Transcript for Webinar Series: Quality & Population Health

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Chris Weathington

It's 530 let's get started. Good evening everyone and thank you for participating in this evening's quality and Population Health Webinar. I'm Chris Weathington and I will moderate tonight's forum, tonight's webinar is produced by North Carolina Medicaid in North Carolina AHEC to help providers and practices across all 100 counties, adapt and thrive under Medicaid managed care. This collaboration produces educational programming across a variety of Medicaid managed care topics. In addition, a tech Practice Support coaches are available to provide one to one assistance directly to your practice at cost more information about our programming, and our practice support resources are available at ncahec.net. If you need technical assistance tonight, please email us at technicalassistanceCOVID19@gmail.com. Everyone, other than our presenters is muted and the chat function is turned off, you can ask questions or make comments either by using the q&a feature on the black bar at the bottom of your screen, or if you're dialing in. Send an email to questionsCOVID19webinar@gmail.com the slides for tonight's presentation are available on our website at ncahec.net. There is also a link to them in the q&a box. We will provide a recording, and a written transcript of tonight's presentation on our website tomorrow. We have learned in past webinars that the presenters will alternate address your questions during their presentations. We encourage you to pause until the presenters are through before submitting the question now, I'll turn it over to Kelly Crosbie and the team from North Carolina Medicaid and NC AHEC Kelly, the floor is yours.

Kelly Crosbie

Thank you so much, Chris. Hello everyone, welcome to our webinar tonight. Um, these last time we hosted these they were called the Advanced Medical Home webinars we've sort of expanded our reach

to, and now they're called the quality and Population Health Webinar Series. So thank you all for joining us tonight and we intend to cover in these meetings. Advanced Medical Home topics, tailored care management topics as well as quality topics, so tonight you'll see a bit of both, we'll talk about a majors but we'll talk about quality measures, as they relate to advanced medical homes, but also the practice supports available to primary care and OB practice this year, as we launch our 2022 statewide quality improvement projects. So thank you all for being here with us tonight. I am joined tonight by a wonderful panel of folks that will be speaking to you. You know me, I think you know Taylor and Beth and we've got a great AHEC team as well. Chris, Mo, Tammy and Shanon will be speaking to you as well. Next slide please.

We do have a packed agenda, we're actually going to talk about North Carolina Medicaid quality measures, again, some of you have seen these and other sessions, but we're going to talk about the mechanics of it all in one place. These things are published we've talked about them in other sessions I think most recently in the April fireside chat, but we tried to distill the mechanics of how the quality measures work and how they would apply to you as an advanced medical home. We tried to distill that down on a couple of slides, we're actually going to talk about historical data on those measures, we're going to talk specifically about the advanced medical home measures, we're going to talk about the three statewide performance improvement projects that we'll be working on this year as a state with our health plans, and with a AHEC, and then we will talk about the practice support that's available to you through these webinars but also through our health plans, and through a hack, and we're going to tell you about a quality form that will be taking place next month where we'll do a deeper dive on the QA projects as well as practice supports available to you. Next slide please. So let's talk a bit, and again this is review but we're trying to distill it all in one place, the mechanics of the North Carolina Medicaid quality measure set. Next slide.

Hopefully by now, folks are very familiar with the Medicaid quality management and improvement webpage. It has our Medicaid quality strategy which is a really dense document but it does talk about our quality management plan how we intend to measure improve and assure that we have quality here across all Medicaid product lines. So standard plans tailor plans Medicaid direct travel option. All of it's included in the Medicaid quality strategy on that webpage, you'll also find our Annual Quality Report. It's a good report. It's an awesome report really proud of the team for that one, and it has four years of data on Medicaid quality. Lots and lots of data, it goes through all of our different indicators that align with our Medicaid policy strategy tenable actually hit some of the highlights of that tonight. And it does have really interesting data where we see variation in rates, year over year, especially where we are stratifying by race, ethnicity, geography, so we've highlighted some of those disparities that we actually see in the data. So we'll talk about that a little bit more later. And another really important document is our quality measure Technical Specifications Manual, there's a link when you look at the slides there's a link to it and there's a link to the webpage itself. This actually talks about the mechanics of the quality measures, what we will measure across plans and across Medicaid direct. So again, you're all providers, you'll probably be in standard plan sale plans and have patients and Medicaid direct. So we talked about the measure sets for each of those, there's tremendous overlap, tremendous overlap, that is by design, of course, the technical specifications we try to follow national standard technical specifications, we talk

about the way that we set targets. The way that we, what years we use for baselines, the measurement periods. So we tried to have as much as we can try to standardize that and we'll talk about that in the next couple of slides. So if you go to the next slide I'm going to talk a little bit more about the mechanics. So for the Medicaid quality measures, and I'm going to talk at large, again we have Medicaid measures for the entire Medicaid program. Tonight's focus really will be on the standard plan set but more specifically the Advanced Medical Home set which is a subset of the Standard Plan quality measures. But again, in the quality strategy in the Annual Quality report you'll see quality measures for members or Medicaid members and health twist members also, but right now let's just focus on our standard plan measure set.

