Quality and Population Health: AMH Measures, Statewide QI Projects

NC Area Health Education Centers and
NC Division of Health Benefits

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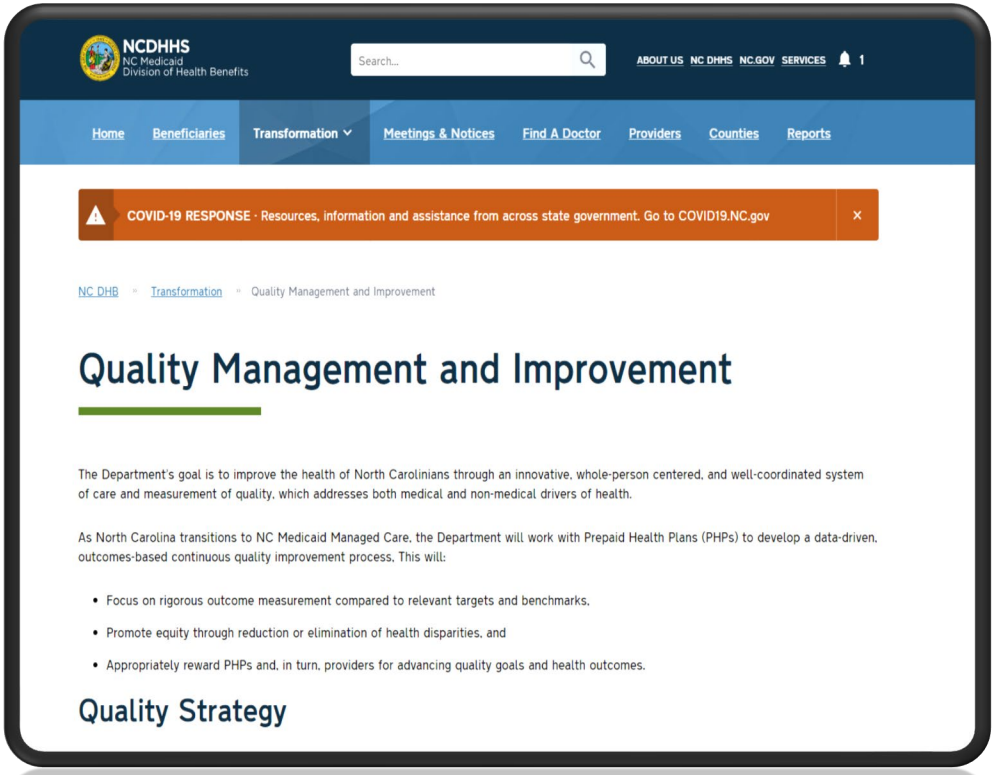
Overview of Presentation

- Welcome!
- NC Medicaid Quality Measure Mechanics
- Historical Data & Performance Measures
- Advanced Medical Home Quality Measures
- FY2022 Statewide Performance Improvement Projects (PIPs)
- Practice Supports—DHB, Plan & AHEC
- Question & Answer

NC MEDICAID QUALITY MEASURE MECHANICS

NC Medicaid Quality Management and Improvement



- ✓ ***Medicaid Quality Strategy***—outlines aims, goals, objectives and interventions to assure, monitor, and improve quality
- ✓ ***Annual Quality Report (AQR)***—4 years of data on Medicaid quality
- ✓ ***Quality Measure Technical Specifications:*** Standard Plan and Tailored Plan measure sets with technical specifications and targets

Link: ***https://medicaid.ncdhhs.gov/transformation/quality-management-and-improvement***

NC Medicaid Quality Measure Mechanics

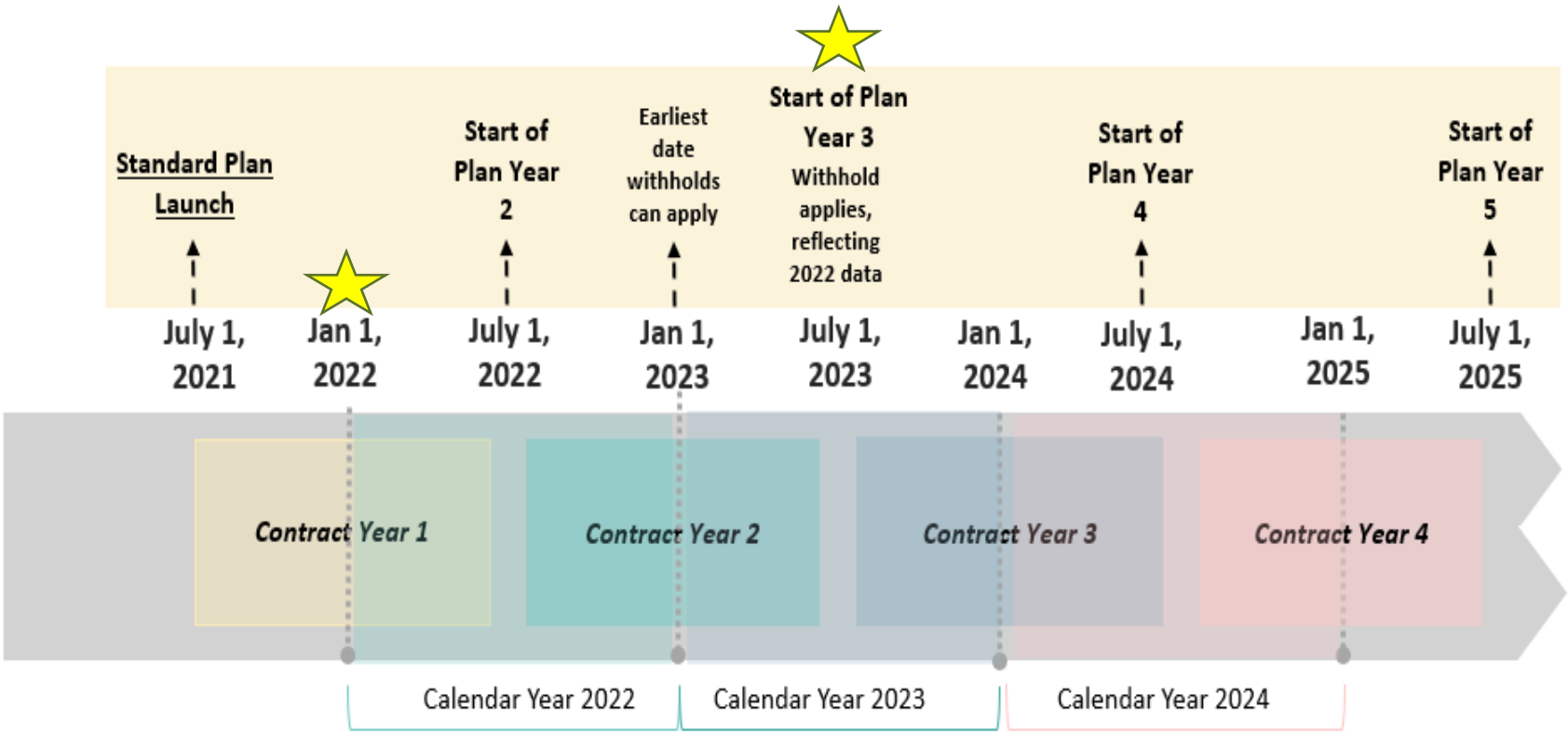
- **HISTORY**: DHB selected the Standard Plan (SP) quality measure set to reflect key focus areas informed by prior performance.
- MCAC Quality Subcommittee
- NCIOM Task Force (Managed Care Metrics)
- Managed care plans given **historical baselines** for all measures for which comparable historical data are available at the state level.
- **State rates** (when available) back to 2016 were published in the AQR.
  - Performance on these measures has varied: some are above and others below the National Median.
  - In some cases, measure performance is difficult to interpret due to limitations in coding and documentation.
- **Baselines for Plans/Providers: CY 2019 Statewide Rate**
- **The AMH set is a sub-set of health plan measures.** *They were selected for their relevance to primary care and care management.*

