Transcript for Virtual Quality Forum

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12:00-1:30 pm

Presenters:

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Taylor Zublena
Beth McDermott
Lena Klumper
Jeanne Leslie
Dr. George Cheely
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Chris Weathington

Is 12 o'clock lets get started. Good afternoon everyone. I'm Chris Weathington and I will moderate today's forum. Today's event is produced by NC Medicaid and NC AHEC to help providers and practices across all one hundred counties thrive under Medicaid managed care. This collaboration produces educational programming across a variety of Medicaid managed care topics. In addition, AHEC Practice Support coaches are available to provide one to one assistance directly to your practice at no cost. If you need technical assistance today please email us at technicalassistancecovid19@gmail.com. Everyone, other than our presenters is muted and the chat function is turned off. You may ask questions or make comments by using the q&a feature on the black bar at the bottom of your screen, the slides for today's presentation are available on the Medicaid managed care section of our website at ncahec.net. There will also be a link to them in the q&a box. We will provide a recording and written transcript of today's presentation on our website tomorrow. We've learned in past webinars that the presenters waltz and address their questions during their presentations. We encourage you to pause until the presenters are through before submitting a question.

I'll go on to the next slide with the agenda, we will make brief introductions to North Carolina Medicaid, provide a DHHS NC Medicaid Managed Care Quality Strategy overview, and also a brief presentation on the quality measure data and reporting to the advanced medical homes. In addition to health plans will provide information around performance improvement initiatives related to childhood immunizations diabetes control and timeliness of prenatal care, we'll also review the COVID-19 vaccine strategies, and finally health plan in a provider supports. Next slide. Just a brief introduction on the provider Quality Forum objectives at the end of this session, you should be able to understand why health plans are conducting the performance improvement projects, otherwise known as pips, list the DHB specified pips for your year one, summarize the quality indicator definitions, recognize the importance of individual

practice performance. Discuss the connection between published clinical practice guidelines and pips and also understand and know how a heck of a PHP practice support services are available, and who to contact. Next slide. I just like to give a brief, shout out to everyone on the Quality Forum workgroup. From DHHS a head, and the five perspective health plans at Carolina complete health AmeriHealth Caritas healthy blue United Healthcare and wealthier. Next slide. Now I'll turn it over to Kelly Crosbie at North Carolina Medicaid.

Kelly Crosbie

Thank you so much Chris, and I want to say thank you to the whole AHEC team, all of the health plan quality directors and their teams, and to our quality team right here at Medicaid. I know that a lot of collaborative work has gone into preparing for the regional forums today. And a lot of work has gone into preparing for these statewide performance improvement projects for this fiscal year. I want to get a little framing for how we got here today. We actually started Standard Plan quality design almost five years ago. It's been a long time, and we work with stakeholders across North Carolina, like our North Carolina Institute of Medicine, like our medical care advisory committee or NCAC to develop a high level quality framework, And we really follow the Quadruple Aim, so we want satisfied and engaged members satisfied and engaged providers. Of course we want member outcomes, and we want to use our money as wisely as we can. In a moment, Jimmy, Wilkins is going to do a high level overview of our quality strategy, and some other quality governance documents. My cat has decided to join us Taylor Zublena is going to do a high level overview of the indicators we're using to measure progress towards those aims goals and objectives. And from that set of indicators, we worked with our internal and external stakeholders to pick three topics that mattered a lot to us. Medicaid serves a lot of members primarily children, women during the antenatal and postpartum periods, and people with disabilities and support needs. So we picked three pips, one that focuses on children, one that focuses on pregnant women and one that focuses on adults with chronic conditions. We are really excited to launch these three statewide performance improvement projects. We want all plans, all providers, and AHEC all rowing in the same direction, because we think that's a really powerful thing. We want to make sure that providers have the data, the resources and the tools they need to be successful. And we want to promote payment structures that move us towards these outcomes. This is really a first step we're very excited for this kickoff. We are very committed to health equity to healthier people and communities to a better whole person care delivery system and to spending money on the things that are going to get us there. And now I'm going to turn things over to Jaimica Wilkins, she's our Deputy Director for quality and pop Health here at Medicaid.

Jaimica Wilkins

Thank you, Kelly. So I'm just gonna briefly go over her quality strategy as well as our quality management and improvement web page. As you can see on the screen this is a snapshot of our web page, that's our repository for our trio quality documents. So first you see listed our Medicaid quality strategy. It details our NC Medicaid managed care aims goals and objectives as well as interventions to assure monitor and improve quality of care for North Carolinians. We also have our Annual Quality Report, which provides our context for quality measures by overviewing North Carolina Medicaid

performance in comparison to national median in past years, so you'll see four years of data within our Medicaid quality listed in this report, and it also explores the reasons behind performance initiatives intended to improve performance. And lastly we have raw quality measures technical specifications, our health plan quality and accountability is listed in this document according to our Quality Strategy goals, and it outlines all of the measures within the Technical Specifications Manual. It also includes both standard plans tailored plans and any other measure sets in the future as we update the quality strategy and the quality technical specification documents. In addition, and includes our targets, you'll also see at the bottom of the screen, a link for your convenience to access this web page. Next slide.

This is our quality strategy framework. And within this framework you'll see our aims goals and objectives. There are three, or better health care delivery, healthier people and communities as well as smarter spending as Kelly alluded to, the quality Strategy is required federally by each state contract with a managed care organization or prepaid inpatient health plan for Ambulatory Health Plan for primary care case management entity. And we also have to update this policy strategy when there are significant changes, or at minimum every three years so we will be updating it, as you know we're phasing in portions of managed care over the next few years. So, on an annual basis we will be updating this document to reflect that. There is a public comment process that's available, and allows for our internal and external stakeholders to contribute to the process of framing the quality strategy. The quality strategy framework is structured on the three central aims, and also aligns with our key DHHS initiatives including non opioid action plan, our early childhood action plan up here a mental health strategic plan on maternal health strategic plan and healthy North Carolina 2030. We also have six goals that align with our three aims and 18 objectives that tie into those particular goals, we'll turn it over to Taylor in a little bit to talk a little more about the measurement that you see in the blue line, the measurement, part of the framework will be presented to talk about those measures that pertain to that area of the framework, and then we'll talk more about how we drive those measures through improvement in our performance improvement section, and then our health plan colleagues will also have like, how they will interact with us providers and performance improvement and the expectations going forward, as they meet with you, or provider supports as well as in clinical quality. So now we'll turn it over to Taylor Zublena who will talk more about our measurement within adult child and maternal health, Taylor.