So, just a little bit about the history to remind folks. We actually started coming to ground on our standard plan measure said years ago, when the North Carolina Institute of Medicine, convened a task force for us on managed care metrics. I think it's actually Manister analytics I think was the, was the name of the taskforce that the link there actually shows you the published document that was created by that convening that made recommendations on the measures that we should look at for North Carolina managed care. Um, so we've, we've kind of taken that forward we've, you know, changed a little bit over time, but really we do use a governance process when we're picking the measures. And we really rely on our MCAC quality subcommittee, There's the link of is a public committee to help us refine our measure set year over year. So that original measure set has gone through the MCAC quality subcommittee, we've showed the committee rates year over year. We've amended adopted and abandoned a certain that the measure set somewhat not too much, but that's, we do have a governance process for how we reach that specific set of measures that we're doing that using today. And we will use that committee in our governance process year over year to further enhance change retire adopt new measures. So this is a bit of the history about how even came to that measure set.

So let's talk mechanics a little bit. So, managed care plans were given historical baselines for all measures. So in cases where we actually had historical data available so some measures rely on EHR data, so we don't have historical measures, and, and of course new measures come and measures change, so we don't always have a historical baseline for new measures for example. So the state rates when available were published back to 2016 in the Annual Quality Report so please do look at it so you'll actually see our state rates year over year, and performance and measures is varied. Some are above and others are below the national median but that's kind of where we trend. We trend in general around the national median. And again, there's a lot to say about that. We are often comparing ourselves to managed care states and plants that have very different benefit packages than us, or very different in Medicaid eligibility and many expansion states and we are not so, you know, you always have to put a little asterix when you say that we compare ourselves to the national median, but we're around the median, sum of income below and that's been fairly consistent year over year here in Medicaid. And in some cases measure performance is a bit difficult to interpret due to known limitations in coding billing and documentation. So you know some of our rates are artificially low because of data limitations. So, again, look at the annual color pregnancy based rates and Taylor will talk about this a little bit more. So we used all of that, we use these wonderful, brilliant governance folks, we used our historical state rates going back at least to 2016, and we've shared that publicly we shared it with health

plans, we shared it with a governance committee and we made the decision to set a baseline for our quality measures for using calendar year 2019. So the baseline for everyone's performance in standard plans so standard plans and advanced medical homes is calendar year 2019 statewide.

Kelly Crosbie

rates. Um, so, Taylor will take a little bit more about the 2019 rate compared to the 2020 rate because I know there's a lot of concern around how much ground we may have lost in 2020 and folks are concerned about the obviously losing ground on measures in 2021 Obviously as well. But she's going to tell you a little bit about what we're seeing so far in the later session we'll be able to share the measures a bit more in depth, but we do have a little bit of first blush on some of the rates. The Advanced Medical Home set is a subset of health plan measures, Taylor will go through that with you as well. These measures were selected, it is a small set, they were selected for their relevance to primary care into care management. So the measures we think that primary care can impact and care management can also help impact. Next slide.

So targets targets for standard plans, these aren't targets for him, he says, We do not set targets for AMHS we set targets for standard plans, but we want you to know the targets that we've set for standard plans, so you, You can think about that as you're negotiating and talking with standard plans about your performance in an advanced medical home. So the benchmark for performance for standard plans is a 5% relative improvement over the 2019 statewide rate. So when we talk about the 5% relative improvement, it is not a 5% whole number. So to give you an example, say a particular rate. Let's just say childhood immunizations combo 10. The statewide rate is 40% It's not, but I'm just picking a nice round number, it's 40%. That's the statewide Medicaid rate 40% all populations in. So the 5% target is 5% of 40, so it's two percentage points. So the target for actually calendar year 2022, we'll talk about the calendar minute would be 42% So that's 5% relative improvement over that 40% baseline in 2019. So those are our overall rates. We also have rates for measures in which we see a disparity. If you look at the technical specifications and previous presentations we talked about how we define a disparity. So disparity is a place where we see 10% difference when we stratify rate, say by race or ethnicity. So for example, let me use that same example. So if we were looking at childhood immunizations combo 10 the statewide rate 40, but the rate for Black and African American children is 30% That's too low. That's 10% lower than that statewide 40% So the target for that is actually a 10% improvement. So for that 30% The target improvement is actually 3%. So there's a more aggressive target for improvement in rates where we see an objective by number disparity. That was just super rough example, just wanted to give you a super rough example because we get a lot of questions about, do you really expect us to have a five percentage point increase we do not, it is 5% off of the 2019 baseline rate. And we do differentiate on rates for we see disparity, look at the technical specifications look at all presentations, because we actually explain the methodology for looking at rates with disparities, but we are absolutely committed completely committed to setting much more aggressive targets for measures which, in which we see disparities.

Okay, so that's been targeting your pitch withholds and incentives, this is incredibly important, because I know folks are particularly worried about the baseline year we're using worried about the ability to

improve worried about over aggressive targets for improvement. There is no penalty. There is no withhold. Nor is there ability for us to incentivize health plans for the first 18 months after a managed care launch that's the law. So, though it is very very important for us to set targets for health plans and to be working towards this targets absolutely working towards those targets. There was no penalty of folks do not reach those targets. Now after 18 months that that can change, so we are allowed to use those kind of mechanics, over time, but in law right now, we cannot for the first 18 months after Managed Care launch. Right. The mercial specifications as I said, are in the technical specifications guide DHB will calculate measure performance for health plans, they'll also calculate their own of course they will. And they'll report the calculations to us but we will calculate the rates for health plans, Health Plans and term calculate rates for providers, and we know you will also calculate your own rates for your CINS will calculate your own rates. But in terms of sources of truth, we will calculate this for health plans and health plans will calculate them for you as provider, but again, we're trying to go to a common technical specifications venue is not perfect but we're trying very hard to be as crisp and as aligned as we possibly can be.

