The Provider Network Development team is responsible for an assigned list of providers where they are the liaison for issues that may arise regarding the use of local and state funds, service delivery, and adherence to best practice standards and contractual requirements. You can find the assignment list on the Alliance website.
All Provider Meeting
March 15, 2017
1:00pm – 3:00pm
4600 Emperor Boulevard, Durham, NC
Rooms 104-105
Welcome and Introductions

Alliance Provider Advisory Council (APAC) Updates (Wendy Wenzel)

Alliance Updates

MCO Leadership Updates (Beth Melcher) 10 min
Legislative Updates (Sara Wilson/Brian Perkins) 15 min
Therapeutic Foster Care database and referrals- Kate Peterson 10 min
Update on Crisis Facility- Kate Peterson 10 min
Opioid Epidemic Discussion- Dr. Anderson- Brown and Vera Reinstein 20 min
Access to Care overview- Tina Howard 20 min
Health Information Exchange overview- Cathy Estes 15 min
Questions

NEXT MEETING June 21, 2017 1-3 PM
THERAPEUTIC FOSTER CARE INFORMATION

Did you know that anyone can make a referral for Therapeutic Foster Care by going to www.ncrapidresource.org? Referrals go to all Alliance Network providers. Instructions are found here:


All referrals for TFC to Alliance Network Providers must be entered into the RRFF Database. By doing this our providers are able to match placements for best geographic location and treatment program and give choices to referrers. Moves are also tracked. In order to have optimal consideration for an open bed, please enter as much information as you possibly can. Therapeutic Foster Care unlike other residential options requires a “matching process”. This process entails cross referencing a list of youth and family treatment needs with the demographics and strengths of the treatment family. Our goal is to have one treatment placement for a youth as multiple TFC placements can contribute to cumulative trauma.

Questions about making a referral? contact@ncrapidresource.org
Questions about Alliance TFC: kpeterson@alliancebhc.org

Thank you for helping us get the best outcomes for youth and families!
TFC DATABASE REFERRAL FLOW---www.ncrapidresource.org
briesser@ncrapidresource.org       Ben Riesser, RRFF Data Analyst
kpeterson@alliancebhc.org          Kate Peterson, Healthcare
Network Project Manager

Any referral entered by a provider agency: consult your internal policies and procedures regarding ROI’s. You can have a release to Rapid Resource for Families/Alliance Network if your policies and procedures allow. If your agency wants a list of Network providers, please email Kate Peterson and she will be happy to provide one.
Referral into the database

- www.ncrapidresource.org

Alert goes to Alliance Network TFC Approved Users

- Alliance TFC Provider Staff

Provider Staff view and determine Yes, No, Maybe-if maybe,

- Disposition maybe or yes, provider works the referral, disposition no, the referral disappears from provider’s screen.

Provider gets more information from the referrer to determine appropriate match

Placement date set with legal custodian and TFC agency
Medical Affairs Department Update

All Provider Meeting
3/15/2017

Tedra Anderson-Brown, M.D.

Vera Reinstein, Pharm.D.
Clinical Practice Guidelines
Approved at 2/20/17 CAC meeting

- [https://www.alliancebhc.org/providers/alliance-clinical-guidelines/](https://www.alliancebhc.org/providers/alliance-clinical-guidelines/)
- **Bipolar**: GUIDELINE WATCH (NOVEMBER 2005): PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH BIPOLAR DISORDER, 2ND EDITION (update to 2002 Guideline)
- **Dementia**: GUIDELINE WATCH (OCTOBER 2014): PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH ALZHEIMER’S DISEASE AND OTHER DEMENTIAS (update to 2007 Guideline)
- **OCD Adults**: GUIDELINE WATCH (MARCH 2013): PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH OBSESSIVE-COMPULSIVE DISORDER (update to 2007 Guideline)
- **PTSD in Adults**: GUIDELINE WATCH (MARCH 2009): PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH ACUTE STRESS DISORDER AND POSTTRAUMATIC STRESS DISORDER (update to 2004 Guideline)
- **Schizophrenia in Adults**: GUIDELINE WATCH (SEPTEMBER 2009): PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH SCHIZOPHRENIA (update to 2004 Guideline)
- **SUD in Adults**: GUIDELINE WATCH (APRIL 2007): PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH SUBSTANCE USE DISORDERS, 2ND EDITION (update to 2006 Guideline)
STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROB COOPER
GOVERNOR

March 7, 2017

MANDY COHEN, MD, MPH
SECRETARY

Dear Colleague:

I need your help. North Carolina, like the rest of the nation, is experiencing an opioid epidemic, and its harmful effects are clear. We arrived at this unfortunate place on a path paved with good intentions. Nearly two decades ago, physicians and other clinicians were encouraged to treat pain more aggressively, sometimes without proper safety guidelines and training. Similarly, patients were incorrectly counselled that all pain could be readily and quickly controlled without long-term negative impacts. We now know that these along with complex social and economic factors and the highly addictive properties of opioids have created a perfect storm resulting in this crisis.