Taylor Zublena

Good morning or afternoon everyone, because it might help if I got off of mute, so we're going to dive in a little bit deeper to these measures and every, every measure and value that you see on the slides is also available are also available in the Annual Quality report that we have posted Kelly and Jaimica both spoke to, so we do have historical data, not just for 2016 to 19, that's what's captured in the Annual Quality Report so I just wanted to provide some accompanying metrics and secondary indicators as we're focusing on our year one performance improvement projects today. So it looks like the bucket box is going a little skewed for the orange area but as you can see childhood immunizations are one of our focus areas for year one performance improvement project specifically combination 10 shown here, and received by the child's birthday in 2020, North Carolina Department of Health and Human Services, engaged with community care of North Carolina, in North Carolina AHEC on keeping kids while

campaign, which was designed to address well child visits, and immunization rates in response to a decline in rates due to COVID-19, as well as an effort to improve performance and access to pediatric care. So according to the data. Earlier this year, provided the gaps in care from that campaign have not increased with these continued interventions through the recent transition to managed care, which echoes the great success in the initiative and significant efforts at the systemic level and at the point of care that you will see at the practice level. And so closing gaps between these groups, remains a focus of quality, performance, each year through the Standard Plan performance improvement projects that we're presenting today, and performance improvement expectations overall for the plans and where we want to work together to improve those quality and health outcomes. So as you can see on the right side of the screen while we have continued improvement, and even through 2020, despite the current public health emergency intervention such as keeping kids well, there are still improvements needed to reach the national benchmark. We're not far off but we want to continue the momentum to reach and exceed national medians, certainly not just from a measure perspective but for what's best for children to avoid preventable illness through these vaccines is life saving vaccines to improve overall child wellness and prevention. And so you also see other supportive measures and secondary indicators on this slide, such as well child visits, those are typically done and not always but typically done in the same visit as immunizations and the periodicity schedule. So how can we look at care gaps to reduce those who have not received the full recommended combination for vaccinations, along with those well child checks, and how can we maximize care management rates for at risk children, and in doing so through care management at the practice level, the health plan level, or in the North Carolina care management for at risk children program, as well as supports for families and identifying those care needs. Why do we need those vaccinations, why are they important what's the access to services, and what's the continuum of their health journey. Next slide please.

And so the screenshots on this slide are from the annual body report as well and I've linked it at the bottom of the slide, so you'll have a few slides in a few slides of the presentation that you received after today, and I know this is a lot of data to present but the key items to bring forward are the measures to highlight the expansion of indicators for maternal health, beyond the selected Performance Improvement Project measure. So for maternal health timely prenatal care is crucial to improving maternal health and infant health outcomes, and with postpartum care within the weeks after delivery, as vital to maternal physical, social and emotional well being. And I know there's a lot to be done in the space. So if we look to the right side of the screen postpartum care by geography we can look at some of those impacts to postpartum care as well, so it's not a performance improvement project for postpartum care, but knowing that they're well integrated together and impact each other it's important to look at the quality, quality picture not just the performance improvement project metrics. And so coming back to the left side of the screen. If you look two rows below you see a -- like measure for timeliness of care, the Medicaid analytics team and the clinical leaders here drove drove down to the swing into potential causes for this historically lower rate and identified for their planes with a pregnancy diagnosis code pregnancy related procedure codes to reflect a more accurate, accurate picture of timeliness. And so the importance of this variance highlights the potential impacts of the kitas measure, and what the true root cause of the rationale for that rate, what were the causes and impacts to that rate being what it is according to the -- technical specifications, and where can we further drill down into potential contributors and areas for improvement, other supportive measures that you'll see

in this slide are to improving timeliness of prenatal care also through pregnancy risk screening, you see at the bottom of the screen to identify pregnant beneficiaries. And that's typically completed at the first prenatal care visit but the OB provider, and with that screening, risk and beneficiary tier needs are identified to then support outreach and engagement in care management for high risk pregnancies, through the care management by its pregnancies programs within the practices as well. And again, underscoring the impact of care management on engagement and care and accessing care for the timeliness of prenatal care and maternal health overall. I mean, the next slide please.

And so for postpartum care to kind of grow a little bit further into the same map that was on the prior page. When we break this same measure down for postpartum care down by race and ethnicity, you see the rates for the Hispanic or Latin X population are steadily higher than those of the black and white population. The discipline here doesn't quite indicate a statistically significant disparity today, but it's important to know that you can drill down into contributors or key drivers of experience as a potentially emerging disparity the disparity excuse me so what's driving the increase rates and the variance between populations. Where does that need to be reduced, one of the causes. So certainly a systemic overview but then also drill to the practice level to see the dynamics of your patient panel. And when we stratified by geography as we're mentioning, you can see the divergent outliers by counting such as Duplin and McDowell is significantly below the state average, and Guilford and Halifax counties as above the state average, it's important again to drill into access to care. What's the availability of providers in those areas the cultural components and impacts and barriers to care perceived in those areas as well. And where can we maximize the use of this data to provide support to you in the practice to improve not only performance, but the quality of care and a more targeted approach at all levels at statewide what are the interventions the strategic plans that we can maximize at the regional level and access to care and otherwise. And then, even to the practice level of what you're seeing, day to day in the practice and the patients within the panel. Next slide please.

The third and final performance improvement project for year one for standard plans focuses on diabetes prevention and control. So the chart on the left shows the CDC behavioral risk, I'm going to say this slowly because it's a long one. Behavioral Risk Factor Surveillance System survey BRFSS another abbreviation that would come in the news, which is performed by the North Carolina State Center for Health Statistics, and that surveys on Carolina residents on many domains not specific to Medicaid, but for health and health risk behaviors. So here it shows with statistical significance for prevalence, the most recent years captured those with Medicaid health insurance, self reported having diabetes at a statistically significant higher rate than other residents with no or other health insurance. So this self reported measure indicates the potential disproportional prevalence of diabetes for those insured by Medicaid. And an important indicator to further assess impacts and contributors to this increased prevalence, there are many available metrics and interventions that we have and that are available across the state, aimed at diabetes prevention and care. And for another supportive measure for diabetes control is the rate of those who are diagnosed with diabetes when percentage received hemoglobin CCNC testing. So this is likely a familiar test, I'm sure for most of you participating today, but it's a lab test to indicate diabetes control over a longer period of time, like like six months and provides a direct insight into support for the diagnosis of diabetes and control over time for assessing and

monitoring the quality of diabetes care. And as we all know, but to state again if, if not properly managed, diabetes can lead to serious complications to name a few blindness, kidney failure, heart disease, particularly in those with other comorbidities such as hypertension, which affects around 1/3 of North Carolina adults according to CDC, and of course results in higher utilization and costs due to poor management and disease complications and advancement, which impresses the importance of selecting this as a year one performance improvement project for the first year so the diabetes comorbidities, the impacts to the population, the ability at the practice level, the system level to support diabetes prevention interventions to improve health outcomes is really what we want to drive to focus on. Next slide please.

And so to drill into this a little bit more for accompanying and secondary metrics for diabetes prevention and control the 2018 BRFSS survey as mentioned on the last slide also indicated over 40% of North Carolina Medicaid beneficiaries have at least one chronic condition. One of the most prevalent being diabetes. Specifically, the percentage of beneficiaries with diabetes has increased in the last decade, from 10 to more than 15%, consistent with national trends. Importantly, North Carolina also has high rates of diabetes risk factors such as 65% of adults in North Carolina Medicaid are either overweight or obese. So appropriate and timely management of these chronic conditions can reduce unnecessary, and high costs utilization of tertiary care such as hospital admissions, and potentially avoidable ad utilization, to show other indicators of diabetes control and management or national utilization measures that you see in the slide by AHRQ, which show for both the pediatric population where you see that one's call it box for PDI. And the adult measure population which is raised, PQI, the rate of potentially preventable admission specific today. So a lower rate indicates better performance, and you'll see North Carolina's performing higher for the adult populations and the pediatric population, and our indicators of population level diabetes control, but it's steadily increasing which is what we do not want to happen.

