

AHRQ Infrastructure for Maintaining Primary Care Transformation (IMPACT) Grants

North Carolina IMPACT: Advancing and Spreading Primary Care Transformation

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Overview of Primary Care Extension in North Carolina



Model State: North Carolina

Partner States: Idaho, Maryland, Montana, West Virginia

AHRQ's IMPACT grants were designed to support State-level primary care improvement efforts using extension agents (i.e., practice coaches)—and to learn how these programs could serve as models for other States.

The North Carolina IMPACT project deepened the State's existing multipronged approach to primary care improvement, which included practice facilitation, electronic data exchange, and care coordination and case management. The program grew from two statewide primary care support organizations, Community Care of North Carolina (CCNC) and the North Carolina Area Health Education Centers (AHEC). CCNC

originated to promote the idea of medical homes for patients enrolled in Medicaid. It evolved into a public/private partnership working through the medical home model to support practice transformation and quality improvement. CCNC is organized as a regional network with a board in each region made up of patient, hospital, and practice representatives. The North Carolina AHECs are a regional network of health professionals that has provided extensive training on performance improvement and managed improvement programs. In 2006, formal efforts to align statewide primary care improvement efforts began with the formation of the NC Healthcare Quality Alliance. This initiative fostered partnerships between payers, provider organizations, and patient groups across the State and helped to catalyze efforts, including the regional extension center and Medicaid payment reform.

With AHRQ IMPACT funding, Dr. Darren DeWalt worked with CCNC and North Carolina AHEC to design the next step for primary care support, using two types of practice improvement collaboratives to help practice facilitators and practice improvement professionals become more effective in quality improvement efforts. Together with the National Academy for State Health Policy, North Carolina disseminated its model to partners in Idaho, Maryland, Montana, and West Virginia.

Infrastructure Elements

"We've been working on this structure for a long time, and so the opportunity to continue to build on that and enhance it and enter a community of other people that are working on this was very appealing to us; this is kind of our life mission."

—Darren DeWalt, MD, Principal Investigator

The Regional Leadership Collaborative was designed to enhance quality improvement capacity as well as partnerships among leaders and staff in regional areas. North Carolina IMPACT leaders formed teams in each region with local AHEC and CCNC personnel, and brought in national experts to help facilitate learning. Each regional team selected and

implemented projects by applying quality improvement techniques from the regional leadership collaborative curriculum.



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The **Primary Care Transitions Planning Collaborative** applied the quality improvement infrastructure to improve care processes that occur when a patient is discharged from a hospital setting. To date, most efforts to reduce hospital readmissions have been hospital-focused, but primary care practices also have a key role in preventing avoidable readmissions. From April 2012 to September 2013, nine North Carolina primary care practices participated in a Web-based learning collaborative focused on improving care transitions. The practices developed and tested processes that would help them provide timely visits following a hospitalization and communicate and coordinate an ongoing care plan, with the ultimate goal of reducing avoidable hospital readmissions and emergency department visits.

Program Impacts

The Regional Leadership Collaborative selected improvement topics ranging from improving clinical processes and targets to instituting a population health management database. Through these efforts, collaboration increased between the CCNC and AHEC networks and the practices they serve. In addition, several regions made process improvements and increased use of data for quality improvement. In many cases, monthly meetings and data monitoring are expected to continue.

The accomplishments of the Primary Care Transitions Planning Collaborative range from increasing followup care for recently discharged patients to learning about how to set up a system for tracking patients during care transitions. The collaborative determined that primary care practices do not automatically have a communication line with admitting hospitals, so the change process may involve developing a mechanism for hospitals to share discharge summaries with primary care practices. The collaborative synthesized learnings into a change package that can be used by CCNC or AHEC to support other practices who want to improve post-hospital care.

“The regional leadership collaborative and the work around that really advanced the CCNC/AHEC/practice relationship and developed both regional strength and experience in those teams, as well as at the State level.”

–Darren DeWalt

Dissemination Efforts to Partner State

North Carolina IMPaCT spread efforts were facilitated by the National Academy for State Health Policy. While North Carolina IMPaCT focused on amplifying existing quality improvement support through the regional leadership collaborative, efforts in partner States focused on helping teams understand how the North Carolina support structure could be applied to the existing networks within their State.

North Carolina selected four partner States through a competitive application that was designed to assess applicants' comprehensive capacity for improvement, including a commitment to advancing policy and practice changes; multisector State-level collaborations; and involvement of an entity that could function as a primary care extension service. The selected partner States received individual and group technical assistance from North Carolina faculty and experts, and peer-to-peer learning with other partner States. Each State convened a team of about five people consisting of State government representatives and providers. There were two in-person meetings, several Webinars, and frequent interactions throughout the life of the grant. Each State adapted the North Carolina model to meet their specific needs, as described below, but all gravitated to the care management resources and insights, likely because of the potential for cost reductions.