Kind of the final frontier is attribution. So we are actually working with the standard plans I think we're going to show that this week. We spent a lot of time on an attribution model that does align with PCP assignment. So much of our program is built on that foundational assumption that we really want folks in primary care. So the attribution model really does use the measure itself has an attribution role right you need like X amount of months or days of continuous enrollment to that we are adding a continuous enrollment standard that tracks back to the assigned PCP but stay tuned, we really want to workshop that with our standard plan partners first, and then we will share it with you all as well as our governance groups like the image tag like the MCC quality committee for feedback around that attribution model. So this is this is just baseline, this is just baseline the way we've set up the mechanics of the program right now, over time will absolutely evolve this model quite a bit, looked at measure sets as I mentioned, what absolutely okay benchmarks over time. We must evolve. We can retire things that were tapped out and we're doing well on, we need to add new measures, when we have new priorities and things that are really important to us and we absolutely need to rethink through our targeting approach, as we see data, up until two months ago we actually didn't know how members, which which plan they would be in, we didn't know. So it's very hard to, to, before folks were split up into plans for us to be able to actually look at baselines by clan, but now the folks are split into plans this year we can start to look at baseline rates per plant. We can look at baseline rates per region. So we have a lot more flexibility and actually looking at plant based, or regional targets, but for now we don't, we didn't have that. So we're using the statewide rate, but we'll do a lot over time because we really want to use all of these levers that I'm talking about tonight, to improve things to enough about mechanics. The real point is is how we want to use provider support so that's that's we're going to get to that as soon as we can, but stay tuned, and the other thing I want to, we have a little stay tuned to, we're going to talk a little bit more about he measures in a future webinar, because one of the tips that we're actually going to talk about tonight is diabetes control for which you cannot get the information readily through claims, right, so we've actually picked a performance improvement improvement project that relies on EHR clinical data. So, we are working hard with plans on an aligned approach for collecting clinical data, so stay tuned, a little bit more for that. Okay, next slide.

This is just our timeline for those measure nerds out there, and I'm honored that you're here tonight, and I'd like to be an I aspire to be a measure nerd. I'm just not that fluent yet. But this is our timeline of measurement, even though the contract started July 1 of 2021, our measurement Year does not begin until January one of 2022. There's a lot of setup right now, when we measure 2021 rates, it's going to be a half a year effects and Medicaid direct and half year fixed and clean, you know plans. So we're actually looking at rates that are really could potentially be a bit messy because of the change, but maybe not. I mean, it'll be interesting to see what we see, the official measurement you're actually begins in calendar 2020 calendar year 2022 That's the first measurement year calendar year 2022 second measurement years calendar year 2023 And you'll see that second start that's when we can actually start using levers like with olds. If he goes in to drive performance. Next slide. I'm actually going to turn it over to Taylor, who's actually going to dig a little bit deeper into historical performance rates in general, but specifically for our advanced medical measures. Thanks Taylor.

Taylor Zublena

Thank you, Kelly. So just and Kelly gave a great overview of the Annual Quality Report, but just to serve as kind of framing for some of the measures and values that I'm going to show to the subsequent slides are first Annual Quality report was published earlier this year and it assesses our performance on historical rates for calendar years 2016 to 18 is clearly mentioned that drive towards the three aims of our quality strategy that you see on the screen, that are care delivery, healthier people and communities and smarter spending, and as Kelly mentioned, the history of the measures how they were developed for inclusion and standard playing measure sets in events Medical Home measure sets from there and the strong consideration and engagement to determine these measures that's along with aligning with national measure sets being the Centers for Medicare and Medicaid Services, of course that's there's a pediatric and adult health, behavioral health and maternal health course that we align closely with as well. And again just to emphasize where the baseline is sourced from you'll find this within the quality report that is linked on slide Five of this presentation on our webpage as well, includes the 2019 rates which are the baseline rates that we selected for year one, so if you're looking for rates measure by measure its the 2019 calendar year and you can find all that you're able to in the evaluation within the annual quality report. It's a very dense report, lots of valuable information it's not a quick read, but there's a specific area you want to focus on, including the performance improvement projects and other relevant measures that I'll dive into. It's an excellent source and encourage you to click the link and web page to get more information. Next slide please.

To go into the measures themselves again it's hard not to have a lot of information when it relates to measures and data so I'm going to try to make this as simple as possible just to focus on the information so to find the information on this slide. The measures on the slide are selected from the Medicaid Standard Plan measure sets for year one accountability and these are specific to the pediatric population. So on the left you'll see the measure title, the National Quality Forum or NQF identifier, it's a numerical code, just for context NQF endorses these measures based on established standards for measure -- widespread applicability and national measures and standardization so you can do a Google search, you can go through the end qf identifiers and you should see the same measure titles and descriptions. And then if you see to the right of that you'll see our calendar year. North Carolina rates