Disease prevent prevalence in NC isn't -- to Medicaid and this is why it's essential to work collaboratively with the communities with you all with the health plans and all levels to improve population health and to align with state and national partners to improve health statewide, such as the NC, the healthy North Carolina 2030 project, statewide plan and task force with the division public health, along with other partners that Jaimica mentioned earlier in determining a set of priority health indicators for statewide improvement across North Carolina. So the burden and adverse health outcomes are larger than Medicaid and at the Medicaid level, but we all can play a huge part in making it better. So to round out the closer look at these metrics in the performance improvement projects, looking at potential secondary and supportive indicators in these domains. The next step is to talk about how we improve these focus areas for health, for quality of care outcomes and how we do it collaboratively and then also what what are our indicators at every level. What's accountability at a Medicaid level and PHP level and how can providers support improvement in these areas seeing what your patients are experiencing their health and health behaviors, how can we improve that. So what we want to focus on today is how will we accomplish this, what will, what provider supports where you need to support improvement. How can the health plans and AHEC as partners with Medicaid and you all look closely at these impacts and contributors to quality and working within your practice.

Next slide please. And so just to round out looking at quality and performance improvement with events, medical homes, and how they're incentivized through these measures to support quality health outcomes for both children and adults. These incentives support improved quality and care and are required for plans to offer to tier three events. And of course being optional for tiers one to two Performance Improvement Project measures for year one, which we'll go into a little bit deeper, you see on the screen here in the Amh measures that are childhood immunizations and diabetes control as two of these a major measures, and these are where we want to further focus collaborative improvements needed such as getting children the appropriate vaccinations for preventable disease. And for better control of diabetes with earliest intervention possible to reduce disease severity and complication, leading to sustain improve over time. The benefit, excuse me, Beth McDermott will further show the priorities and designing the year one performance improvement projects what they are, and then we'll dive deeper into each, so thank you.

Beth McDermott

Thank you, Taylor. Next slide please. When creating these performance improvement priorities we did work collaboratively with the standard plans to align on the pips for contract to your one standardization does effectuate the optimum, optimum excuse me space for providers, be able to focus in the same areas across all health plans, reducing provider abrasion and burden, since this is a major transition from fee for service to managed care, we aligned in three domains that affect the quality strategies aims goals and objectives, namely, aim to which is healthier people healthier communities, the focus areas for year one, are Diabetes Prevention and control specifically HB A1C for control greater than nine childhood immunization status or CIS combo 10 for prenatal and postpartum care, with a focus on timeliness of prenatal care, managed care and state funded services will be reviewed by DHB as well as DMH and our goal is to really standardize across the state, among all of the plans. Next slide please. So the three areas again that we're focusing on as the adult chronic care specifically the percentage of beneficiaries with diabetes, that it's increased over the past decade from 10% to more than 15%, consistent with national trends. Importantly, North Carolina also has high rates of diabetes risk factors, for example 65% of adults in NC Medicaid are either overweight or obese as Taylor mentioned the diabetes prevention and control measure again is part of aim two.

Beth McDermott

goal for improving chronic care management in objective 4.2 which is improving diabetes management, more than 85% of our NC Medicaid population are women and children. Medicaid is continued focus on these populations, aligns with goal three. Some of the bright spots are children's wellness and prevention which we track closely to national performance benchmarks in 2020 primarily rates for many of these measures should continue stability as supported and impacted by keeping kids well, which was led by the quality team. So our second performance improvement priority for contract year one, is childhood immunization status that aligns with aim two and goal three which is promoting wellness and prevention and objective 3.1 promoting child health, development and wellness. We also included maternal health, HEDIS measure rates for timeliness of prenatal care, show that North Carolina performs significantly below the national median. This provides an opportunity for North Carolina to improve its timeliness of prenatal care, and it's also an opportunity to to access the extent in which our providers are able to accurately document, and bill for prenatal visits known impact to the accuracy of

this measure in North Carolina. This also aligns with aim two and goal three objective 3.2 which is promoting woman's health. The slide also demonstrates the overall historical performance statewide for the three measures selected for the performance improvement projects for year one, the 2019 rates are the baseline for designing and implementing the PYP interventions for targeted improvements. I'll now pass it over to Lena Klumper she is presenting on childhood immunization status. Thank you.

Lena Klumper

Thank you, Beth. Next slide please. I'm happy to be here with all of you this afternoon to talk about the childhood immunizations combo 10 Pip. The reason for this pip was to, as was discussed earlier was to try to increase the compliance rate, particularly of the combo 10 immunizations for children. One major reason for some of the low rates are and I'll go over the rates in a moment, are the National Institutes of Health had conducted a study to look at why this probably is happening and one of the reasons they saw was that about one in four parents had indicated a concern about safety of the vaccines and we know that in the last year or so, this was in 2019 but in the last year or so, that probably has increased. We don't know that for sure just due to vaccine hesitancy for come for COVID-19. Other reasons for there were children that were ill and they didn't meet the deadline by the 24th month for some of these immunizations. But we want to say that the hesitancy far exceeds parents refusing altogether immunization so that's why we're going to talk about some strategies to help meet that and in a few moments. The combo 10 vaccine measurement consists of the following, you see there to the left is the number of the vaccine for instance there are 4 DtaP vaccinations and so on as you can see, and then I'm going to give you some information on where you can find more information about when these are due, and the actual types of vaccines, so the first link there the 2021 recommended child adolescent immunization schedule by the CDC, that link will be very helpful to you because it gives you a full schedule of recommended vaccines, with links and information. And then the second one is, is a handout actually a PDF that excuse me that one actually is the ACF guidelines that provides you with updates that are provided every year, and it would be good if annually, you could check that just to see what's been changed regarding these vaccines. Next slide please.

So as you can see here we have US Medicaid fee for service, median, as of calendar year 2019 was 37.47, and the North Carolina Medicaid fee for service rate for that same year was 35.02. Our goal is to increase these by about, increase in North Carolina rate by five percentage points so the first year, we certainly want to do better than that but we want to start there due to the low rate you can see that we're kind of in line with the US median but we still need to do better. So one of the impact questions for this tip is does the implementation of targeted education awareness, increase the rate of compliance with childhood immunizations combo 10 from our baseline, and especially 35.02 and 2019 for eligible members, and then are we addressing social determinants of health to improve the compliance rate, and that we'll be looking at know homeless populations, families living in poverty, ethnic and racial populations where there's low compliance, and other populations with unique identify me. Next slide please.