The results have been devastating. More than 13,000 North Carolinians have died unnecessarily from unintentional overdoses since 1999. Communities in North Carolina are being ravaged by opioids. Our state dispensed nearly 10 million opioid prescriptions last year alone. Yet, pain severity reported by patients remains unchanged. Prescriptions opioid use disorders are contributing to increased use of heroin and fentanyl, a powerful synthetic drug 50 to 100 times more potent than morphine. Additionally, illicit opioid use contributes to the spread of illnesses such as HIV and hepatitis C.

Although solving the opioid crisis will not be easy, our state is uniquely positioned to help end this epidemic. At DHHS and across Governor Cooper’s administration, we are working in a coordinated fashion to ramp up prevention, treatment and recovery efforts. But, we can’t do it alone—we need your help.

In line with the U.S. Surgeon General’s recent pledge to Turn the Tide—we are asking that you join us in taking the following important steps:

- Visit CDC’s Guideline for Prescribing Opioids for Chronic Pain. This guideline has been adopted by the NC Medical Board, and free provider trainings and presentations are now underway.
- Register with and utilize the NC Controlled Substance Reporting System (CSEIS) to review patient prescription histories and incorporate them into clinical best practices around prescribing.
- Use DEA compliant e-prescribing software where possible to communicate prescription orders more securely and accurately, especially for drugs that are prone to abuse and diversion.
- Screen patients to determine risk for or presence of opioid use disorder, and provide or connect them with evidence-based treatments. This web link contains many useful resources.
- Transform perceptions about addiction by talking about it and treating it as a treatable chronic disease.

We all have an obligation to step forward and address the opioid crisis head-on in North Carolina. The health of our communities depends on it.

Thank you for your leadership.

Mandy Cohen, MD, MPH
Secretary
Secretary Mandy Cohen’s Letter

Important Steps for Providers

• CDC Guideline for Prescribing Opioids for Chronic Pain adopted by NCMB
• Register/utilize CSRS
• E-prescribe ALL medications
• Screen for OUD and connect to EB treatment
• Help transform society perception of addiction by talking about it as a treatable disease
March/April 2017 events

Convenient drop-off locations statewide!

Drop off site locations, days, and times are listed on reverse side for Cumberland, Durham, and Wake Counties.

Or visit www.ncsafekids.org to find a drop box near you.

*YEAR-ROUND* drop-off sites can be found by visiting the DEA website
https://apps.deaversion.usdoj.gov/pubdispsearch/spring/main?execution=e1s1

DEA National Take-Back Day is April 29, 2017 – 10AM to 2PM
Check DEA site after April 1 for more information
https://www.deaversion.usdoj.gov/drug_disposal/takeback/

Operation Medicine Drop is a program administered by Safe Kids North Carolina and the N.C. Department of Insurance in partnership with:
For more information visit www.ncsafekids.org.
## Operation Medicine Drop (side 2 flyer)

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<td>Cumberland Co. Law Enforcement Center 131 Dick Street</td>
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<td>Kroger 1802 N. Pointe Drive</td>
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<td>Kroger 202 NC Highway 54</td>
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</table>
Access to Care QIPs

Presentation to All Provider Meeting
March 2017
How is Access to Services Defined?

Funder (DMA/DMH) Contracts:

• Alliance shall ensure network providers meet standards: provider must provide face to face services within set timeframe (based on urgency level) after request is received from LME/MCO or enrollee (consumer)
• Refer consumers to provider of choice
• Report quarterly a summary of consumers screened by LME/MCO
• State identified these measures as “Key Performance Indicators”
What are Urgency Levels/Benchmarks?

Emergent:

• Life threatening condition, immediate need for care
• Measured as: start of call until face to face care is delivered
• State Benchmark: 97% of callers receive care in 2:15 hours

Urgent:

• Moderate risk or incapacitation in one or more areas of functioning, includes active substance abuse & individuals releasing from incarceration
• State Benchmark: 82% receive care in 2 days
• Alliance Goal: 62%
What are Urgency Levels/Benchmarks?