NC Medicaid Quality Measure Mechanics

- **Targets:** *Benchmark for each SP measure will be a 5% relative improvement over the 2019 Statewide Rates*
- **Targets to Promote Health Equity:** *For measures with a race/ethnicity disparity (10% relative difference), the Plan target is a 10% relative improvement over 2019 Statewide Rates.*
- **Withholds/Incentives:** *18 months after managed care launch*
- **Measure Specifications:** technical specifications and targets
  - *DHB will calculate measure performance by Health Plan. Health Plans will calculate measures for providers.*
- **Attribution:** *DHB/SP working on a standardized attribution model that aligns with PCP assignment*
- **FUTURE EVOLUTION:** *DHB will update the quality measure sets and benchmarks annually to address:*
  - *Evolution of measure sets and technical specifications.*
  - *Disparate performance by region, plan, group*

Stay Tuned for Information on eMeasures in a future webinar

Standard Plan Quality Measurement Timeline



Historical Data and Performance Measures

NC Medicaid Annual Quality Report

- **Annual Report assessing performance on and accountability for quality measures related to aims and goals of the Quality Strategy**

  1) Better Care Delivery, 2) Healthier People and Communities, and 3) Smarter Spending

  - **Measures are organized by Aims/Goals**
    - **Measures developed by NCIOM, Medicaid MCAC Quality Committee, Medicaid Quality & Health Outcomes Committee, CMS Core Sets**
  - **Measures from 2015-2019 are included**
    - **Including baselines for all Standard Plan measures using 2019 statewide performance**

  - **Measures are claims and survey-based**
  - **Measure rates are stratified with key disparities highlighted**
  - **NC statewide rates are compared to National Medicaid median where available**
  - **DHB assigned a statewide performance score ( ) based on measure performance in an AIM/GOAL area**

Standard Plan Measures: Pediatric

Measure	NQF #	Measure Group	CY2019 NC Rate	CY2019 US Median	CY2020 NC Rate	AMH Measure
Adolescent Well-Care Visit (AWC)*		Pediatric	43.4	57.18		x*
Childhood Immunization Status (Combination 10) (CIS-CH)	0038	Pediatric	35.02	37.47	36.16	x
Percentage of Low Birthweight Births	N/A	Pediatric	11.5	9.5		
Follow-Up After Hospitalization for Mental Illness	0576					
7- Day Follow-up (Ages 0-18)		Pediatric	-	-	38.16	
30-Day Follow-up (Ages 0-18)		Pediatric	-	-	60.98	
7- Day Follow-up (Ages 19-20)		Pediatric	29	-		
30-Day Follow-up (Ages 19-20)		Pediatric	47	-		
Immunization for Adolescents (Combination 2) (IMA)	1407	Pediatric	31.55	36.86	31.21	x
Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	N/A	Pediatric	52.1	49.1	-	
Screening for Depression and Follow-Up Plan (CDF)	0418/ 0418e	Pediatric/Adult	-	-		x
Total Eligibles Receiving at least One Initial or Periodic Screen (Federal Fiscal Year)	N/A	Pediatric	52.98	-		
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	2801	Pediatric	52.09	64.89	50.82	
Well-Child Visits in the First 15 Months of Life - 6 or More Visits (W15)*	1392	Pediatric	65.71	67.88	62.3	x*
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*	1516	Pediatric	70.48	74.7		x

*Measure included here to report historical rates. PHPs will report the revised NCQA measures, **W30 and WCV**; are also AMH measures.

Standard Plan Measures: Adult

Measure	NQF #	Measure Group	CY2019 NC Rate	CY2019 US Median	CY2020 NC Rate	AMH Measure
Cervical Cancer Screening (CCS)	0032	Adult	43.82	61.31	42.83	x
Chlamydia Screening in Women (Total Rate) (CHL)	0033	Adult	58.22	58.44	57.19	x
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)	0059	Adult	-	-	-	x
Concurrent Use of Prescription Opioids and Benzodiazepines (COB)	3389	Adult	14.86	-	-	
Controlling High Blood Pressure (CBP)	0018	Adult	-	61.8	-	x
Follow-Up After Hospitalization for Mental Illness	0576					
7- Day Follow-up (Age 21+)		Adult	30	-		
30-Day Follow-up (Age 21+)		Adult	45	-		
Flu Vaccinations for Adults (FVA)	0039	Adult	42.9	43.44	-	
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	0027					
Advising Smokers and Tobacco Users to Quit		Adult	77.9	77.66		
Discussing Cessation Medications		Adult	48.1	54.15		
Discussing Cessation Strategies		Adult	49.0	47.92		
Plan All-Cause Readmissions - Observed to expected ratio (PCR)	1768	Adult	0.93	-	0.99	x
Use of Opioids at High Dosage in Persons Without Cancer (OHD)	2940	Adult	-	-	-	

AMH Quality Measures

Quality Initiatives within the AMH Program

The Department requires Standard Plans to monitor the performance of AMHs in all tiers to ensure delivery of high-quality care.

- All practices will be eligible to earn negotiated Performance Incentive Payments based on the set of measures in the AMH measure set, **which were selected for their relevance to primary care and care coordination.**
  - Performance Incentive Payments are optional for Tier 1 and 2 AMHs.
  - Standard Plans are required to offer opportunities for such payments to Tier 3 AMHs.
- Standard Plans are not required to use all the AMH measures, but **any quality measures they choose must be drawn from this set;** plans are not permitted to use measures drawn elsewhere.