And some other things I want to look at is awareness around, making sure that providers are using correct billing codes, and we know that that can be easily that can easily happen are the codes can be incorrect and or that providers aren't reporting as, as often as they need to into the North Carolina immunization registry, also to remember that, including correct codes and billing for administration of vaccines from the Federal Vaccines for Children immunization stuff sometimes staff may not know that that's where the immunizations are from. So we want to make sure that clinics and other agencies giving immunizations do provide correct billing information, some potential interventions that have shown to be helpful and to impact the compliance rate are to offer driving vaccination clinics, I know that not all providers can do that, but where it can be done it's been helpful to provide handouts for parents and clinics and practices that are I want to point out, they should be I friendly just handing out information about immunizations some parents will just toss them aside, I mean, I might as well but if they're I friendly and can catch their attention will be helpful as well as a mailing a postcard reminder to families. I've seen some postcards that have like me have appointment reminders on them that can be helpful and you want to have it small enough that they can put into their wallet or put it on the refrigerator but not too large, where they're just going to toss it somewhere. I know that's easier said than done, also implement a wellchild or immunization promotion monthly with gift card drawings that's been shown to be helpful, and it doesn't even have to be very much 10, 15, $25 to places that parents will go to such as Walmart or Target or places like that. And then partnering with our PHPs and North Carolina DHHS to promote preventive care, and conduct in conjunction with childcare centers and faith based groups providing public service announcements, as well as state agency funded events, and then PHP initiated care alerts such as text messaging, emails live inbound calls or integrated voice response messaging. We can send out information just about reminders of vaccine and vaccines and even some information on possible reasons why parents might be hesitant. And then in a moment I'm gonna show you a link that you can go to that gives you more information about that, that you can provide to families. So some suggested practical strategies for improvement. Some of these are best practices, but not all of them are best practices per our peer reviewed literature so we're listing this as strategies for improvement, but one is to target disparate populations by generating a list from your electronic health record systems. This would be very helpful, particularly for groups that are or families that live in rural areas or those who have transportation issues. There are a lot of families in rural areas that don't have access to public transportation lines such as buses so you may want to look at those kinds of identifiers document documenting the EHR too about the North Carolina immunization registry and immunizations are received elsewhere. This can be a common problem such as parents going to public health departments and getting it registered there, but not into the PCP the primary care physicians records. So practices can develop a workflow document to determine if immunizations were received elsewhere. And that might help but you can even put a question such as. Did you receive actually did a child receive action vaccination somewhere else such as the health department, and then be able to track that and pull those records from there.

Also you can use standing orders to empower nurses or other qualified health professionals to administer vaccines, we know that all healthcare professionals are so busy, and particularly our doctors so more than likely nurses and other staff are more available to provide those vaccines while the child is in the clinic, seeing the doctor. Also you can use already developed handouts, as I mentioned earlier for parents related to the importance of vaccines and there's some out there on vaccine hesitancy and

safety, and there's a link here to immunize.org I think that will be very helpful to you print them, they're free. Partner with local health departments so again to coordinate documents, obtaining documents if you need to, and information even to provide information about if you're providing. Say a free clinic or something like that or clinic day a month, you might be able to advertise they're working with the th peas as well with communication and coordination flow, utilizing NCCARE360 partnering with school systems to advertise your immunization efforts and your dates but also a childcare center since that this combination 10 is for up to 24 months so you want to target childcare centers more than likely, and you can also run kid friendly videos in well chalk clinics, on the importance of vaccinations that seems to be very helpful. I'll be happy to answer any questions that are in the q&a, and I'm going to turn this over to Jeanne Leslie. For more about the diabetes control pip.

Jeanne Leslie

Thank you. Lena, and thanks for the opportunity to present a few slides on our diabetes performance improvement project focused on monitoring agency lab results. Next slide. This project in specific is focused on monitoring the percentage of members, diagnosed with diabetes type one and type two, whose last a one see result in a calendar year is greater than nine, and this is a reverse measure meaning a large percentage of a large percentage is undesirable indicating the population of diabetics being monitored, demonstrates uncontrolled diabetes so lowering the percentage indicates an overall trend toward management of diabetes in the population. This metric was developed by the measure steward NCQA on it's part of a larger NCQA data set. NCQA develops his measures through committees of center better experts and consideration of industry standard guidelines, and for this measure um, the guideline referenced to a large extent is the American Diabetes Association standards of medical care for diabetes NCQA does diabetes care also addresses other types of metrics but for this pip are mainly focused on measuring the population of diabetics who demonstrate uncontrolled diabetes. So, one topic that is always a consideration related to any healthcare metric is data capture. For this measure claim submitted for payment of lab testing lab tests do not include lab results, and so we have to focus on how to capture that data and several ways to assure a diabetic patient or health plan member, and we'll see results are processed and included, and reporting the most desirable methods are through electronic data submissions to standard plans, who are responsible for collecting and company data for reporting. One way is the billing of CPT two codes from the office setting on an office claim. For instance, CPT 23044 F indicates a result, less than or equal to nine, or CPT 23046 indicates a result greater than nine. Another way is for provider providers to connect to the state, HIV, health connects, I realized that goal may be not happen for both Medicaid providers and standard plans until later at 2022 or early 2023 But there is another electronic option and that is for providers to submit an electronic file and CVS or text format to each standard plan. So, and that that method and once the results are included, and that file. Um, and it's particularly valuable when a provider utilizes a provider appointed care lab or an internal provider system laboratory. So any lab results that are not collected by national lab like lab core really need some attention to submission of the results for this measure, working toward sharing a wensing lab results electronically will greatly enhance reporting for this NMH measure that's commonly used in provider Value Based Payment agreements. Additional information on how to submit electronic data, or any Hmh tier provider can be supported by each standard plans provider support team. And at the end of this presentation we have listed all of the providers support contacts for each standard plan. Next slide.

So this slide gives some historical perspective on diabetic results compared to targets for a one C test, which means the lab test was simply completed. In addition to a one C results greater than nine, it's always helpful to identify identify targets in order to aim for improvement. So, because we don't have a lot of historical fee for service, results for anyone say over nine, I've included some of the NCQA percentile targets. So far, but first, focusing on the second row of the table. The North Carolina fee for service 2019 rate for A1 C test was 74.76 I think Taylor presented some historical data from 2016 through 2019 but here we have just 2019 rate, focusing on five percentage points above that, we would aspire to reach 78.50, and then you'll see NCQA collects information for Medicaid HMOs across the United States they express targets in terms of percentile rankings. So you'll see percentile rank targets for the 25th 50th 75th, and 90th percentile. Historically, North Carolina is a bit below the 25th percentile. So you'll see for A1C over nine, we don't have any historical data available, but we can look at NCQA rankings. And, and that's helpful, and achievement, your targets. Next slide.

So, the next few slides, include considerations and recommendations from the American Diabetes Association, the ADA indicates health inequities, but certain diabetic populations at risk for outcomes. In addition, the ADA reminds us to tailor -- plans to incorporate any existing social determinants, food insecurity, housing, homelessness financial barriers, and social support systems. We have some NCCARE360 is a great tool, a great web based opportunity resources that's very helpful and useful in assisting patients address existing needs. The ADA also reminds us that the most powerful tool for diabetics and their caregivers is to learn self management skills. Next slide please. So in January 2019, the ADA and their diabetes care journal indicate included an article titled, improving care and promoting health and population standards of medical care in diabetes. And this slide outline six of the core strategies to optimize the care of patients with chronic disease. These core strategies very much aligned with concepts of a medical home. I won't read all of these to you but I will elaborate on a few delivery system design which focuses on movement from reactive to proactive care coordination using a team based approach. That might include schedule clinic or group practice huddles, to discuss scheduled incoming scheduled patients for patients with new diagnostic results to proactively coordinate care, clinical information systems. This core strategy references use of registries are our focus and our Carolina Health connects is our common registry of choice, stated plans are focused on gaining access to important health connects data, and we need in North Carolina providers to also target that as a goal. Also, this will greatly enhance our data capture accurately reflect accurately help us reflect population health, health, health outcomes. Community Resources tapping into state resources for management of diabetes their North Carolina has a couple of really good resources for diabetes care diabetes management and see a resource that connects North Carolinians diagnosed with diabetes to various diabetes self management education and support services, easily accessible at diabetes management thought diabetes management nc.com Or I'll manage again, I'll just mention again in NCCARE360 Also, another great resource. Next slide.