Routine:
- Mild risk or incapacitation in one or more areas of functioning
- State Benchmark: 75% receive care in 14 days
- Alliance Goal: 63%

Does not include callers who are already open to providers or discharging from inpatient or crisis services
How is Data Evaluated?

For Routine & Urgent callers, data is based on claims submitted for first service delivered after call or incarceration release date (we also look at provider self-report as comparison); For Emergent, data is based on provider self-report.

In FY 17, we began to include all claims submitted, including adjudicated, denied, or approved (in line with HEDIS measures); does not include reverted claims.

For Routine & Urgent callers, provider data is analyzed by the provider receiving the referral from Alliance’s Access & Information Center.
## Emergent Callers: Overall Results

### Percent Met
- The table below compares overall performance from FY 17, Q4 (Baseline):

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Total # of Calls</th>
<th># show in 2:15</th>
<th>% show in 2:15</th>
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</thead>
<tbody>
<tr>
<td>FY 16, Q4 (Apr-Jun 2016)</td>
<td>205</td>
<td>137</td>
<td>67%</td>
</tr>
<tr>
<td>FY 17, Q1 (Jul-Sep 2016)</td>
<td>136</td>
<td>114</td>
<td>84%</td>
</tr>
<tr>
<td>FY 17, Q2 (Oct-Dec 2016)*</td>
<td>162</td>
<td>95</td>
<td>59%</td>
</tr>
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</table>

*All claims for Q2 most likely not submitted, yet.*
Emergent Callers: Barrier Analysis

Barrier Analysis, Calls > 2:15 hours

- Call to police was not 1st disposition: 2
- Internal/Escalation of Call: 34%
- Consumer: 63%
- MCT: 3%

<table>
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<tr>
<th>Barrier Analysis</th>
<th>911/Emergency Referrals</th>
<th>Internal/External Factors</th>
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<tbody>
<tr>
<td>Call to police was not 1st</td>
<td>2</td>
<td>Internal/Escalation of Call</td>
</tr>
<tr>
<td>disposition</td>
<td></td>
<td></td>
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</table>
Routine Callers: Overall Results

Percent Met
• Using ONLY paid claims:
  • Percent met is: **Q1 - 48% (365/753), Q2 - 37% (260/699)**

• If we eliminate those callers for whom we would not expect a claim (individuals with Medicare/Medicaid or with private insurance or VA benefits, Q1=22, Q2=29):
  • Percent met is: **Q1 - 50% (365/731), Q2 - 39% (260/670)**

• The table below compares performance based solely on claims (not eliminating callers with Medicare or private insurance):

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Total # of Calls</th>
<th># show in 14</th>
<th>% show in 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 16, Q1 (Jul-Sep 2015)</td>
<td>1,051</td>
<td>424</td>
<td>40%</td>
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<tr>
<td>FY 16, Q2 (Oct-Dec 2015)</td>
<td>959</td>
<td>430</td>
<td>45%</td>
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<tr>
<td>FY 16, Q3 (Jan-Mar 2016)</td>
<td>778</td>
<td>370</td>
<td>48%</td>
</tr>
<tr>
<td>FY 16, Q4 (Apr-Jun 2016)</td>
<td>806</td>
<td>361</td>
<td>45%</td>
</tr>
<tr>
<td>FY 17, Q1 (Jul-Sep 2016)</td>
<td>753</td>
<td>365</td>
<td>48%</td>
</tr>
<tr>
<td>FY 17, Q2 (Oct-Dec 2016)*</td>
<td>699</td>
<td>260</td>
<td>37%</td>
</tr>
</tbody>
</table>

*All claims for Q2 most likely not submitted, yet.
For the 806 Routine callers, data on paid claims was analyzed in order to compare to provider self-reported attendance. Results ranged from a low of 26% showing for care in 14 days to a high of 64%. Most fell below Alliance goal of 63%.
**Urgent Callers: Results**

**Percent Met**

- The table below compares overall performance based on claims and attendance status:

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<tr>
<td>FY 16, Q4 (Apr-Jun 2016)-claims</td>
<td>452</td>
<td>84</td>
<td>19%</td>
</tr>
<tr>
<td>FY 16, Q4 (Jul-Sep 2016)-attend status</td>
<td>452</td>
<td>122</td>
<td>27%</td>
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<tr>
<td>FY 17, Q1 (Jul-Sep 2016)-claims</td>
<td>479</td>
<td>89</td>
<td>19%</td>
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<td>FY 17, Q1 (Jul-Sep 2016)-attend status</td>
<td>479</td>
<td>122</td>
<td>26%</td>
</tr>
<tr>
<td>FY 17, Q2 (Oct-Dec 2016)-claims</td>
<td>447</td>
<td>67</td>
<td>15%</td>
</tr>
<tr>
<td>FY 17, Q2 (Oct-Dec 2016)-attend status</td>
<td>447</td>
<td>123</td>
<td>28%</td>
</tr>
</tbody>
</table>
For the last three quarters, Johnston County had the fewest percent with a timely appointment particularly for individuals with Medicaid (18% in Q1, 44% in Q2). In Q1, Wake had the highest percent overall, while in Q2 Durham and Cumberland had the highest percent with timely appointments. There was an increase in individuals with Medicaid receiving timely appointments (Q1-61%, Q2-71%), while the percent of individuals without Medicaid receiving timely appointments remained the same (64%). Main reasons appointments not available: availability of provider (primary reason), caller request, and no appointments available in time frame. Some of the providers receiving the most referrals had average wait times of 7, 6, and 5 days.

*Data does not include two callers residing outside of the catchment area.
The average amount of time between the expected release date and date of appointment (in Q1) was 2.05 days, above the standard but less than the days for non post-release appointments. Wake County callers in Q1 requesting services following incarceration had the highest percent with appointments in two days, while Cumberland had the highest percent in Q2. The trend shows Johnston with the lowest (even though percent was close to other counties in Q1). 75% of the Q1 callers and 65% of Q2 callers in this population had an appointment within 2 days (compared to 65% in the 4th quarter). Mirroring findings from the 4th Quarter, the vast majority of individuals in this population (Q1-83%, Q2-85%) do not have Medicaid.
Consistent with the data from the 4th quarter, individuals who called on Fridays were least likely to attend an appointment within 2 days. In contrast, individuals calling on Sundays - Wednesdays were most likely. Cumberland had the lowest percent of callers who showed within timeframe (18%) in Q1, while Johnston had the lowest (11%) in Q2. Wake continues to have had the highest volume of callers on Fridays and Saturdays who did not show in time (Q1-22, Q2-25). **Data for the CJ-Post Release population shows a similar pattern—no one released on a Friday (and Saturday) showed for the appointment in two days.**
The provider receiving the referral clearly impacts whether a caller receives an appointment within the time standard of 2 days. Provider A had the highest percent of appointments within 2 days (61%) and the highest percent showing for the 2-day appointments (77%). Provider B and Provider C had the lowest percentages (38%) of individuals showing for appointments that were made within 2 days.

*Data graphed for providers who received more than 10 referrals. Project Lead did not include paid claims due to the very low number that had been submitted.*
The overall attendance rate at 2-day appointments was lower for this population than for the non post-release population. Only 27% of callers were reported as attending appointments within 2 days for all providers (19% had claims for services in 2 days). None of the providers receiving referrals had a show rate above 40%, even when calculating the denominator as the appointments scheduled within 2 days. The provider with the highest engagement percent was Provider A with 38% showed who had appointments scheduled in 2 days (25% for all referrals), although this percent may be misleading due to the low numbers.

* Data graphed for providers who received more than 5 referrals.
Alliance Action Steps

Overall

• Continue efforts to educate providers on using and updating appointments, correctly entering attendance status, and accurately submitting claims for services

• Data continues to be analyzed by provider and emailed to providers for QA use, technical assistance offered to providers, a meeting will be held with providers receiving most referrals

• Created project team to study and implement recommendations for improving engagement of post-release population
Alliance Action Steps

**Emergent Callers**

- Improve quality and timeliness of Mobile Crisis services

**Urgent Callers**

- Expedite creation of assessment services on Friday and Saturdays, particularly in Wake County

**Routine Callers**

- Continue reminder calls to individuals with appointments that began in January 2016
NC Health Information Exchange Authority
Overview
ARE YOU PREPARED?

https://hiea.nc.gov/

• The information contained in this overview comes from https://hiea.nc.gov/

• Please contact references in this presentation for any further questions-this was provided by Alliance for informational purposes only

• Source: NCHICA Update October 2016
General Background

What is a health information exchange and who is the NC HIEA?