CY2022 = First Measurement Period
CY2019 = Baseline Statewide Rates

Advanced Medical Home Measure Set

NQF#	Measure Name	Steward	Frequency*
Pediatric Measures			
NA	Child and Adolescent Well-Care Visits (WCV)	NCQA	Annually
0038	Childhood Immunization Status (Combo 10) (CIS)	NCQA	Annually
1407	Immunizations for Adolescents (Combo 2) (IMA)	NCQA	Annually
NA	Well-Child Visits in the First 30 Months of Life (W30)	NCQA	Annually
Adult Measures			
0032	Cervical Cancer Screening (CCS)	NCQA	Annually
0033	Chlamydia Screening in Women (CHL)	NCQA	Annually
0018	Controlling High Blood Pressure (CBP)	NCQA	Annually
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	Annually
1768	Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]	NCQA	Annually
0418/ 0418e	Screening for Depression and Follow-up Plan (CDF)	CMS	Annually
NA	Total Cost of Care		Annually

*Monthly gap measure reports are also required.

NC Medicaid SY 2022 Performance Improvement Projects (3 PIP)

FY2022 Medicaid Performance Improvement Priorities

Standard Plans are required to conduct Performance Improvement Projects (PIPs) that:

- Are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction;
- Include measurement of performance using objective quality indicators;
- Include implementation of interventions to achieve improvement in access to and quality of care;
- Include evaluation of the effectiveness of the interventions; and
- Include planning and initiation of activities for increasing or sustaining improvement.
- Address disparities and promote health equity

FY22 PIPs

- **Diabetes prevention and control**
- **Childhood Immunizations**
- **Maternal Health- Timeliness of Prenatal Care**

FY2022 Medicaid Performance Improvement Priorities

Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Comparison to 2019 National Median
Childhood Immunization Status (Combination 10)[28]	32.81	34.16	30.29	35.02	★★
Timeliness of Prenatal Care (HEDIS)	37.66	36.92	36.37	35.53	★
Hemoglobin A1c (HBA1c) Testing ★	77.71	77.35	75.71	74.76	★

★ While historical rates for this measure are not available for HbA1c Control, secondary indicator rates of hemoglobin A1c (HbA1c) testing provide historical performance on diabetes care in NC Medicaid

* https://files.nc.gov/ncdma/documents/AnnualReports/AnnualReport_SFY2017_20171230.pdf

Maternal Health Indicators

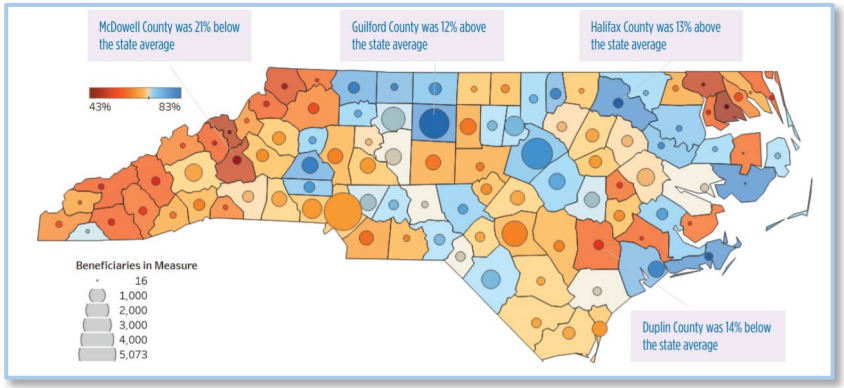
Includes the goal of **promoting wellness and prevention for women's health**.

More than **85%*** of the NC Medicaid population are women and children. Medicaid's continued focus on these populations is evident through the NC DHHS aligned:

- Early Childhood Action Plan
- Perinatal Health Action Plan
- Maternal Health Strategic Plan

Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Comparison to 2019 National Median
Breast Cancer Screening	49.67	46.76	43.64	41.35	★
Cervical Cancer Screening	52.44	49.83	46.47	43.82	★
Chlamydia Screening	58.19	58.2	57.86	58.22	★★
Contraceptive Care for Postpartum Women: Most & Moderately Effective Methods (Ages 15-20) CCP[38]					
3 Days Postpartum Rate 1 (Most or moderately effective FDA-approved)	5.5	3.6	7.9	9	N/A
60 Days Postpartum Rate 1 (Most or moderately effective FDA-approved)	41.1	47	48.4	46	N/A
3 Days Postpartum Rate 2 (LARC)[39]	1.2	0.5	1.9	3.6	N/A
60 Days Postpartum Rate 2 (LARC)	16.4	21.1	18.9	18	N/A
Contraceptive Care: Most & Moderately Effective Methods (Ages 21-44) CCP					
3 Days Postpartum Rate 1 (Most or moderately effective FDA-approved)	13.2	10.8	15	15	N/A
60 Days Postpartum Rate 1 (Most or moderately effective FDA-approved)	38.4	43.7	44.4	43.2	N/A
3 Days Postpartum Rate 2 (LARC)	0.6	0.3	0.75	2.2	N/A
60 Days Postpartum Rate 2 (LARC)	11	14.9	12.5	13	N/A
Percentage of Low Birthweight Births[40]	8.9	9.1	9.2	9.4	◊ 8.2
Prenatal and Postpartum Care (Both Rates)					
Timeliness of Prenatal Care (HEDIS)	37.66	36.92	36.37	35.53	★
Postpartum Care (HEDIS)	59.03	59.36	58.89	68.77	★★
Timeliness of Prenatal Care[41] (HEDIS-like)	–		77.48		
Postpartum Care (HEDIS-like)	–		71.36		
Rate of Screening for Pregnancy Risk	78.2	78	77.9	77.5	N/A

Postpartum Care by Geography



The proportion of deliveries that had a postpartum visit on or between 21 and 56 days after delivery by geography.