The lastly, a little bit more detail on the ADA strategy for improvement and focus on systems approach. They specifically call out a focus on maximizing multidisciplinary care teams use of telemedicine, when it's appropriate for the situation. And, again, focusing on patient behavior change, and making sure that

that is integrated into each individual patient's care plan. So with that, I will pass that pass off to Carla Theobald, who will cover timeliness of prenatal care.

Carla

Thanks Jeanne. Alright so the next few slides we're going to talk about the timeliness of prenatal care, Pip. Next slide. So this slide is going to really provide the measure overview for the timeliness of prenatal care, Pip. This is a process measure which means that it's captured when an activity has been accomplished. This includes the percentage of deliveries of live births between October 8 of the year prior to the measurement year, and October 7 of the measure year, for these women, the measure assesses the following facets of prenatal and postpartum care. So timeliness of prenatal care. This is the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, are within the first 42 days of enrollment into the program. You can go next slide. Okay, so on the slide are the clinical guidelines for this measure again this is the NCQA measure steward. And these NCQA HEDIS measures are based on industry guidelines, and we're pulling from some of the following. So guidelines published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. And they recommend a prenatal visit in the first trimester for all women. ACOG also recommends that all women have contact with their obstetrician or gynecologist, or any other obstetric provider within three weeks postpartum followed by ongoing care as needed and concluding with a comprehensive postpartum visit no later than 12 weeks after birth. Okay. And for this side, this is just outlining some healthy opportunity considerations. So as part of health the opportunity considerations related to timeliness of prenatal care. The ACOG committee on health care for underserved women issued a white paper, and released a collective opinion on which they reaffirmed in 2018. So projections suggest that people of color will represent most of the US population by 2050, and yet significant racial and ethnic disparities persist in women's health and healthcare. Although socio and economic status accounts for some of these disparities factors that the patient practitioner, and healthcare system levels contribute to existing and evolving disparities and women's health outcomes. And although the existing literature is replete with examples of differences in outcomes in black and white women, more work is needed to explore disparities among American Indian, Alaskan native and Asian women. In addition, more granular data collection on ethnicity would help to elucidate the heterogeneity of health outcomes within the broad categories of Asian, Hispanic and other groups. So we have a link here that. More details can be accessed, which really includes national disparity rates for prenatal care in the first trimester. Okay, next slide.

So DHHS has provided the prepaid health plans, a target for improvement of timeliness to prenatal care for the first two years of managed care implementation, the department's benchmark for each measure will be a 5% relative improvement of the prior years, North Carolina, Medicaid statewide performance for that measure. So this slide shows the US and North Carolina Medicaid fee for service, medium for calendar year to 2019. So, really want to draw your eye to the substantial difference in the rates for North Carolina compared to the US median rates, and included on the slides again just as reference in other slides are the rates that would need to be achieved in order to see that 5% relative improvement with this measure. So for North Carolina we would want to take the current 35.5 free rate to a 37.31 rate. Next slide. Alright I'm because postpartum care is included in the prenatal and postpartum care

measure set you'll notice that the next two slides are going to contain both interventions to address timeliness to prenatal care, as well as closing the gaps for postpartum care. So understanding that data capture. As mentioned previously, is a key component of accurate measurement. It's important to note that appropriate billing for prenatal care is an area of opportunity and we do have that called out as an awareness on this slide. So if submitting a global payment or global bill for payment, the prenatal visit is not included, and should be submitted as a separate claim that will really help with some of that data capture some of the other call outs, particularly on this slide related to timeliness to prenatal care would be a social determinant of health screening. Screening and reproductive life planning, right, next one. Okay. And on this particular slide we have listed several strategies to assist in improving timeliness to prenatal care. Some of the ones I'd really like to highlight here are creative scheduling really looking at, you know, expanding evening and weekend hours if possible. Implicit bias trainings for all staff using race, ethnic and geographical data to focus on targeted interventions with sub populations, and really utilizing and considering member and provider incentives. We've heard some of the other speakers speak to some of the same topic. And probably the one I find most important here is really including our primary care providers and family medicine providers and the overall strategy, incorporating preconception health discussions at every visit and including the importance of early prenatal care. So at this time I will turn it over to George Cheely for COVID 19 vaccination strategies.

Dr. George Cheely

Thank you, Carla and thank you all for the chance to share a few words related to COVID-19. We can go to the next slide. And my first really focuses on a recognition that as a Quality Forum are want is to focus on opportunities for improvement. But I also think it's important, particularly in the context of COVID to reflect on some recent notes from Dr Dowler that were many states comparing 2019 HEDIS performance to 2018 HEDIS performance saw a dip. Not true Measure for Measure but in general, North Carolina saw maintenance of performance which I think speaks to all of us to the hard work providers across the state have continued to to take on. Despite the dress of COVID to help patients get get needed care and to deliver high quality care. So, first message is a big thank you to all those in attendance for all of your efforts. Despite the twists, turns, and challenges COVID continues to bring to bear. We also wanted to point to some additional tools in the toolbox, available on health plan provider portal so you can download gaps in care reports for your panels work with your staff members to identify patients that may need outreach or may need to come in for a visit, and then work with your staff to schedule the health plans also have staff who are willing and eager to help and assist to decrease some of the burden for outreach as well so please view us as collaborators and important avenues to offer assistance, particularly during this tough time. In, we can go on to the next slide. I think to turn more fully to one of the questions at front and center for all of us, relates to the COVID-19 vaccination efforts, but I think we all recognize that that trusted relationship with a provider is vital for being able to reach those who remain hesitant about getting the COVID vaccine, and particularly if you're taking the time to have that discussion with the patient being able to offer the shot in your clinic right then and there is, is an especially useful way to seize the moment and the department has really done a nice job of collecting resources for practices. If your practice has been thinking about it but not yet, join the effort, please follow the link in the slides, and, and view the resources and tools available in the toolkits. To learn more about how to get started. We could go into the next slide.

And I think we all know that, convincing people to undergo preventive efforts in treatments, particularly at a time when some of these foundational public health interventions are especially charged takes a lot of time, being able to understand the motives and address the potential sources of misinformation that may be at play with the patient in front of you is, is that involved conversation, and health plans are eager to offer reimbursement using the counseling code. The department has defined for those services, and then we all also are mirroring the department, in terms of covering administration CPT codes for vaccinations as well. I think in the near future, providers can expect access to COVID vaccination information at their patient panel level and certainly PHPs are excited to work with the department to continue to develop approaches to reach those sensitive populations. And with that, I am going to turn it over to Donetta Godwin to share some information about practice supports.