A health information exchange is a secure and electronic network that gives authorized health care providers the ability to access and share health-related information across a statewide information highway. It exists to improve health care quality, enhance patient safety, improve health outcomes, and reduce overall health care costs by enabling health information to be available securely whenever doctors, nurses and patients need it.

The North Carolina Health Information Exchange Authority (NC HIEA) was created by the North Carolina General Assembly to oversee and administer the state-designated HIE (NCGS 90-414.7). They will receive input and advice from an Advisory Board consisting of patients, hospital systems, physicians, technology experts, public health officials and other key stakeholders to continuously improve the HIE Network, now called NC HealthConnex, and move towards more efficient and effective care.
Who is “required” to use NC HealthConnex?

The new law requires that as of February 1, 2018, all Medicaid providers must be connected and submitting data to NC HealthConnex in order to continue to receive payments for Medicaid services provided. By June 1, 2018, all other entities that receive state funds for the provision of health services, including local management entities/managed care organizations, also must be connected. (NCGS 90-414.4)
What does connected mean?

To meet the state’s mandate, a Medicaid provider is “connected” when its clinical and demographic information pertaining to services paid for by Medicaid and other State-funded health care funds are being sent to the NC HealthConnex at least twice daily – either through a direct connection to NC HealthConnex or via a hub (i.e. a larger system with which it participates, another HIE with which it participates, or EHR vendor).
I am a behavioral health or substance abuse treatment provider in North Carolina. Am I required to connect to NC HealthConnex?

If you are a behavioral health provider that bills NC Medicaid for reimbursement for behavioral or mental health services, you are required to connect to the HIE Network, now called NC HealthConnex, by February 1, 2018.

**How do I connect to NC HealthConnex?**

1) The first step in connection is reviewing and signing the Participation Agreement. If you have questions regarding this process, please contact Alice Miller via email alice.miller@nc.gov or by phone 919-754-6912.

2) The second step is to have an ONC-certified EMR product that can send HL7 version 2.0 and higher.

3) The third step is to identify three points of contact within your medical practice that will collaborate with the NC HIEA and the technology partner, SAS, to complete a successful connection.
Do you have a list of EMR systems that support connection to NC HealthConnex?

Any ONC-ATB certified EMR product that can send HL7 version 2.0 and higher will support the connection to NC HealthConnex. Following is a list of EMR vendors that are connected to NC HealthConnex currently (October 2016) or that they have experience with building the connection:

Allscripts Professional
Allscripts Touchworks
Amazing Charts
Aprima
AthenaHealth
Centricity
CureMD
eClinicalWorks
Epic
Greenway Primesuite
McKesson Practice Partners
Medinformatix
MicroMD
NextGen
Patagonia
EHR Integrations - The NC HIEA continues to work with a list of EHR vendors (Allscripts, AthenaHealth, eClinical Works, Cure MD) to build multi-tenant connections that will enable participants to access patient records in NC HealthConnex via an EHR integration. They hope to have these agreements in place in the near term so that those healthcare providers who have signed Participation Agreements with the NC HIEA can begin utilizing NC HealthConnex for the secure exchange of patient information. They recommend that healthcare providers contact your EHR vendor and request their timeframe for connection so you can begin your planning and preparations.
What happens if my practice doesn’t want to connect to NC HealthConnex?
Recently passed legislation requires that as of February 1, 2018, all Medicaid providers must be connected to the HIE in order to continue to receive payments for Medicaid services provided. By June 1, 2018, all other entities that receive state funds for the provision of health services, including local management entities/managed care organizations, must be connected.
General Inquiries
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Phone: 919-754-6912
The NC HIEA Business Office regular hours are Monday through Friday 9 a.m. to 5 p.m.

Mailing Address:
NC Health Information Exchange Authority
Mail Service Center 4101
Raleigh, NC 27699-4101
Other News
NC Medicaid EHR Incentive Program - If you haven’t already heard, the NC Medicaid EHR Incentive Program gives eligible providers the chance to earn $63,750 over six years if they are using their certified EHR to meet Meaningful Use. If you’re an eligible provider type with a certified EHR and you see 30% Medicaid patients, now is the time to get started. There are resources available to help you attest for a payment. The NC Medicaid EHR Incentive Program has attestation guides to walk you through the process step by step, a library of FAQs, webinars to bring it all to life and a dedicated help desk to answer your questions. Visit https://www2.ncdhhs.gov/dma/provider/ehr.htm or NCMedicaid.HIT@dhhs.nc.gov for more information and attest today- Deadline to apply is April 30, 2017!