While you're waiting for us to start, check out the results of HRSA's health center survey… (there is no audio for this slide)

54% of NC health centers responding

Testing Capacity	NC
Health Centers with COVID-19 Testing Capacity	100%
Health Centers with COVID-19 Drive-Up/Walk Up Testing Capacity	80.95%

Average Turnaround Time for COVID-19 Test Results	
Less than 1 Hour	14.29%
12 Hours or Less	0%
24 Hours	23.81%
2-3 Days	42.86%
4-5 Days	19.05%
More than 5 Days	0%

Operations	NC
Health Center Weekly Visits Compared to Pre-COVID 19 Weekly Visits	75.48%
Health Center Sites Temporarily Closed	21
Staff Tested Positive for COVID-19	9
Health Center Staff Unable to Work (due to site/service closure, exposure, family/home obligations, lack of PPE, etc.)	1.9%
Average Percent of Health Center Visits Conducted Virtually	30.95%

Latest Data from September 4th
https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data/nc

While you're waiting for us to start, check out the results of HRSA's health center survey... (there is no audio for this slide)

54% of NC health centers responding

Number of Patients Tested for COVID-19	NC
Patients Tested	3409
Patients Tested Positive	327

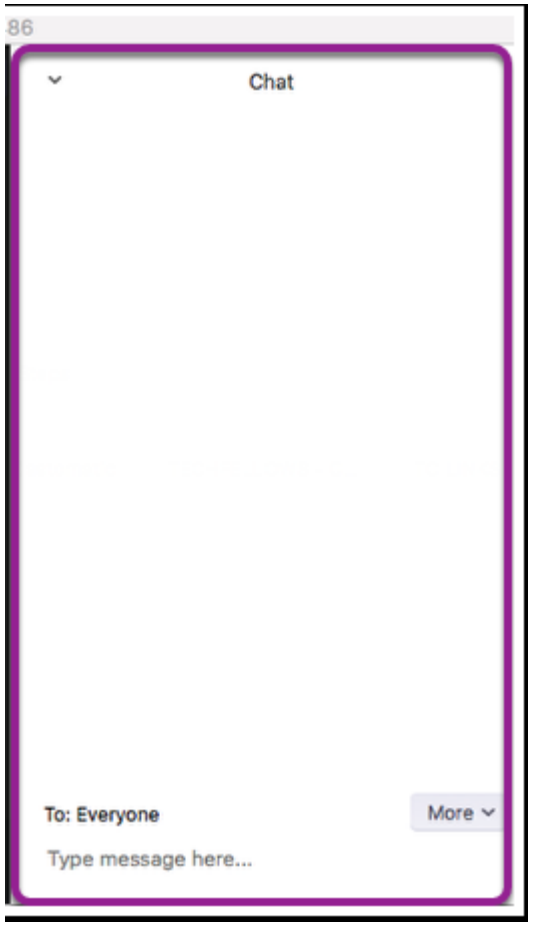
Race/Ethnicity	Patients Tested	Tested Positive
White, Non-Hispanic/Latino	29.58%	23.93%
White, Hispanic/Latino	9.98%	24.54%
Black, Non-Hispanic/Latino	32.2%	20.55%
Black, Hispanic/Latino	1.59%	1.53%
Asian	1.09%	1.53%
American Indian/Alaska Native	0.53%	0.0%
Unreported/Refused to Report	5.74%	3.07%

Latest Data from September 4th
https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data/nc

CHC Task Force Meeting

September 18, 2020

Zoom Help



You can also send questions through Chat. Send questions to Everyone or a specific person.

Everyone will be muted. You can unmute yourself to ask questions by clicking on the microphone or phone button.