for 2019 What the median was and that's specific to Medicaid, a product lines and not to commercial so only Medicaid lines, just to be sure I'm clear here it does not distinguish expansion versus not expand non expansion states, and managed care fee for service but its Medicaid product line overall. And then of course the 2020 North Carolina the rates where we have those available. And on the far right column you see where it's designated if these are also an advanced medical home measure. So to go through the measures kind of top to bottom pretty briefly you see the domains, pretty typically and standard in practice being domains of care for prevention, early intervention well child visits immunizations combo 10 That's one of the performance improvement project measures, we'll look at a little bit later in the presentation. Immunizations continued, dental, prevention, and access. And then the one that highlighted, kind of in the middle of the page screening for depression and follow up. We don't have a value because it's a very complex measure I think across the board nationally there's difficulty in measuring this particular measure, measure, but that doesn't preclude the need to measure it because it, it shows the rate of screening for depression, and then what what's done with that screening if it's positive. What do we do and how that, how can we impact that to get kids to appropriate access and level of care needed, and this is on the pediatric side it's also an adult measure it starts at age 12 and up so we don't have a value for a baseline but certainly where we have stressed importance for to being included from, from here on out, and then moving towards the bottom of the slide some of the welfare measures have changed for their age parameters. So where you see adolescent walk here visit well child visits in the first 15 months of life, and security has changed those measures to be well visits within the first 30 minutes of life, and then child and adolescent well visits so there may not be sort of an apples to apples comparison from 2019 to 2020, and that's only because the measure has changed by NCQA.

And so just to give a quick overview of performance from 2019 to 2020 specific to the pediatric measures, you see there's some variance in fluctuation from year to year in comparison but by and large, they're relatively stable and stable stability really minimizes the, the progress and the in the success of being stable despite the impacts of COVID as a public health emergency. So we're actually very excited to see the continued progress and improvement in some of the measures despite the public health emergency just so just wanted to note while the, the variance doesn't look very significant, not having that significance really proves success to next slide please. And then continuing here with the format for the measures we focused on the adult measures and highlight the measures that not only are standard play measure but are also an advanced medical home measure for year one, with similar focus areas and domains of prevention, appropriate screening and early intervention, as well as chronic condition management in the quality of care provided. So you see the screens at the top of the page, such as cervical cancer chlamydia, chronic condition management of public conditions such as diabetes control and blood pressure, those are highly prevalent conditions in North Carolina, really across the US, but certainly in North Carolina, as well as utilization where you see plan all cause readmissions, which this measure looks at the rate of observed readmissions for any cause versus what is to be expected. And then what is the resulting ratio so we're looking to see a value below 1.0 And you can see, unfortunately there's a rise from 2019 to 2020 for performance in North Carolina, and you would assume more could likely assume the impact of the COVID public health emergency as far as all cause readmissions, I also wanted to note the screening for depression and follow up measures and adult measure as well if I'm included on this slide because I was trying to condense, but it's also an adult measure as well.

And so if we go to the next slide we can look closer at the advanced medical measures and then later we'll later we'll zoom even further into the performance improvement project measures. Next slide please. And so as Kelly introduced, you see the measures listed here are a subset of the Standard Plan measures that we presented, and they were thoughtfully selected through all of the convening groups to be selected as actionable at the practice level, what is relevant and primary, what is relevant at the primary care level for improved care outcomes and then, obviously, in conjunction with care management to support improvement of those outcomes as well. So all practices are eligible to earn performance incentives based on these measures. And so for tiers one and two AMH's, It's optional, but for tier three advanced medical homes standard plants are required to offer opportunities for incentives to tier three. And so the standard plans just to be clear, are not required to use all of the Advanced Medical Home measures as far as contracting and providing incentives, but they can choose as a menu so to speak, obviously in partnership and negotiation with the advanced medical home to select with which measures should be included in that incentive program. And then just to state but not overstate hopefully calendar year 2022 is the first full performance measurement period being the first calendar year because 2021 is flipped from fee for service to manage care transition in 2019 is the baseline rates. Next slide please. And so Beth is going to provide an overview of the performance improvement project selection and then I'll give a little bit of a deeper dive on some of the metrics and support indicators.

Beth McDermott

Thanks Taylor. So the standard plans are responsible for three performance improvement projects in contract year one, the comprehensive diabetes care HBA1 C excuse me greater than 9% And that's a clinical adult measure the childhood immunization status combo 10 And that's the clinical child measure, And the waiver maternal health measure of timeliness of prenatal care. And for each of those pips or performance improvement projects, the standard plan has to design it to achieve that significant improvement in health outcomes and enrollee satisfaction that can be sustained over time, they have to include performance measurement, including quality indicators include an evaluation of the effectiveness of the intervention and dress the disparities and promote health equity, just to highlight a few of those requirements for the standard plans. Next slide please. So, this slide demonstrates an overall historical performance statewide for the three measures selected for performance improvement projects for year one, the 2019 rates are the baseline, used for designing and implementing interventions for targeted improvements. Just a note that historical rates for HBA1 C for control are not available so secondary HBA 1 C provides historical performance on diabetes care for Medicaid. And I will hand it back over to Taylor to go over the measurement data.

Taylor Zublena

Thank you. Thank you, Beth. And thank you for advancing the slide Nevine maternal health indicators so there'll be a much deeper dive within the quality forums and providers reports. As we move on, but wanted to give a little bit of a high level to say, with three each of the three performance improvement projects. There is a primary indicator where you see those rates so hemoglobin A1C for control.