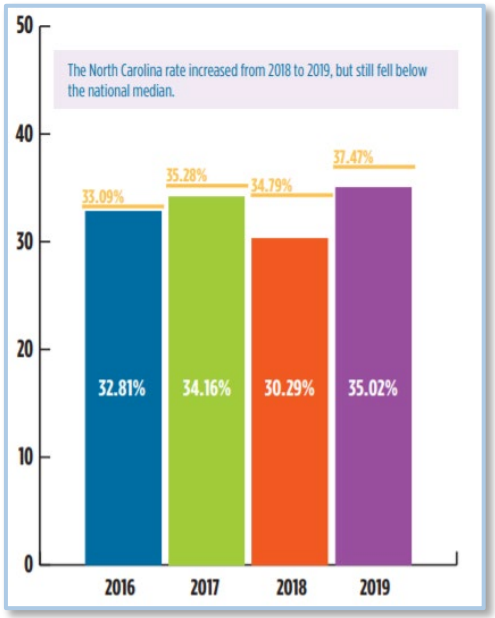
* https://files.nc.gov/ncdma/documents/AnnualReports/AnnualReport_SFY2017_20171230.pdf

Pediatric Prevention: Well Care and Immunizations

Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Comparison to 2019 National Median
Ambulatory Care: ED Visits Ages 0-19 (Per 1000)	—	45.70	45.53	46.83	◊ 43.6[27]
Childhood Immunization Status (Combination 10)[28]	32.81	34.16	30.29	35.02	★★
DTaP	75.23	77.37	74.12	77.62	★★
IPV	90.18	92.42	87.82	92.00	★★
MMR	91.46	91.09	89.45	90.93	★★
HiB	87.40	89.26	86.09	88.92	★★
Hepatitis B	91.91	94.1	84.56	93.6	★★
VZV	91.20	91.03	88.96	90.69	★★
Pneumococcal Conjugate	76.37	79.11	76.22	79.16	★★
Hepatitis A	82.31	82.89	82.56	84.22	★★
Rotavirus	71.77	73.81	72.22	74.55	★★
Influenza	45.42	45.9	44.70	45.34	★★
Follow-Up After Hospitalization for Mental Illness (Ages 6-17 years)					
7-Day Follow-up	—	—	15.8	15.49	★
30-Day Follow-up	—	—	23	22.84	★
Immunizations for Adolescents (Combination 2)[29]					
Combination 2 Rate	15.62	21.67	28.89	31.55	★★
Combination 1 Rate	57.94	72.26	83.91	86.26	★★
Meningococcal	62.17	75.98	85.71	87.89	★★
Tdap (Tetanus, Diphtheria, Acellular Pertussis)	76.83	82.33	87.52	89.25	★★
HPV (Human Papillomavirus)	23.95	26.19	30.91	33.27	★★

Percentage of Eligibles Receiving at least One Initial or Periodic Screen	**52.9**	**51.42**	**51.61**	**52.98**	◊ 51.61[31]
Percentage of Eligible Beneficiaries Who Received Preventive Dental Services (PDENT-CH)[32]	50.6	51	51.4	52.1	◊ 45.86[33]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (the total of all ages for each of the 3 rates)[34]					
Total BMI Percentile documentation	28.9	34.19	38.44	42.56	★
Total Counseling for Nutrition	10.42	15.27	17.93	21.06	★
Total Counseling for Physical Activity	0.85	1.2	2.23	5.2	★
Well-Child Visits in the First 15 Months of Life – 6 or More Visits	59.38	62.52	64.99	67.71	★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.25	69.88	70.14	70.48	★★

Childhood Immunization Status (Combo 10)

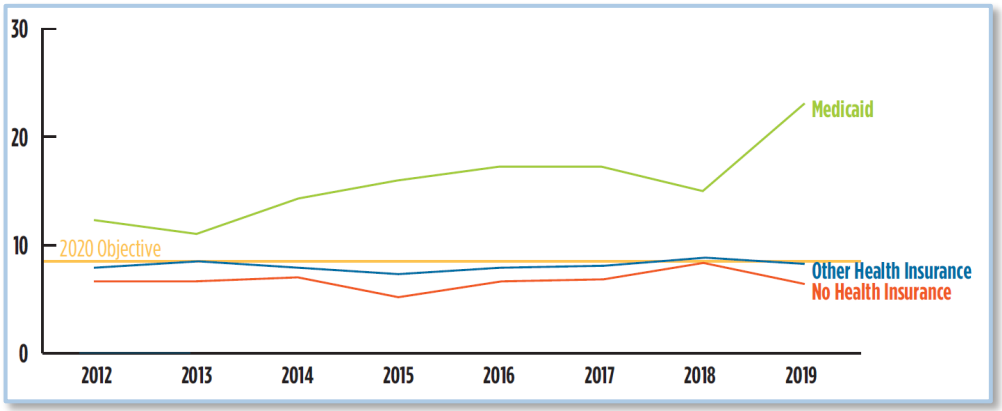


The proportion of children in NC Medicaid who received immunization combo 10 by their second birthday.

- While still below the national median, the rate increased from 2018 to 2019.

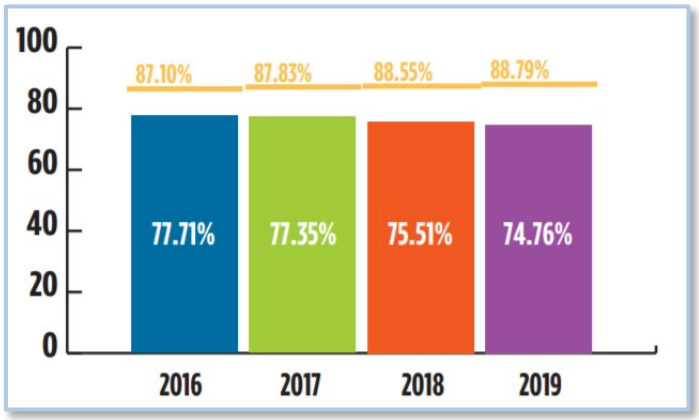
Diabetes Prevention and Control

Diabetes by Insurance Type



The percent of North Carolina adults with diabetes by insurance types based on the BRFSS questionnaire.

HbA1c Testing



The proportion of individuals ages 18 to 75 in NC Medicaid with diabetes who received an HbA1c test.

- Almost a quarter of individuals did not receive this test, despite it providing critical information about glucose control and disease management.
- NC remains below the national median.

* https://schs.dph.ncdhhs.gov/data/brfss/medicaid/docs/Medicaid_2018_tables.pdf

Diabetes Prevention and Control

Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Comparison to 2019 National Median
Asthma Medication Ratio (Total Rate)	62.97	63.5	64.53	65.30	★★
Hemoglobin A1c (HBA1c) Testing	77.71	77.35	75.71	74.76	★
Plan All-Cause Readmissions - Observed to expected ratio	—	0.82	0.82	0.93	◇ 0.83
PQI-01: Diabetes Short-Term Complication Admission Rate	19.26	23.1	24.4	27.8	★★ 19.1[48]
PQI-05: COPD or Asthma in Older Adults Admission Rate	94.37	103.4	71.91	92.7	★★ 71.9[49]
PQI-08: Heart Failure Admission Rate	39.19	42.57	40.79	43.5	★★ 26.4[50]

Includes the goal **of improving chronic condition management**. Over **40%*** of NC Medicaid beneficiaries have a chronic condition.