Donetta Godwin

Thanks so much, Dr. Cheely. I'm going to talk to you a little bit about some of the practice support offerings that you have available to you as a Medicaid provider in North Carolina, you really have an array of different supports, ranging from supports through the Ph Ds through AHEC through DHB, and if you're affiliated with clinically integrated networks or ACOs you have additional supports available through those avenues. Next slide please. So how can AHEC practice support. Each of the PHPs have dedicated provider support and Connections team, they might be called PR they might be called PE they might have another fancy name, but each of the PHPs do have provider support available and ready to support you with all of your needs related to the health plans, the health plans and AHEC and the clinically integrated networks and ACOs really do try to collaborate with one another to support practice needs this, this whole program really has been set up just to try to make all of our providers successful in Medicaid transformation. And to give you the opportunities to really provide the best care you can for your Medicaid and other members, the strategies that they use are customized based on the needs of the practice each PHP has different offerings, but they all share a common mission really to improve performance, improve quality and improve satisfaction among our providers and members, we focus a lot on performance tools and analytics value based contracting pay for performance incentives and provider engagement in relation programs. Most of the PHPs have embedded local boots on the ground support that offer eventually to her in a non pandemic time hopefully on site visits I know most of us are doing virtual visits and zooms right now, but we do hope to initially get back out there on arm and arm with our providers. We also focus on administrative simplification and provider satisfaction, all the PHPs have really been collaborating and using feedback that we've received from the field to try and make this process as less abrasive honestly we know that it's difficult going from one payer system to five, and we're trying to be sensitive to that and we made a lot of progress with trying to eliminate some of that duplication and administrative burden. We know we still have a long way to go and we would love to get more feedback on things that we could do to streamline some of those efforts, health plans are also able to assist practices with health plans specific needs, again you have the AHEC program, and other resources that are more of a broad approach but if you need specific information or help to support you from the PHP standpoint, then those are available within each of the PHPs, AHEC is available to assist practices across a broad spectrum of practice support needs and Monique will talk to you a little bit about that in just a little bit. Next slide please.

Help plan provider support, again, a lot of different offerings from each PHP that is set up to support you to be successful. We offer wraparound support that really is meant to connect the provider and the member process to provide that continuity of care and, and just really kind of link that provider satisfaction and member satisfaction piece. Our goal was to enhance the member experience. And we do that by making our provider training and support programs individualized, it's not a one size fits all approach. We aim to focus on driving innovation and education we provide resources and tools, regarding best practices and clinical outcomes. Our hope is to leverage best practices from the providers, down the road as we get more access to data, and we can see who the high performers are we'll hopefully leverage those types of experiences and link those together so that we can all succeed together innovative portal features all the PHPs have secure provider portals have an array of different features they are a little bit different for each PHP provided care gap closure support and provider incentives. So again, all of that is available within the different portals. Next slide please.

Health Plan data and analytics support each health plan focuses on driving performance through actionable data so that really is the goal was to take all of this points data and all of this other data and put it in a format for providers so that it's understandable and it's easy to act upon data doesn't do you any good if you can't trust the data and if you can't do anything with the data. So we try to focus on customizing reports and dashboards in a timely fashion so that they're actionable, actionable, and they're also available through the Secure Provider Portal. Pay for performance and quality instead of data is also available assistance with reviewing and interpreting that performance data each of the PHPs have staff available to help review that data with you and explain that data so that you can take steps to act on that data and improve your member care. They also have support staff to provide education and support around panel management and care gap closed. Next slide please.

Each health plan also has very specific reporting and analytical tools that are available to you. They may look a little bit different but most of them will contain the same type of data, they'll include information on key performance indicators cost and utilization data, emergency room utilization data so you can identify which numbers are the frequent fliers are those who need to have certain interventions, pharmacy data quality performance data again integrated care gap data with drill down capability. If you're in a value based contract that data and those types of dashboards will be available for you. And then of course single member and practitioner drill down functionality. So again you'll have summary data and then you'll have the capability to drill down so that you can truly see which members are in the numerator and denominator within those metrics so that you can act upon that next step.

Donetta Godwin

Providers with care management to the members so that we can all work together to make sure that our members are coming into your office to be seen, and are getting all the care that they need EPSDT education and outreach. And we also have the ability to go out and help analyze that performance data and target improvement efforts with you so maybe it's around the PDFs that were mentioned earlier, Maybe it's a different piece of data that you've identified that you need support from the PHP that

support as is definitely available with all five PHPs and again our goal is to reduce health disparities and improve social determinants of health. Next slide please. And the slide that I think everyone has been asking for. So this particular slide is in the slide deck, it is available for you. It has a listing of all five of the PHP contact website, phone number, all of those resources so that if you do have specific, I know there was a few questions in the chat about claims and denials and who to reach out to four specific health plan support. So again if you have questions or need support from any of the health plans, these are the folks you're going to want to reach out to and also we've included on DH HSS information as well, and mail I'm going to turn it over to our partners at eight HC and Monique Mackey is going to talk to you more about a lot of the practice support offerings that are our AHEC Program has to offer you guys.

Monique Mackey

Hi everyone and I am here today to talk to you all a little bit about what the AHEC practice support team can offer to you as you work through the performance improvement projects that have been described today, as Chris and Donetta both mentioned we are the contracted partner within C Medicaid to provide both Practice Support Services and educational programming for providers across all 100 counties and AHEC has a strong 50 year history of working with the state's health workforce to improve both the health and well being of the folks who live here in North Carolina, while helping the providers to become experts and and sort of working in a value based care world so we, our goal is to work with you to look at your total patient panel, and not just nest not just your folks who are Medicaid beneficiaries, they want you to be able to provide optimal care to your patients, and we offer our services at no cost to all healthcare providers in the state we have a cadre of about 40 coaches that work, knee to knee with providers across the state on performance improvement projects and so we're very proud of, of our coaches, they are all steeped in the quality improvement framework and can help with that. So next slide please.

What you see here are a list of places in which, with which our coaches can assist you as you move forward with these projects. I won't read through them for you but as you can see we offer a wide variety of services. And so we can help you with a lot of the things that were mentioned today to help you meet the criteria that have been laid out by the health plans to help you be successful with this work. Next slide please. So what you see here is a map of North Carolina AHEC regions we have non regions across the state. Each region has, as I mentioned a group of coaches that are affiliated with that region. And those coaches will provide services to providers within their specific AHEC region. So, you see the team leads the practice 14 leads listed here for each of the regions, and you can just locate your county and you can see that you would need to contact, or to receive practice support services from our coaches, hopefully many of you are already working with us and are already familiar with the work that we do. And so if you need us, this is a way to reach us kind of on the micro level. Next slide please. Or you can reach out to us on the macro level by contacting us at practice support at NCAHEC.net to let us know that you'd like for us to come out and help you be successful, and working with the health plans, and with with the Department of Health Benefits on this project that we're getting all getting ready to embark upon. To find more information about our services you can go to practice or at NC AHEC and we provide a link to that here. Next slide please.