Immunization status and prenatal care but wanted to give a little bit of a next level to say what are some secondary indicators that support the impact of improving those rates, not just improving those rates to have a numerical value but improving the care, improving the outcomes where we want to see those improvements. So to look closer at the three performance improvement projects, and the screenshots on this slide and some of the following slides are from the Annual Quality Report. I think you can tell, I really want you guys take a look at that report to see the rich data that's in there, and it's linked on the bottom of this slide as well. It's a lot of data to present this evening, but the key items to bring forward tonight are the measures to highlight the expansion of indicators for maternal health beyond the selected Performance Improvement Project measures. So you see an orange box around the, I'm gonna say Pip, I know we use a lot of acronyms, but it's easier to save in performance improvement projects. So for the pip for timeliness for prenatal care and how historically unfortunately it's a lower rate than what the national median is you can see the, the sad one star there, but there's a little bit more into it like a lot of data and rate, there's more to the story than what you see at face value. So, looking at root cause analysis, what are the indicators what's impacting that right. And so if you look at two rows below that you'll see a heat is like measure for timeliness of care. The Medicaid analytics team and the clinical leaders and Medicaid, were able to drill down into potential causes for this historically lower rate and identified if further claims with a pregnancy diagnosis code or pregnancy related procedure codes are included they reflect a more accurate picture of timeliness of care. And so the importance of illustrating this variance, highlight the potential impacts to think he does measure from billing and coding, and perhaps some areas to target for potential areas for improvement. Another supportive measure to improving timeliness of prenatal care is also through pregnancy risk screening, the measure you see at the bottom of your screen to identify pregnant beneficiaries and that's completed, typically the first prenatal care visit by the OB provider. And with that screening, the risk and beneficiary care needs are identified to then support outreach and engagement and care management for high risk pregnancies, through the CM HRP or the care management for high risk pregnancies program as well. So it impacts the timeliness of prenatal care and maternal health overall. Next slide please.

So the second performance improvement project is focused around childhood immunizations specifically combination 10, shown here in received by the child's second birthday so as you see on the right side of your screen, while we have continued improvement and even through 2020. Despite the COVID public health emergency. There are still improvements needed to reach the national benchmark we're not far off, but want to continue momentum to reach and exceed the median certainly not just from a measure perspective but for children to avoid preventable illness, and through these vaccines for overall overall child wellness and prevention. And so they're supportive measures for this are for well child visits, those are typically done, not always but typically done in the same visit where immunizations are provided to also look at care gaps to reduce those who have not received the full recommended vaccine combination at the right enroll, as well as care management rates for at risk children in the North Carolina CMARC or care management for at risk children program. Next slide please.

And so the third and final tip focuses on diabetes prevention and control the. The chart on the left shows the CDC Behavioral Risk Factor Surveillance System survey, that's a lot to say. So you'll see it's

abbreviated as BRFSS and in North Carolina that's performed by the State Center for Health Statistics, which the survey, surveys, North Carolina red residents on many domains of health and health risk behaviors. So here it shows with statistical significance for prevalence for most recent years captured those with Medicaid health insurance self reported having diabetes at a higher rate than those registered residents with no or other health insurance. And that's significant to say what's the prevalence of diabetes and how the disproportionality. For those Medicaid may have a higher prevalence of diabetes and what do we need to do to support that. So that is a bit of the imperative for including as a urine performance improvement project. And for another supportive measure for diabetes control is the rate of those who are diagnosed with diabetes, What percentage received that hemoglobin A1C testing, and this is a familiar test I'm sure with those here this evening but just to be clear, it's a lab test to indicate diabetes control over a longer period of time, six months, and provides the most direct insight into support for the diagnosis of diabetes, as well as control over time. And for assessing and monitoring the quality of diabetes care. And so we are below for hemoglobin A1C testing. This is a composite measure for complete care for diabetes, and where we want to see for control and the availability of that data, and the reduction of work control over time. Next slide please. And so just to show two final indicators to support Diabetes Prevention and Control and how we're measuring in performance improvement. There are national utilization measures by AHRQ, which show for both the pediatric population so you see the PDI measure that's highlighted, and the adult version of the measure, which is the PQ I measure the rate of potentially preventable admission specific to diabetes. So a lower rate here indicates better performance and NorthCarolina as you see is performing better or higher for the adult population I'm sorry I'm saying that pimper So performing at a higher rate for the adult population than the pediatric population, so to round out and have a closer look at the performance improvement projects and potential secondary or supportive indicators in these domains. The next step is to talk about how we improve these focus areas for health and the quality of care outcome so how will we accomplish this improvement, and what are the providers supports that are needed to support improvement. Next slide please. And so I'll hand it over to the rest of the team to focus on provider support. Thank you.

Beth McDermott

Thank you, Taylor. So provider supports is going to be a partnership between DHB the health plans, and a, what we want to do is build upon North Carolina's existing infrastructure to support clinical improvement. So the department's providing additional resources, tailored to advance state interventions and ensure that providers ability to achieve the goals of the quality strategy, the supports are offered to assist providers in clinical transformation and care improvement efforts. And the practice and regional levels. The department will be offering state led training and feedback sessions through webinars fireside and back porch chats, and were feasible in person trainings to educate providers and keep them up to date on programmatic development. Additionally, the standard plans are responsible for training providers on claims specific policies and programs, and must develop a provider support plan that will be reviewed by the department and updated on an annual basis. AHEC and DHB have partnered to facilitate virtual office hour sessions as well. Those offer an interactive format for providers to have their questions answered those office hours, covering a wide range of Medicaid managed care topics. Next slide please. So plans are responsible for training providers on their plan specific policies, and these provider support plans include the standard plans, technical support activities. details on how

those activities will help achieve an advanced the aim goals and objectives set by the department, and an overview of how the plan will evaluate progress over time. But we don't do this alone. We do have the help and support of AHEC, MME will go over how they support provider practices. Thank you.