Utilization Measures

Most of these measures are prevention indicators aimed at identifying potentially preventable utilization, thus a lower rate is better.

Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Comparison to 2019 National Median
PDI-14: Asthma Admission Rate[69]	103.01	98.75	93.81	90.3	◇ 80.57[70]
PDI-15: Diabetes Short-Term Complications Admission Rate	39.88	44.59	40.09	40.87	◇ 25.09
PDI-16: Gastroenteritis Admission Rate	23.55	24.65	21.59	27.37	◇ 36.26
PDI-18: Urinary Tract Infection Admission Rate	24.14	22.83	17.17	20.07	◇ 20.55
PQI-01: Diabetes Short-Term Complication Admission Rate	12.2	23.38	24.43	27.8	★★ 19.1[71]

Provider Supports

Provider Supports—DHB, Health Plans & AHEC

Providers are critical partners in ensuring that the goals and objectives of the Quality Strategy are achieved and that interventions are successfully deployed.

- **DHB in partnership with AHEC and Health Plans offer training and feedback sessions (e.g. webinars, virtual office hours, fireside chats)** to train providers and keep them up to date on programmatic developments.
- AHEC Managed Care Webinars
  - Webinars: Quality & Population Health Series (like this)
  - Virtual Quality Forum (October 12)
- **AHEC will offer practice coaching.**
- **Standard Plans have each developed a *Provider Support Plan*** that was reviewed by DHB and will be updated on an annual basis.

Standard Plans: Provider Support Plan

Each plan must develop a report detailing:

All planned technical support activities;

Detailed information regarding how its proposed provider supports activities will advance the aims, goals, and objectives outlined within the Department's Quality Strategy; and

An overview of which metrics the Plan will use to evaluate its provider engagement progress over time.

AHEC Supports

NC AHEC Practice Support: The Beginning

Began in 2005 as Improving Performance in Practice (IPIP)

- funded by Robert Wood Johnson – CO and NC pilot states
- Collaborative partnership between NC AHEC, CCNC, DPH and other medical societies and agencies
  - Eastern and western NC – Wave 1 = 18 practices
  - Rest of state – Wave 2 = 95 practices
- Diabetes and asthma
- Chronic Care Model; Model for Improvement
- Common quality measures – tied to national measures
- Regional collaborative learning networks (AHEC coaches & CCNC staff)
- Alignment of initiatives (MOC IV, Practice-Based CME, etc.)
- Monthly data reporting – no PHI
  - Wave 1: HbA1c > 9.0 - T1=15%; T2=10%; T3=9%
  - Wave 1: Asthma Action Plan – T1=48%; T2=71%; T3=67%
- **Recognized key drivers**

Newton, WP, Lefebvre A, Donahue KA, Bacon T, and Dobson A. (2010). *J Contin Educ Health Prof* ; 30(2):106-113.

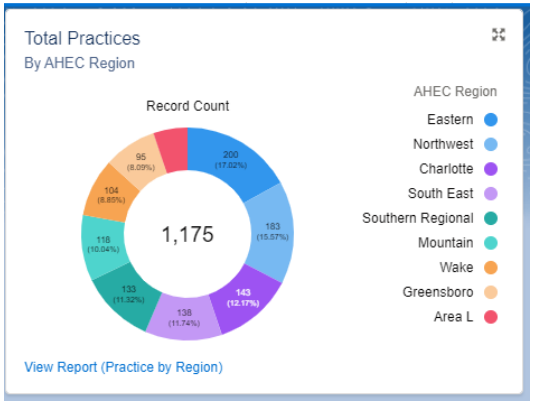
NC AHEC Practice Support – Key Drivers & Key Driver Implementation Scale (KDIS)

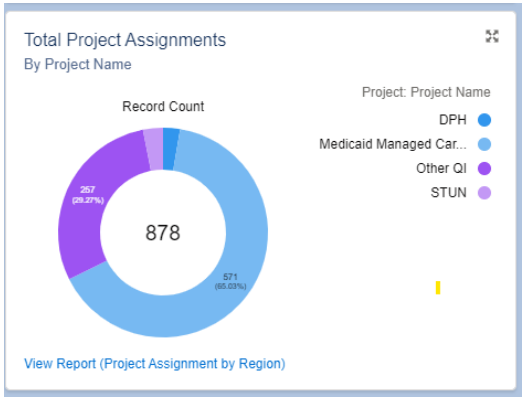
Key Driver	
Robust Clinical Information Systems (CIS)	Care team has reliable access to the patient health information needed to: 1) provide safe and effective care 2) facilitate quality improvement and 3) support provider decision making
Patient-Centered, Team-Based Care	Care Team is aware of patient needs and works together to ensure all needed services are completed
Standardization	Care Team ensures that the right patient gets the right care from the right person at the right time
Experience of Care	Positive, non-biased patient experiences precipitate improved adherence, enhanced clinical outcomes, and improved financial margins
Patient Empowerment	Patients who have the knowledge, skills, and confidence to manage their care have enhanced clinical outcomes and better experiences of care; patient activation can improve over time
Financial Health	To thrive in the value-based payment world practices must implement sound, effective business plans - No margin, No mission

Heart Health NOW! Baseline mean ASCVD risk score among high-risk patients = 23.4%; Post intervention 17.1% Cykert S, Keyserling TC, Pignone M, et.al. (2020). *Health Ser Res* 2020 ; 55: 944-953

NC AHEC Practice Support: Current State

- 33 Coaches
  - 3 TCM coaches and hiring more
- 1182 - 878 projects
- Coach practices to improve patient outcomes, improve patient and staff experience, and thrive in Value-Based Payment Models
  - Diabetes, childhood immunizations, and timely pre-natal care
- AMH Tier 2 to Tier 3
  - Tier Support Tool
- 700 Medicaid Essential Practices to MMC





Heart Health Now (HHN) Dashboard

Practice Expectations

Late roll-out

Data Challenges

Other Challenges

Controversy over Aspirin guidelines for Primary Prevention

Provider buy-in

Cardiovascular Risk Scores & Patient Identification

Overcoming Challenges

Study Clinical Team

Clinical Decision Supports

Manual Risk Score Calculation

Patient Identification systems

Custom Reports

AMH Tier Support Tool

Do I need a CIN?

How do I gather data?

Care Management

Risk Stratification?

Attest to Tier 3?

Medicaid Tier 2?