- **Idaho** took a statewide approach to the redesign of primary care support. The core team included members from the State Medicaid agency, the Idaho Hospital Association, the Idaho Medical Association, and the Idaho Primary Care Association. These partners designed a statewide improvement model building on the Idaho Medical Home Collaborative and other existing



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initiatives. Extensive outreach to multiple stakeholders led to application for a State Innovation Model design grant.

- **Maryland** built its program on the Maryland Learning Collaborative, which provided practice coaching to help practices achieve patient-centered medical home (PCMH) recognition from the National Committee on Quality Assurance (NCQA), with funding from the Multi-Payer Program for PCMHs. The University of Maryland used the North Carolina AHEC model of practice facilitation and coaching and reached out to practices one at a time. Maryland hired and trained two practice coaches and each supported approximately 15 practices. Maryland also extended North Carolina's care management work; each participating practice identified a person to lead care management tasks with a job description based on CCNC guidance. Maryland assisted practices with electronic health record implementation and with connecting to the State health information exchange. Through a combination of practice coaching and academic detailing, each of the 52 participating practices received NCQA level II or III PCMH recognition, and all implemented an electronic health record.
- **Montana** built on existing State efforts to help practices achieve NCQA PCMH recognition, as well as AHEC efforts, such as community health worker training. Montana introduced and advocated for legislation to promote PCMH through provisions to allow multiple payers to share the costs of primary care transformation, State oversight, and rulemaking authority for standards for the insurance commissioner. While use of the political process had the advantage of fostering alignment at high levels, this approach was slower than expected. Montana also extended the data infrastructure available to support improvement through partnership with a Quality Improvement Organization.
- **West Virginia** convened many stakeholders to produce a shared vision and a white paper titled "Building the Infrastructure for a Healthy and Prosperous West Virginia." The West Virginia Health Care Innovation Collaborative originated from this work. The Collaborative is a public/private partnership working to achieve better health care quality, lower health care costs, and better health outcomes for West Virginians through healthy lifestyles.

Lessons Learned and Implications for Others

- **Balance alignment and tailor local programs to build statewide engagement.** In North Carolina, senior leaders from multiple organizations have been committed to developing productive relationships over time, which has led to sustained commitment in the State that has withstood changes in political leadership. Even though a comprehensive and aligned approach can catalyze change, local tailoring remains essential. For example, the topics of the Regional Leadership Collaborative varied by region and practice priorities within the region, highlighting the need for a flexible approach.
- **Practice improvement efforts need to fit with practice realities.** North Carolina IMPaCT structured its quality improvement presentations as a "train the trainer" approach focused on practice coaches, so it could communicate best practices to primary care practices at convenient times. Practice coaches encouraged practices to initially focus on locally-selected process measures, because affecting outcome measures (e.g., readmission and emergency department visit rates) takes more time. Through the collaboratives, North Carolina also learned that making process changes part of practice policy is key to ensuring that process changes are adopted and sustained despite changing priorities over time. Some ways that it has learned to institutionalize continuous improvement include clearly identifying who is responsible for a process and creating a feedback loop between primary care practices and State and regional improvement leaders.



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- **State-based models need to be adapted for broader use.** North Carolina’s long-standing model provided a structure that partner States could use to shape their transformation efforts. The CCNC online toolkit, resources on the North Carolina AHEC site, and technical assistance enabled adaptation of implementation of primary care transformation by the partner States. At the same time, North Carolina’s comprehensive model was not easy or quick to replicate. The partner States all struggled with limited budgets and competing demands from other health reform initiatives, including the implementation of health information technology and health information exchange. In addition, three of the partner States—Montana, West Virginia, and Idaho—are largely rural, and many health care providers in these States do not have access to community resources that are part of the North Carolina model. Further, the partner States focused on the integrated care management system. This steered the direction of spread work toward quality improvement more than practice facilitation in general. The partnerships and activities that resulted have been sustained through State Innovation Model grant awards in Maryland and Idaho and the National Academy for State Health Policy Multi-Payer Medical Home Learning Collaborative in Montana and West Virginia.

For More Information:

Hinkle L, Heider F. Building Infrastructure to Promote Primary Care Transformation: Lessons from a Four State Learning Community. National Academy for State Health Policy, 2013; Available from: www.nashp.org.

Community Care of North Carolina. The Community Care of North Carolina Toolkit. 2015; Available from: <http://commonwealth.communitycarenc.org>.