Monique Mackey

Thank you Beth. Next slide please. Hi everyone, I'm Monique Mackey and I'm the quality improvement manager for the North Carolina head Practice Support Program, and I'm excited to be here tonight to talk with you about our work and how our coaches can support providers in their work. The Practice Support Program began in 2005 as the improving performance and practice project, project was funded by Robert Wood Johnson in North Carolina and Colorado were selected as pilot states, the founders were very interested to see if practices would agree to work with quality improvement coaches, and if so, whether those quality improvement coaches could help practices improve outcomes for patients with diabetes and asthma, diabetes and asthma were chosen because patients who have these conditions are more likely to interact with individuals in all areas of the practice, and the goal was to teach all practice staff about the chronic care model and how to use the model for improvement practices would be coached on how to pull in review data, how to use the data to identify areas that needed to be improved, how to look for ways to improve how to test the proposed changes, and then to look at the data and determine whether the changes resulted in an improvement. All practices use the set of common quality indicators which were tied to national measures practices for enrolled and eastern and western North Carolina and one coach cover all the 15 wave one practices based on wave one results. The second wave was started and coaches were hired to statewide to work with 95 practices that made up wave two. The project was designed to allow participants to align initiatives. So for example, physicians that participated in the project could earn maintenance of certification port for credit, and also practice performance improvement, continuing medical education credits. Additionally, the quality improvement coaches and CCNC staff worked together to schedule and host collaborative training and learning sessions, so that participants could learn from each other and also from experts. The project was a success. As you can see from the results shown here. These are for two measures for white one practices, If as you look at this information T1 was data that was collected at baseline. T2 was data that was collected about midway into the project so about a year into the project, and T3 was two years into the project. So one thing I want to point out here remind everyone, is that A1C greater than 9% is a reverse measure so what we want to see is those rates going down over time and as you can see here, and both HBA 1C greater than nine and patients that have an asthma action plan practices, improved from baseline, and were able to sustain that improvement in two years into the project. So, during the project, we found out that practices focus their efforts on a few specific areas they tended to realize the most improvement. These grew and what we now call the key drivers. These key drivers for the foundation of our approach. Next slide please.

What you see here is the third iteration of those key drivers, they still include the original drivers but have been expanded based on what we've seen in practices over the past 16 years. The model still works. As you can see from data from a more recent project which was heart health now practices who worked with a coach during that project were able to reduce the baseline mean 10 year ASCBD risk score for patients at high risk from an average of 23.1% at baseline to an average of 17.1% post

intervention. So you can see our key drivers are in the areas of using and and robust clinical information systems, providing patient centered team based care using standardization of the way care is provided across the practice from provider to provider, working to ensure a, an excellent experience of care for the patients, making sure that we're doing everything that we can so that patients feel empowered to take responsibility as partners in their care, and making sure that our practice is financially healthy because as everyone knows, if there's no margin, there's no mission. Next slide please.

Monique Mackey

Today we have 33 coaches working across the state, 3 of those coaches are focuse on working in tailored care management and we plan to hire more coaches to work in TCM over the next few weeks, we have about 1200 practices working on 800 projects ranging from improving MIPS scores to assisting practices become recognized as patient centered medical homes. We also work with practice on improving outcomes on several diseases and conditions including hypertension, diabetes, asthma, and IBD. We're currently coaching practice to improve their Amh tier status from tier two to fear tier three using our Tier support tool which you'll hear a little bit more about in a minute. And we've assisted about 700 practices identified by Medicaid as essential and their transition to Medicaid managed care. Through the years, our focus has remained the same, to coach practices to improve patient outcomes improve patient and staff experience and thrive and Value Based Payment Models. We're excited about assisting practices as they focus on diabetes childhood immunizations and timely prenatal care, as part of NC Medicaid improvement priorities. Now I'd like to turn it over to two of our extremely valuable and knowledgeable coaches Tammy and Shannon so they can tell you about the work that they do when they go out into practices, Tammy.

Tammy Yount

Thanks, tonight I'm going to talk to you about the heart health now project that we worked on and how we helped practices and improving quality, through this grant. So heart health now was one of seven cooperatives across the US, to be funded through AHRQ is evidence now grant. The purpose of the heart health now grant was to help small to medium sized practices, adopt and implement evidence based guidelines around heart health, to build capacity to implement new evidence going forward and learn how to utilize practice facilitators to drive improvement in health outcomes, and ultimately to build out the blueprint for using practice facilitation as a mechanism for improvement in primary care. So as Monique mentioned earlier AHEC coaches use the chronic care model, the model for improvement and our key driver implementation scale to coach practices and the development and or adjustment of workflows or systems optimization, among other things, to drive improvement around eight part health now measures in this brand. A few of the measures were already nationally recognized and available on most systems, but most of the measures were new so as part of the grant proposal the cooperative funded the building of the HHN dashboard to build out the new measure set, and the dashboard was intended to interface with various EHRs and aggregate data from the practices EHR systems, with the ultimate goal of producing patient lists and automatically calculating a 10 year ASCVD risk score for those patients who were at risk for heart disease. Early on in the recruitment process. We promise the practices this this dashboard to produce these patient lists and the calculated risk or, and we set some high expectations for them, and that became hard to overcome when it didn't quite go as we planned. And so we faced many challenges in building the dashboard, much of which revolved around integrating