AMH Tier Support Tool

Front Admin Gap

- Access- After Hours Communication
- Access- Hour of Operation
- Billing & Claims Readiness
- Front Office- Member Eligibility
- PHP Identification & Onboarding
- Practice Management- PHP Participation
- Practice Management- Quality Strategy

Clinical Admin Gap

- Care Management Enrollment
- Care Management Process
- Cultural Competency
- Patient Documentation Requirement
- Population Health- Empanelment
- Language Line
- Referral Management
- SDOH in Action
- Health Information Exchange
- Transitional Care Management
- Patient Value Added Services
- Vaccine Management

Tier 2 Practices

FRONT ADMIN GAP

Standard	Area	Step ID #	Requirements (in bold) and Recommendations	Practice or CIN?	Status	Tier Level
PHP Identification & Onboarding	Front Office	F1T2	**Do the front office staff know which PHPs are in-network with your practice?**		Ready	Tier 2
PHP Identification & Onboarding	Front Office	F2T2	**Have the front desk staff been trained on identifying each PHP insurance card?**		Needed	Tier 2
PHP Identification & Onboarding	Administrative	F4T2	**Are all contracted PHP insurances built into the practice management system?**		Needed	Tier 2
Practice Management- Quality Strategy	Administrative	Q1T2	**Has the practice reviewed the Medicaid Managed Care Quality Strategy?**		Ready	Tier 2
Practice Management- Quality Strategy	Administrative	Q2T2	**Can the prac reports provic plans?**			

Filter Tier Levels

CLINICAL ADMIN GAP

Standard	Area	Step ID #	Requirements (in bold) and Recommendations	Practice or CIN?	Status	Tier Level
Cultural Competency	Administrative	CU1T2	Has the practice met cultural competency requirements per each of their PHP contracts?		Needed	Tier 2
Patient Documentation Requirements	Clinical Care Team	DOC3	Advance Directives or a Living Will (including resources to help patients get the documents created)?		Needed	Tier 2
Population Health-Empanelment	Clinical Care Team	EP1	**Does the practice know their current Medicaid attribution or have a report of current Medicaid active patients?**		Ready	Tier 2
Population Health-Empanelment	Clinical Care Team	EP2	**Does the practice have a process for accepting new patients, opening and closing panels, and panel size?**		Needed	Tier 2
Population Health-Empanelment	Clinical Care Team	EP3	**Does the practice instruct current Medicaid patients on the meaning of a Primary Care Provider? Does the practice work to ensure all current active Medicaid patients have had an appointment/service within the past year?**		Ready	Tier 2

Status can be filtered from Needed, In Progress, or Ready to reflect practice's current state and track changes

Decision Aid

CLINICAL ADMIN GAP

Standard	Area	Step ID #	Requirements (in bold) and Recommendations	Practice or CIN?	Status	Tier Level
Care Management Enrollment	Clinical Care Team	C2T2	**Has the practice determined enrollment criteria for referral or enrollment in care management?**	Practice	Ready	Tier 2
Care Management Enrollment	Clinical Care Team	C3T2	**Does the practice include high-risk reports, HCC scores, Co-Morbidity Diagnosis and/or prevalence of social determinates in care management referral criteria?**	CIN	In Progress	Tier 2
Care Management Enrollment	Clinical Care Team	C4T3	**Does the practice use care management enrollment criteria to stratify patients by risk levels and incorporates risk reports in all aspects of patient care? Does the practice have a designated staff member to receive and compile PHP risk scoring results?**	CIN	Needed	Tier 3
Care Management Enrollment	Administrative	C5T3	**Tier 3 ONLY – Has the practice determined who will receive and compile PHP Risk Scoring results?**	Practice	Needed	Tier 3
Care Management Process	Clinical Care Team	C6T2	**Has the practice determined a communication workflow between the PCP and the assigned Care Manager?**	CIN	Needed	Tier 2
Care Management Process	Clinical Care Team	C7T2	**Has the practice determined a process for patient referral to care management services? Does the practice include communication workflow between the PCP and the assigned Care Manager as part of the process?**	CIN	Ready	Tier 2
Care Management Process	Clinical Care Team	C8T2	**Does the practice use a formalized workflow for referring patients to care management and tracks referrals to ensure patients are using the service?**		Needed	Tier 2
Care Management Process	Clinical Care Team	C9T3	**Does the practice use a CIN, care management organization or has hired a staff member to provide care management services to patients internally in their practice? Are Care Plans sent electronically to primary care provider after each appointment?**	CIN	Ready	Tier 3

Tier 3 Practices

PROJECT PLAN

Standard	Area	Step ID #	Requirement	Practice or CIN?	Status	Tier Level	Actions Required	Due Date
Front Office - Member Eligibility	Front Office	EG3T2	Has the practice successfully checked eligibility on Medicaid Managed Care Plan test patients?	Practice	In Progress	Tier 2		
Practice Management- PHP Participati	Administrative	F7T2	Has the practice completed PHP Orientation & Training?	Practice	In Progress	Tier 2	Practice Manager will communicate with PHPs to schedule for Providers and Staff	6/1/2021
Population Health-Empanelment	Clinical Care Team	EP5	Has the practice reconciled the PHP patient attribution list with the practice's EHR patient panel list. Are the patient panel lists up to date in the EHR? Does the practice have a policy in place to determine process and frequency of reconciling the panel lists?	Practice	In Progress	Tier 3	Currently in enrollment so lists will be available in the future	7/1/2021
Language Line	Administrative	LL1T2	Is the practice aware of PHP language line resources?	Practice	Needed	Tier 2	Practice Manager will review PHP Provider Manuals to gather details	6/1/2021
Referral Management	Clinical Care Team	REF2T2	Does the practice understand which PHP plans require prior authorization for referrals to specialists?	Practice	Needed	Tier 2	Referral staff will view each PHP Provider Manual	7/1/2021
Referral Management	Clinical Care Team	REF3T2	Are clinical providers & referral coordinators aware of common referral providers that are in-network with patient plans?	Practice	In Progress	Tier 2	Referral staff will call most commonly used specialists and inquire about PHP network status	6/15/2021
SDOH In Action	Administrative	SD5T2	Tier 3 ONLY - Has the practice determined who will receive "Care Needs Screening" reports and how those are going to be documented in the EHR and communicated to the PCP provider?	Practice	Needed	Tier 3		
Health Information Exchange	Clinical Care Team	TC3T3	Tier 3 ONLY - Has the practice enrolled in NC* Notify?	Practice	In Progress	Tier 3	Enrollment form submitted, Practice Manager will follw up on status	5/31/2021

https://www.ncahec.net/practice-support/advanced-medical-home/

COMING SOON

Coming Soon

- **Quality Forum, October 12**

  Registration: https://www.ncahec.net/medicaid-managed-care/

- **Next QPH Webinar (October)**
  - **Healthy Opportunities Pilots**
  - **Integrated Care for Kids Pilots**
- **Tailored Care Management (TCM) Webinars (October-December)**
- **2020 Quality Measure Rates, COVID Vaccination Data on Medicaid Members—Fall 2021**
- Advanced Medical Home Technical Advisory Group | NC Medicaid (ncdhhs.gov)
  - September 14

