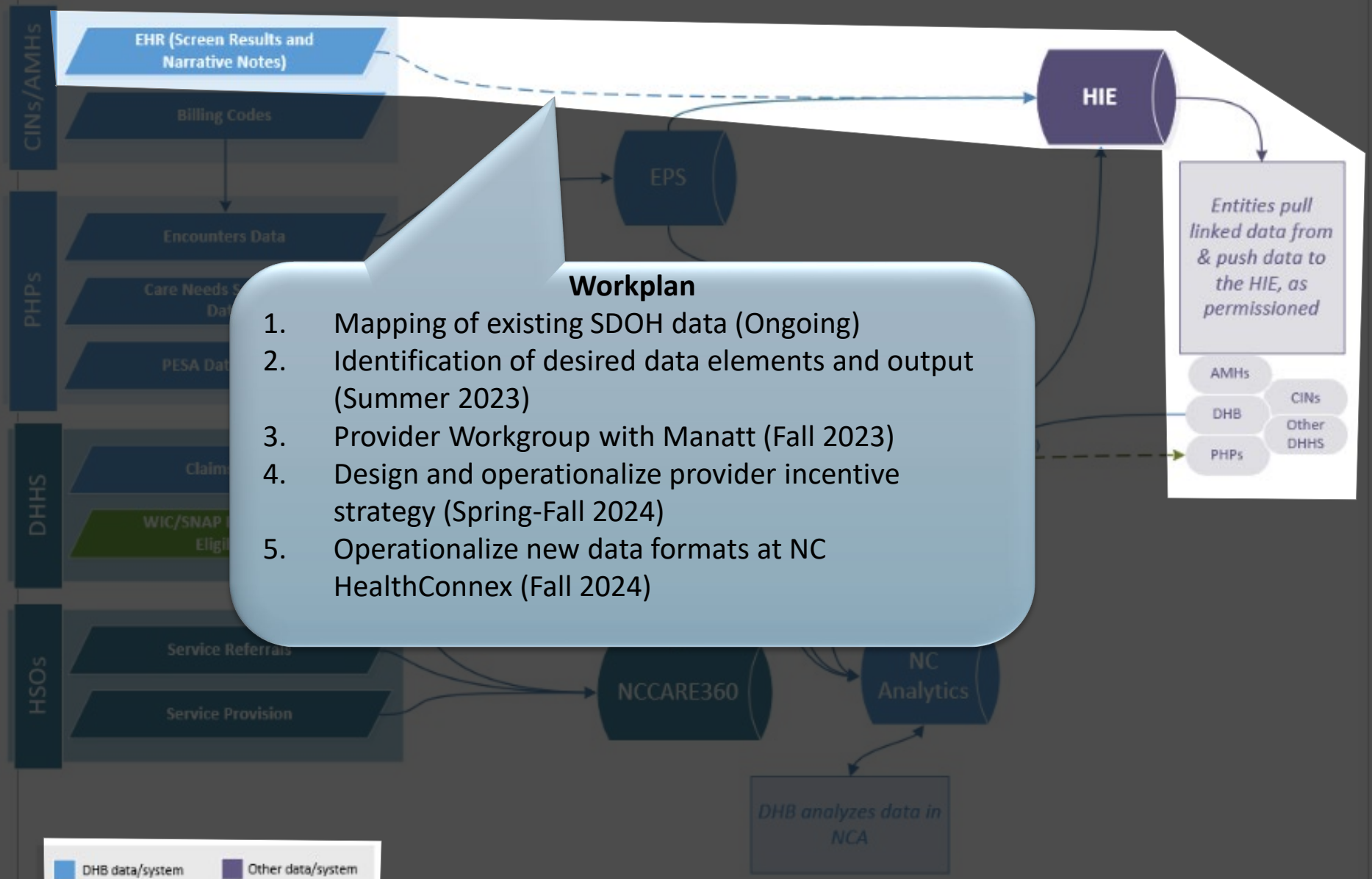
Entity Workflows



SDOH Data Flow: Current State



SDOH Data Flow: Current State



Workplan

1. Mapping of existing SDOH data (Ongoing)
2. Identification of desired data elements and output (Summer 2023)
3. Provider Workgroup with Manatt (Fall 2023)
4. Design and operationalize provider incentive strategy (Spring-Fall 2024)
5. Operationalize new data formats at NC HealthConnex (Fall 2024)

Proposed SDOH Data Flow: Minimum Viable Product