with the disparate EHR systems and this led to there being a late rollout and for some, it just wasn't available simply because their EHR wouldn't interface with the dashboard. So as a result, many of the practices were reluctant to start the intervention phase or even participate without having a dashboard. So, even with the practices that did have access to the dashboard we had other real challenges. There was the data in the dashboard was incomplete, some of it was incorrect. We just had some missing elements and the missing data made it almost impossible to calculate or automatically calculate the risks for. So without this data, it was really difficult to identify which patients needed the intervention. Next slide please.

So, in addition to the data challenges that we had, we also experienced some other challenges such as getting buy in from the providers around using aspirin for primary prevention, and not all of the providers agreed with the new guidelines. Another real challenge we had was, you know, getting the providers to manually calculate the risk score and providers that didn't have access to the dashboard at all, or where we saw the gaps in the data that prevented the automatic calculation, they were really reluctant to participate because they didn't want to have to manually calculate the cardiovascular risk for. Next slide please. So, how do we overcome these challenges. So we did what a head coaches always do, we met the practices and the providers where they were. One of the hallmarks of our practice facilitation program is being able to start with the practices and find ways to improve, even in a less than perfect situation with perfect data that we convinced our practices to start the intervention without the perfect data set or the dashboard. And despite their reluctance to adopt the new guidelines. We did this by encouraging them to start working in areas they were most comfortable, and we pulled out all of our tools and our hefty toolbox and we got to work. So when the providers had disagreements over the guidelines we engaged our clinical study team to have those peer to peer conversations to see if they could facilitate a better understanding, we helped practices set up clinical decision support systems that were, by and large, already built into their EHR system so they could begin to identify patients who met criteria for risk calculation, and we help the providers. Download the cardiovascular risk calculator on their phones, computers or laptops, and then help them to integrate it into their workflows. And we use features and functions there were primarily available in their EHR to either create registries or other mechanisms for flagging patients with high and moderate risk scores. And in many cases, when all else failed we help them to create custom reports to identify those patients who were in need an intervention. So at the end of the day, despite all of the challenges and a very imperfect system. We overcame and we were able to realize, improvement in the blood pressure control, and ultimately reduce the risk of cardiovascular disease and many North Carolinians. And as Dr Sam Cykert was always quick to remind us, if we helped to save or extend one laugh, it was well worth it. Now I'm going to turn it over to Shanon Farrell who's going to talk to you a little bit about our Hmh work.

Shanon Farrell

Advanced medical home or AMH tier support tool was developed by North Carolina at AHEC and North Carolina DHHS to assist practices in assessing their current state and planning any necessary improvement work that would prepare them for their role as an H in managed care. Now part of the process of transitioning to an AMH required practices throughout North Carolina to consider their capabilities of addressing care management, risk stratification and data collection, and whether these

requirements could be attained internally with new workflows or skills or if it would require receiving support from an outside organization such as a CIN. The AMH tier support tool will help practices by providing them details that would impact the day to day work of their desired tier status, and it's in my experience that the tool is a robust resource that was able to help tier two and tier three practices in making the decisions most appropriate for them. Next slide please. Practices utilize the tier support tool by completing a front admin gap analysis, as well as a clinical admin gap analysis, the front admin gap focused on standards around access billing in plain PHP onboarding and participation, along with the Quality Strategy. While the clinical admin gap focused more on areas around care management referrals, social determinants of health and the health information exchange, detailed requirements and recommendations affiliated with each of these listed standards, allowed practices to thoroughly evaluate their current state, along with support that, along with the support and resources that were available to them. The varying results of these evaluations, highlight the tier support tools ability to assist any practice by meeting them where they are and guiding them through any necessary changes. I'll be sharing several examples that display this However, please note the data shared is for educational purposes only and does not reflect any specific practice. Next slide please.

While working with a practice that was unsure about attesting to tier three, we use the tier support tool is a learning resource, as seen on this slide, there's a column available on a tool that filters the standards by tier level. By using this feature, this particular practice was able to display only the requirements and recommendations for tier two standards. After a review of the filter tool. The practice identified several areas for improvement and ultimately decided that tier two was most appropriate for them at the current time. So now moving forward, the tool will guide this practice and tracking their tier two improvements, and also help them identify the appropriate time to begin working on tier three requirements. Next slide please. Another practice I worked with was able to use the tool is more of a decision aid when they were approached by an outside organization that was offering tier three support. The practice was hesitant about taking on tier three requirements had many questions for this organization around how far their how far their support went, and how they would work with the practice in the future if they chose to align with them. So with the tool filter to tier three requirements. This practice was able to go line by line with the organization, ask their questions, express concerns and really had a meaningful conversation about their role in tier three support. Ultimately the tear tool empowered this practice in a way that allows them to lead the conversation and then be confident in their decision to attest to tier three and contract with the organization. Next slide please. The most common experience I had with practices using the tier support tool was but those that had already tested to tier three and empty tracks, and we're looking to prepare for Medicaid managed care practices that completed the tool were able to develop a project plan based off the results of their front admin and clinical gap analysis. The plan included requirements and recommendations that needed to be worked on. In addition to identifying a responsible party, the actions required, and a due date. This project plan provider practices with an organized checklist that helped them prioritize and stay on track and completing their preparations for being an AMH tier three, The project plan also allowed us as coaches to conduct a more efficient follow up on the practices progress by having one organized place to track their needs. I think there's value in noting that several practices I work with do have the support of a CIN and on several occasions I was able to include a representative from the practices CIN to join our meeting to review this tool, and this really allowed for a collaborative approach in addressing the

requirements and recommendations, and resulted in everyone involved having a better understanding of the practices needs as they work to prepare for tier three.