Tailored Care Management (TCM) Updates

- TCM Certification Candidates who have passed the Desk Review portion of the TCM Certification Process are currently working with AHEC for TA in preparation for Site Review
- Sept. 30th Deadline: Round 2 Application Deadline for TCM Applicants
- Round 1 Site Reviews are slated to begin in November of 2021
- TCM Provider 101 Series: Fridays 12pm-1pm October-December 2021
- TPs are beginning to work with TCM Certification Candidates within their region on assessments and creation of Capacity Building distribution plans for November 1st submission
- Tailored Care Management is expected to officially launch July 1, 2022

DHB is working to finalize contract with NCQA to support the TCM Certification Process.

Q&A

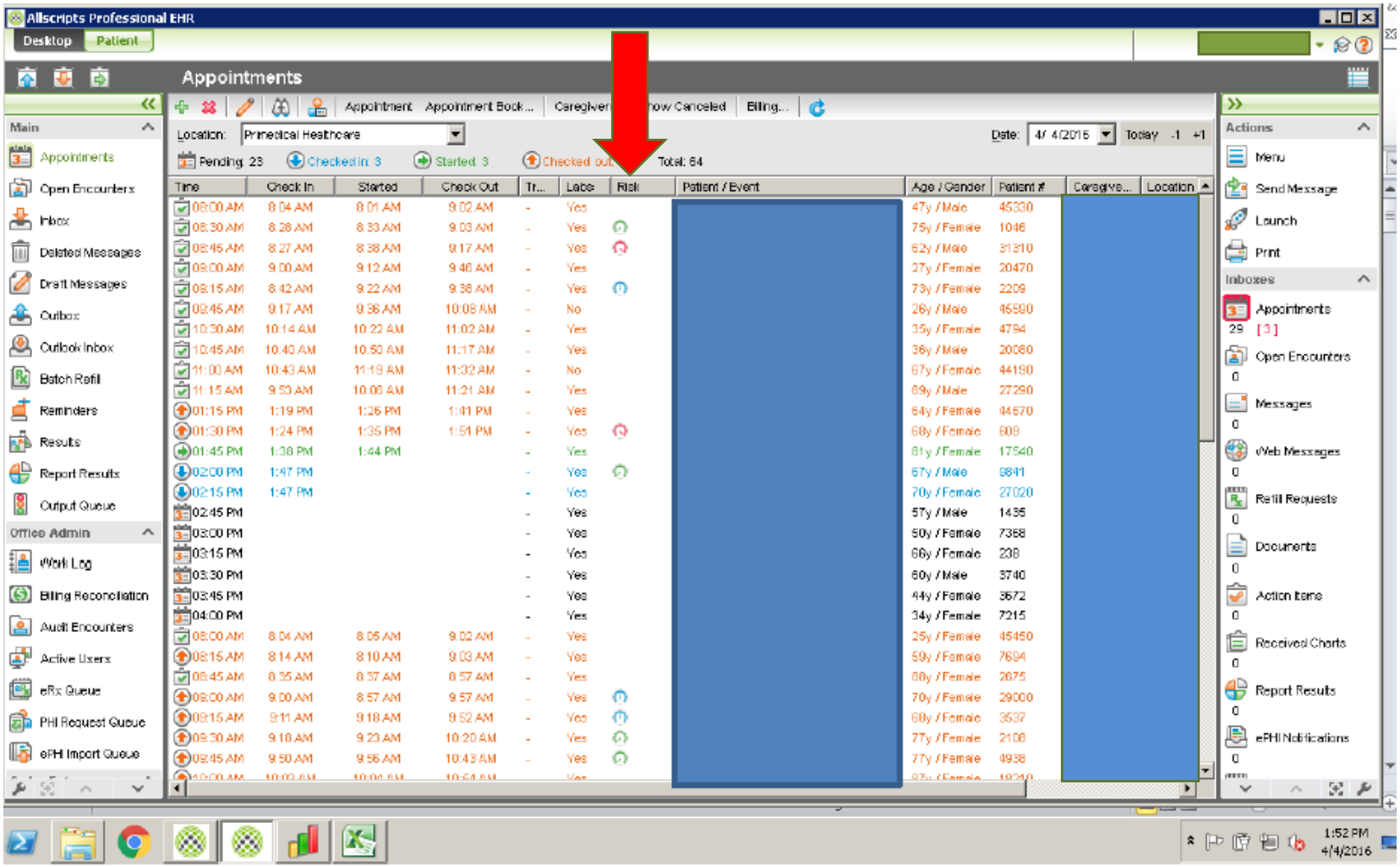