Some other resources that might be helpful to you as you begin your journey. All of the AHEC and North Carolina Medicaid webinars and virtual office hours have been recorded and you can get to those by clicking the link here on the Medicaid managed care webinar series for providers on the NC AHEC website that will take you to, to the slide decks to the recordings and so that can, so I found it to be very helpful to go back and be able to listen to those recordings so I can kind of keep abreast of all the different terminology and all the things that are happening in this arena right now. We also have vacancy Medicaid quality management improvement site listed here. So this is the DHHS site that will give you a little bit more information about the quality strategy and where we'll be going over time. Next slide please. So now I'm going to send it back to Chris Wellington who is going to manage our question and answer session, Chris, back to you.

Chris Weathington

I want to just turn over the question over here about the COVID pandemic and how that might make it a little bit difficult to address these three quality areas so Kelly would you like to kind of elaborate a little bit on that area.

Kelly Crosbie

Yeah, absolutely. Um, hi everyone and of course, anyone else feel free to jump in as well. I'm really appreciate all the questions and thanks again to all the plans and AHEC team members and my team for presenting today. Really appreciate it. Um, we got a few questions, understandably, about practices ability to really focus on quality. During the public health emergency. We completely appreciate that folks are, are taxed in many ways, and really struggle even to, you know office, keep up the stuff in place for critical members. So we know it's incredibly complicated right now, so there's a couple things I want to say, first I hope to be reassuring and second I hope to really capitalize on the strengths that we're seeing as well but just to be reassuring. I think a couple of things I really want to emphasize first is when when Medicaid, not not the plans but when Medicaid talks about targets for quality measures. We do talk about plans specific targets. So the targets we have are actually four plans, they're modest targets they're targets around 5% relative improvement so for many measures that means a percentage increase about one and a half percent in many cases, so we're not looking for massive amounts of improvement and that's at a plan level target, it's not a provider level target, you need to negotiate those with your health plan. The second thing for Medicaid, there's no penalty. There's just no penalty if, if we're unable to make targets in this this first year so no no no penalty for health plans. And so I said it was reassuring, it's not a terribly inspirational right but it's just to kind of reassure folks that, that we are, we did our best faith effort to set targets using our governance process for these measures they are for health plans, they're quite modest, and there's no penalty if we don't hit them. Nonetheless, we do want to set targets and try to keep ourselves moving forward as a system. We did baseline off of 2019 rates but that was always with the caveat that we would look at 2020 rates, and to see if we've lost a lot of ground in 2020 There's Dr. Cheely mentioned, we're getting ready to socialize those measures with more groups we've given the the CMOs of the health plans a little taste of the measures for 2020 the

results we're seeing statewide. We will be socializing, those that are NCAC Quality Committee, and other places, so folks can see what the rates are for 2020. We had, we had some dips. We also had some improvements, but in this measure space in these three preps in particular we've we've held pretty steady, and I agree with what Dr chewy said that's, that's, credit credit to you, not us. And it's quite inspirational that y'all are are still able to get excellent maintain rates during to really, really, incredibly challenging years, so kudos to you all, but knowing that is the promise is that we're looking at 2020 rates, we'll look at 2021 rates, and we're always making sure that we're not trying to set unreasonable targets. Understanding these truly extraordinary circumstances we've lived under in the past few years. So we haven't seen a big dip in rates from 2019 to 2020 credit to y'all. And I think the last thing though is if I approach this really from a, from a QI perspective. And I think about our keeping kids well campaign in particular, when you think about QI, a lot of the speakers today alluded to it, so much of it is absolutely not what happens at the practice right practices, all your practices on here and providers you knock it out of the park, you provide high quality standard of care that's, that's not the issue. The issue is often, how do you help members come in, how do you help overcome barriers in the community for folks to be able to get in and guess what's a huge barrier right now COVID-19 It's a massive barrier right it's a massive barrier, and the whole keeping kids well campaign where we really focused on well business and immunizations in 2020 was exactly because of that barrier. We said we all want to get kids into their, their, their pediatricians office, what are the right things are always going to happen right, you're always going to provide that high caliber well visit you're going to offer counseling and immunizations, I picked two parents who are willing to have their children be immunized. And you're always going to do the right thing. So how did that campaign focus on all those barriers that were keeping children and families for getting to your offices, every office is being able to be open, and well staffed and your staff healthy and well so that's what keeping his balls about, so we know full well that when we think about these performance improvement projects, a lot of what we're going to be working on. Yeah, we're gonna work on correct coding and billing especially and things like that prenatal visit, but we're really going to work on the barriers that are keeping our members coming in for the really high caliber care that you're going to give them. So a lot of what we're gonna do is actually focus on the public health emergency as a barrier to care, so. So I say that in the spirit of QI, in no way to diminish real the real hardships that practices are experiencing right now. So, um, so that was my big answer to multiple COVID Questions COVID related questions that came in. Back to you. Great.

Chris Weathington

Thank you, Kelly. One note that may be important to mention is, it was indicated earlier in one of the slides that there is an incentive from the PHPs to be in a tier three. So we understand that that's more optional for tier one and tier two by the health plans, but is that something that a practice may want to consider in terms of going from a tier two to tier three.

Kelly Crosbie

Anyone else can jump in to. I don't mind I certainly don't mean to intro the questions but I believe Taylor walked through the tier three measures. And so, for the vast majority of our primary care medical homes are the tier three providers, and that incentive measures that Taylor should do is, is required so

health plans have to offer those measures in an incentive program to AMH tier threes. Most majority of health plans are offering those to any primary care practice right like we all win. We all win. We want all primary care to win so if you're not a tier three AHEC, trust me AHEC is here and the health plans are here to help you figure out if you want to be a tier three and how to get there, so flat out, but if you don't want to be at tier three it's not right for you it's not right for you now maybe it is later, and you don't know anything about plant incentive programs please reach out to the contacts here because again, I think we want to incentivize all primary care providers and offer these incentive programs for all.

Chris Weathington

Thank you. I don't see any other questions. Oh, we got a question here. Can you elaborate a little bit more on the different tiers, and basic explanation.

Kelly Crosbie

Sure. And while I'm answering if somebody I'm wondering if Jaimica or Taylor you wouldn't mind putting a link to our advanced medical home webpage in the chat. So that, so we'll put that link out there but the really brief version is, is that if you are a primary care practice so this isn't for everybody on the call but if you're a primary care practice, you can agree to a certain set of practice standards and also care management standards care management functions, and you go through a process where you say yes I raise my hand I want to do this and then the health plan meets with you and sees that you can do all those care management things and all those things that your practice. And, and if so you can become an advanced medical home tier three. So tiers one and two are essentially the same, the tier one and tier two are just is a primary care practice and you agree to provide a bunch of primary and preventative services. Certain have certain access hours at your clinics for Medicaid beneficiaries. So you just got a high caliber primary care practice say Yep. I'd love to do that. And for that you get 250, per month per member, for most of our members, you also get $5 per member per month for our complex members to be a tier three you also say I'm going to do all that really awesome stuff, but I'm also going to do care management, and we have a big old list of care management requirements and what that actually means. And a tier three can if they get certified and contracted they can do all that care management stuff too. And to get paid a care management fee for that, but if someone could cut in the programmatic of blank that would be great.

Chris Weathington

Thank you. We've answered a number of questions, thus far to the team who are serving as our panelists are there any questions that you've seen that you would like to just reiterate verbally.