So whether working with a tier two or tier three practice it was my experience that the Hmh Tier support tool proved time and time again its effectiveness in assisting practices in preparing for Medicaid managed care. And if you would like to access the tier support tool, you can visit the link shared here on this slide at https://www.ncahec.net/practice-support/advanced-medical-home/ to download a free copy today. And next slide I believe we're back to Kelly.

Kelly Crosbie

All right, so really quickly I'm going to tell you some things that are coming soon. We have mentioned several times but here's the link for the registration for our Quality Forum, when we first started planning this years ago it was going to be in person regional forums, but now we're going to have an online Quality Forum, it's going to be great. A heck's going to present the health plans are going to present, because we all are aligned on our statewide quality improvement projects for this fiscal year, so please do attend. There's the link. We hope you can come. Our next webinar next month is actually going to focus on two pilots pilots that do effect and rely heavily in some cases on the advanced medical home model in our care management model that we've built. So we're going to talk about the Healthy opportunities pilots, and we'll talk about Integrated Care for Kids pilots and the asterisk I would put there is, these, these pilots don't affect all advanced medical homes they are in very specific parts of the state, but we want all advanced medical homes to understand the programs. So that's next month's session. We are also in they will tell you more about it in the next slide, we are going to have a whole series of tailored care management webinars, those will actually be during the day, they will be weekly and they will run October through December, wait till the next slide, we have not published, I don't think we've published yet a link to those are a way to sign up, but we are going to do an in depth webinar series on tailored care management, much like we did for advanced medical homes back in the day for those of you that remember, we will be sharing in a subsequent session our 2020 Quality Measure rates as well as stratified rates as well. So you've got a little taste of those tonight, where we see differences between 2019 and 2020, but we'll have the fuller measure set in a later session. Also something that we'll talk about is, we have been doing a lot of work, and I say we, the big group of we certainly not me but wonderful, brilliant people at the department and on my team, working to get Medicaid specific vaccination data. So we're actually trying to get member level data on folks who have not been vaccinated in Medicaid early indications of that data shows us that our Medicaid rates are lower than state rates significantly in some cases COVID vaccination rate so we'll actually be working to give health plan and member level data for folks who have not had a vaccination yet. We will be asking them to share this with advanced medical homes, so you can do outreach and engagement and try to get Medicaid members in for vaccinations, health plans will be also rolling out member incentive programs, and we are exploring provider incentive programs as well, but know that we are working on the data so we can get it to you. Um, and, so stay tuned, but I just kind of wanted to put that out there and we always encourage please in your care management engagement outreach, please make sure that you're asking folks and encouraging them to get vaccinated we truly appreciate y'all doing that, um, our advanced medical home technical advisory group, the next the next meeting is September 14 those are

scheduled now actually throughout the rest of the calendar year, but that's the link to go to the Advanced Medical Home tag, it is a it is a, there is an advisory group. There is a membership but it is an open meeting so we encourage all folks to come that is where we run, run new things by the group and enhancements and changes and advancements in the program, but we'll also start as data is coming in, about how medical homes are performing we'll also be sharing some of the data that we're seeing with the advanced medical home program. We were out of time but the next slide really quickly, it's just a super quick update if I can do one more slide. When tailored care management.

Again, we're going to have a whole webinar series on those, but just, there are folks here who there, there are providers here there are CINs, that are thinking about doing tailored care management or supporting to your management entities. So just as a reminder, tailored care management is, is different than advanced medical homes, it does have a it's it's close, but it's different. There was an entire certification process. It has many steps in our first cohort of folks have come through the impasse the desk review process, that doesn't mean they're certified to provide to other care management does mean they pass test review. Now they're all getting technical assistance from AHEC so thank you for developing a tailored care management, technical assistance coaching program for us to fix you're working with a heck now, folks can apply for our second round of our second cohort of fertility care management by September 30. We will begin site reviews in November of this year that's kind of the second stage, to see how you're progressing in your certification. I did mention that we will be having a tailor care management 101 series going through the whole model in depth in a series of webinars, that's inclusive of the data and the quality metrics for Tailored care management as well. And the last thing I'll say is that tailored plans that we have, you know, Tailored plans are live now I hope some of you were on the call tonight, but they will also start to work very soon with the folks who have passed us reviews who work with them on capacity funding to help them they're getting coaching and capacity funding but again, tune in to this webinars, if you don't know much about Tailored case management but you're interested and you're thinking about it, do tune in and we'll do a deep dive on all of the many facets of Tailored care management. And I think Chris, I'll turn it back to you.

Chris Weathington

Gosh. Thank you everyone. I think we've answered everybody's questions tonight and apologize for running just a little bit over but thank you everyone for your time and your dedication to the patients across North Carolina especially during these challenging times. Thank you everyone and have a wonderful evening.