Appendix

HHN Measures

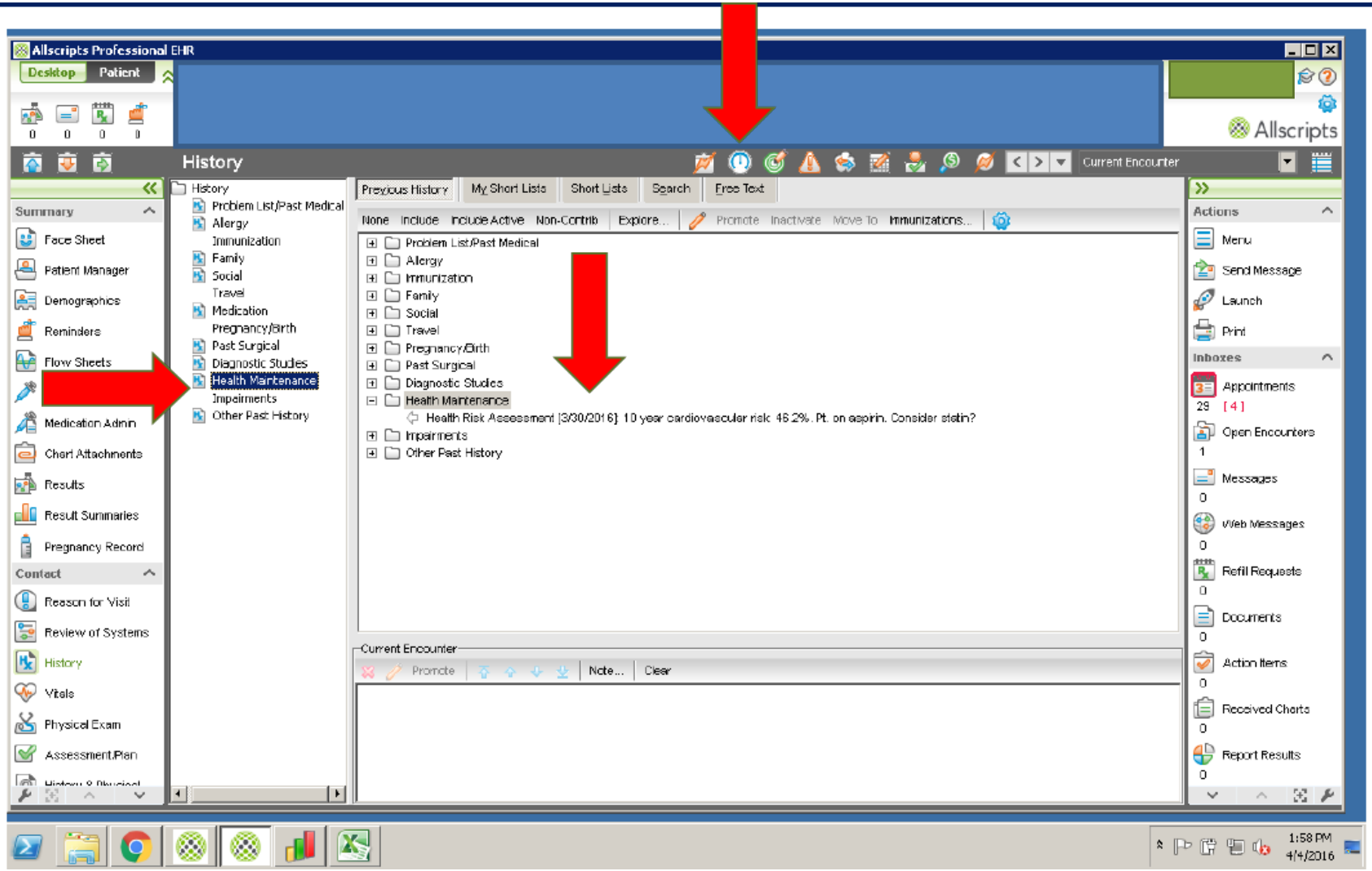
NQF 0028 Tobacco Use: Screening and Cessation Intervention
NQF 0018 Controlling High Blood Pressure
NQF 0068 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
HHN Assessment of Cardiovascular Risk
HHN Risk-based Statin Therapy
HHN Statin Therapy for Prevention and Treatment of Cardiovascular Disease
HHN Blood Pressure Control Multiple Population (JNC8)
HHN Aspirin for the Primary Prevention of Cardiovascular Disease

https://hearthealthnow.org/
https://www.ahrq.gov/evidencenow/projects/heart-health/index.html

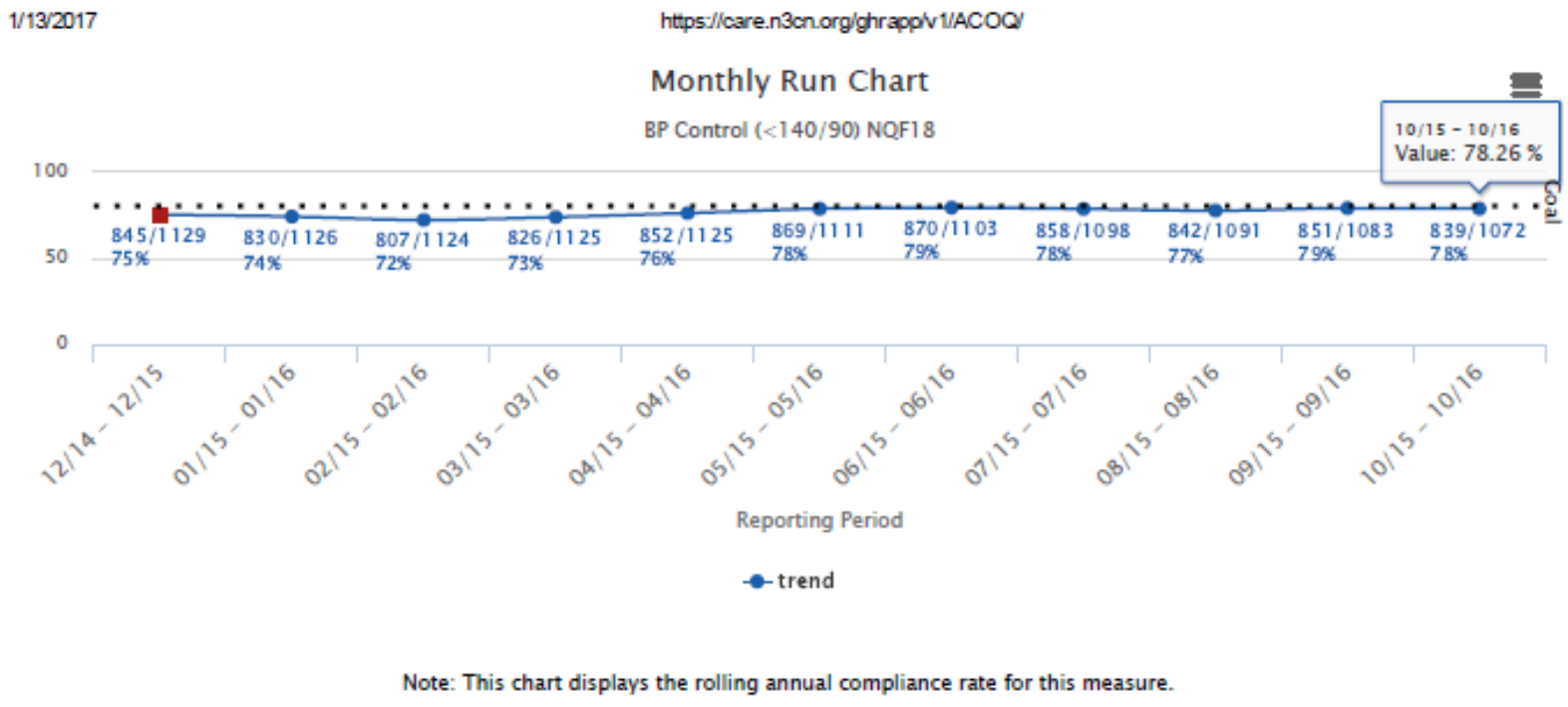
Provider Schedule



Patient Chart



The Improvement



Note: This chart displays the rolling annual compliance rate for this measure.