Kelly Crosbie

I think one of the things that we and you'll see in this slide deck, there's an appendix, since I have the, you know the, I think that the presenters talked about measures where we have, you know what our

target is with 5% relative improvement so again that's not actually a lot. But some of the things the measures mentioned and I mentioned and we don't have a lot of slides in the body of the document the are in the appendix, it is -- where we see a disparity. And so if you look in the annual color report what we did in the last Annual Quality Report is pull up measures where we saw a significant disparity. There's lots of geographic disparity in our measures, there, there just is so many measures you'll actually see a map and you'll see where there's a geographic disparity in the measure. And that obviously has a lot of drivers. We also posted and Taylor shared some of those when she went through the measures today places rehab disparities and rates based on race and ethnicity. So a lot of those really marked ones are in the Annual Quality report you'll see some, some diagrams for those. So like prenatal care, one of our pits, that's where we see a lot of geographic disparity in that particular measure. Some of our wealth visit rates not all but some of them, especially in our birth to 15 range. We do see disparities and in those well visit rates for between Black and African American and white and Caucasian children. So, there are differences in rates and again if you look in the quality reports you'll see some of those highlighted. So in those places we do absolutely have a very aggressive equity targets those rates where we have a disparity like that health plans again this is a health plan target, have to have a 10% relative improvement on. So if the regular target is, is, is a 1.5 percentage points the target and members, before just experiencing a disparity is three point so we do have a much more aggressive target, there's a lot published in our Annual Quality report where you see those disparities. And the next Annual Quality Report is being developed by the way. And so you'll see much more of that we're also publishing I can't give you a date certain but we'll actually be publishing, health, health equity report period. So not only were we showcasing the Annual Quality Report. We'll do a specific health equity report so you'll be able to see very clearly measures where we're seeing disparities among groups based on geography, race, ethnicity, age, gender, lots of things. I just bring that because a lot of people asked about that and I'm glad, because it's so important so thank you. And thank you for asking about those things. We want pips, that are very culturally appropriate and culturally I lost the word that we want to show cultural humility, and we want to ensure that our PHPs are really addressing the needs of our members and community, and that we're never, ever, you know, raising the rate of one group but leaving others behind, absolutely not. So, all of the pips, and the planes are all working on this, they absolutely have a strong component of equity, where we talk about ensuring that we have particular strategies that are addressing groups and communities experiencing disparities. I'm sorry, Chris, you asked. So I think some good questions there about disparities and I truly appreciate the audience for raising this.

Chris Weathington

Okay, some folks are indicating that they are still having trouble with their patient panels, the accuracy of their patient panels, what would, what would you or other folks on the panel recommend in order to clean up those patient panels.

Donetta Godwin

This is Donetta no I can take this one. Yes, thank you, um, it'll be PHP specific Um, one thing I would like to state though is, all the PHPs have been working together to streamline a process in a form for basically requesting for a member to be added onto your panel. So if a member wants to change PCPs.

They want to be removed from your panels and they would call Member Services. In most cases and different PHPs may have a different process. So may you know except fax or email or other, or just call, but the process has been streamlined for having a member, added to your panel. Now I will say there are also some situations where, and I can only speak on behalf of cch where panels, due to like age restrictions and things of that nature, they're just made, honestly, in full transparency might be issues around those panels, in which case it might require a larger movement of patients and so you'll just need to work with each individual PHP dependent upon which of those scenarios you found yourself in on how to work to get those panels resolved and make sure that they're accurate. And we know that it's important for you guys to have accurate panels, not just in order to manage your patients, but we know how important and how concerned some providers have been because your amh fees and potentially your care management fees are tied to those panels so just encourage you to work with the individual PHP is dependent upon your scenario.

Chris Weathington

Thank you Donetta, one question that came in is how would the measure for timeliness to prenatal care be captured. Someone like to answer that on the panel.

Kelly Crosbie

So the question is the timeliness to prenatal care. Is that the question.

Chris Weathington

The timeliness to prenatal care to be captured.

Kelly Crosbie

It's a very, very it we don't like, I just want to say we do not make it up, we use the national standard measure,Taylor

Taylor Zublena

We have the NCQA measure or the HEDIS measure in this space so if you're able to start to kind of be overview for NCQA and the HEDIS measure you can see what the numerator and the denominator are but it basically captures pregnancy related codes that indicate pregnancy and that beneficiary remember, and then the timeliness of care is taken from lab values and specific value sets and codes to identify when that care was received. So again it's taken from the NCQA HEDIS measure to identify with the numerator and denominator are. But for an area of interest that you'd like to work on in performance improvement reaching out to anyone that's been on this call or through the channel to the PHP or through AHEC to look at what the numerator and denominator is within your practice, what

feeds into that Billing Coding members in panel, all of the components that we talked about today to really drill into that. We hope you take that interest.

Chris Weathington

Thank you. This is a question that was raised, what is the equity and inclusion plan for care management.

Kelly Crosbie

That's a fantastic question. So I think part of what I'm. This is kind of a, like what we asked ourselves so we have a lot of care management in the state and we have for a very long time because we have a primary care case management program. And what we didn't know we could tell you what percentage of folks were getting care management. You know, we had good data like that we could look at some of the potential outcomes related to the delivery of care management, like you know good follow up after meeting and then patient who didn't have a lot of good patient level data some member level data so like Who exactly are the people that are getting care management. So one of the first things that we did and we have early data which is very exciting because it actually start collecting member level data so when the plans launched in July, both the plans and the advanced medical home to do the bulk of care management, send us member level data, so we get member level primary care, care management data, health plan care management data and care management data from local health departments here at risk kids and high risk pregnancy care management. So, we actually need that now that now that we are looking at that and making sure the data is high quality and clear, we're actually looking to see who's actually getting care management. Typically care management in our current program say we need to help identify members who are rising risk and high risk and have high unmet resource needs. So sometimes the care management is specifically aimed at groups who experience disproportionate like access issues or disproportionate, health care, health care delivery issues or disproportionate outcomes. So oftentimes, the people being targeted are folks who, who might be experiencing some of those disparities in health care is part of care management, but really we're just starting to actually look at the data around whose getting care management to make sure that it is inclusive, everyone has equal access to care management, and we don't see anything particular happening in who is getting it or who's not getting it. I think one of the things that's really interesting, is understanding not just who's being approached for convention, who's accepting it. So, is there anything we need to do in that space, to make sure our care managers are trained to make sure that we're doing enough in community, to say what care management is that it is a culturally appropriate for members that we're offering it to. So let's say in the whole care management space I think we've done a great job with your management. We're just starting to crack open that net and collect data that is really telling us and helping us evaluate our care management program to make sure that it is identifying and engaging everyone in an equitable manner. So, I would say that we're kind of in early stages of really like digging deep to make sure that we are providing health equity in our care management programs. That's a great question.

Chris Weathington

Thank you, Kelly. That's a very thoughtful answer we appreciate it. We are going to go ahead and close for today's virtual Quality Forum, we want to thank all of you for attending and please note that you can access these slides and audio recording as well as a transcript on the NCAHEC.net website. A special thanks again to all of our panelists from the health plans and from North Carolina Medicaid in North Carolina AHEC. We wish you a wonderful afternoon and thank you again for attending today. Take care everyone.