Agenda

- **Welcome**, Chris Shank, President & CEO, NCCHCA
- **NC Medicaid Advanced Medical Homes: Updates**, Kelly Crosbie & Krystal Hilton, NC Division of Health Benefits
- **Delegation of Care Management to FQHCs: Keys to Successful Implementation**, Art Jones, Health Management Associates & Angelo Aiello, Medical Home Network
- **NCCHCA Updates**
  - **Readiness to Train Assessment**, Sharon Brown-Singleton, Josie Lane-Kuzniar
- **Closing**

Slides & Other Info will be available on our website:
www.ncchca.org/covid-19/covid19-general-information/

Welcome from Chris Shank, President & CEO, NCCHCA





Advanced Medical Homes: Updates

Kelly Crosbie, MSW, LCSW

Director of Quality and Population Health

Krystal Hilton, MPH

Associate Director, Population Health

NC Medicaid

September 2020

Advanced Medical Homes

- **Goal: provide a pathway for practices to have a larger role in managing the health outcomes and cost for their patient populations**

- **Guiding principles**
  1. Preserve broad access to primary care services for enrollees
  2. Strengthen the role of primary care in care management, care coordination, and quality improvement
  3. ***Provide clear incentives for practices to become more focused on cost and quality outcomes, increasing accountability over time***

Advanced Medical Homes

- DHHS has invested heavily in AMH and care management
- Expectations are high:
  - Penetration rates are much higher (22% vs current 10%)
  - Location of care is highly community-based
  - Need to address the continuum of care needs from rising risk to high risk and unmet social needs

- ***AMH program represents an opportunity for providers to fund population health investments critical to a VBP environment***

Advanced Medical Homes

Tiers 1 and 2

- PHP retains primary responsibility for care management
- **Practices will need to interface with multiple PHPs**, which may employ different approaches to care management

Tiers 1 & 2
- Medical Homes Fees Remain the Same ($2.50/$5.00)
- PHPs must offer incentive pgms

Tier 3

- PHP delegates primary responsibility for care management to the AMH
- Practices will have the option to **provide care management in-house** or **through a CIN/other partner** across all Tier 3 PHP contracts

Tier 3
- Medical Homes Fees Remain the Same ($2.50/$5.00)
- PHPs must offer incentive pgms
- NEW Care Management Rate

AMH Tier Care Management Requirements

AMH Tier 3 Requirements

- Risk stratify all empaneled patients
- Provide care management to high-need patients
- Provide short-term, transitional care management along with medication reconciliation to all empaneled patients who are discharged from the ED or an inpatient setting
- Demonstrate active access to an ADT
- Receive claims data feeds and meet State-designated security standards for their storage and use

AMH Oversight

PHPs will verify that AMHs can meet Tier 3 requirements

PHPs will look for evidence of:

- Care management policy, assessment/care plan tools,
- care management workflows,
- risk scoring methodology,
- staffing plans/job description,
- care management documentation system,
- technology system capable of capturing and using encounter data, member data, ADT data

PHPs are responsible for on-going oversight

UPDATES 2020

July-August 2020

- Considering impact of COVID on providers
- DHB Listening Sessions
  - Concerns: reporting burden, lack of standardization, “glidepath” as AMHs launch, care management payments

September-November 2020

- Working with PHPs to streamline and standardize process reporting
- Working to standardize and streamline AMH Tier 3 measure set
- Providing a glide-path for AMH Tier 3s
- Encourage more flexibility and higher level of APMs for those who are ready!
- Restart of AMH TAG & Data TAG (projected October 2020)
- Launching AHEC coaching program (November 2020)

HEALTH MANAGEMENT ASSOCIATES

Delegation of Care Management to FQHCs: Keys to Successful Implementation

North Carolina Community Health Center Association

Angelo Aiello, RN, Senior Director, Clinical Integration, Medical Home Network
Art Jones, MD, CMO, Medical Home Network, Principal, HMA

September 18, 2020

OBJECTIVES

1. Understand care management expectations of Tier 3 Advanced Medical Homes by NC DHHS.
2. Identify steps for meeting those expectations
3. Begin to develop a strategy with a timeline for meeting those expectations by July 1, 2021

CHOOSING A PAYMENT STRATEGY THAT UNDERWRITES BETTER PATIENT OUTCOMES

Preserving Revenue

- Fee-for-service PPS or Capitated APM

A Bigger Piece of the Cake (Market Share)

Icing on the Cake

- CM fee
- AMH
- P4P
- Shared savings/risk
- Partial capitation for non-PCP services

HEALTH MANAGEMENT ASSOCIATES

15

“Complex Care Management extends beyond medical issues to address, to the extent possible, how patients’ psychosocial circumstances affect their ability to follow treatment recommendations and achieve a healthy lifestyle.”

Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?
Commonwealth Fund Issue Brief, August 2014.
Clemens Hong, et al

"The **key task** of the Care Management team is to **build trusting relationships** with **patients/families** as well as with **primary care providers** and their staff"

Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?

Commonwealth Fund Issue Brief, August 2014.

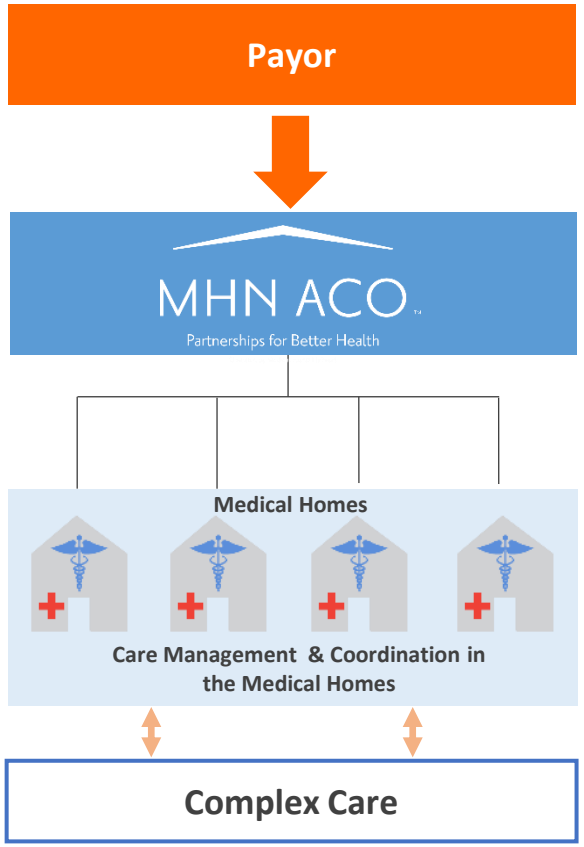
Clemens Hong, et al

HEALTH MANAGEMENT ASSOCIATES

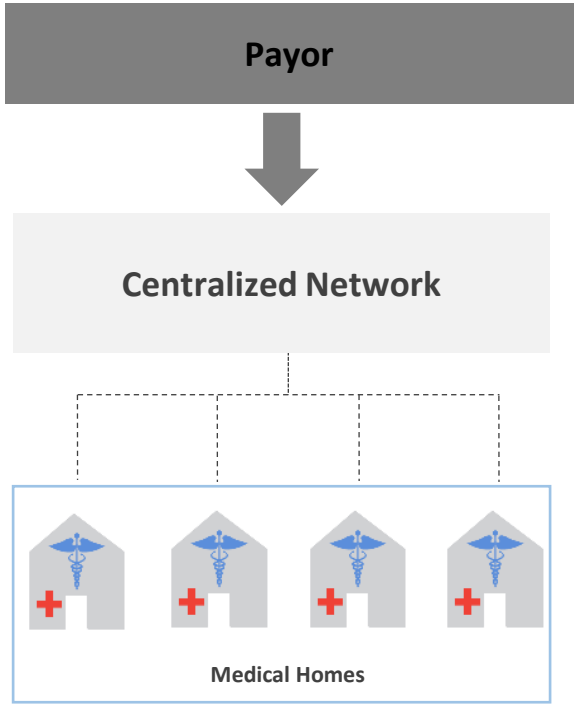
CMS HEALTH HOME PROGRAM REQUIREMENTS

Practice-Level vs. Centralized Care Management

Practice-level Care Management



Centralized Care Management



The Takeaway

- ✓ Better "whole person" care
- ✓ Lower cost
- ✓ Improved outcomes
- ✓ 120 community based created jobs

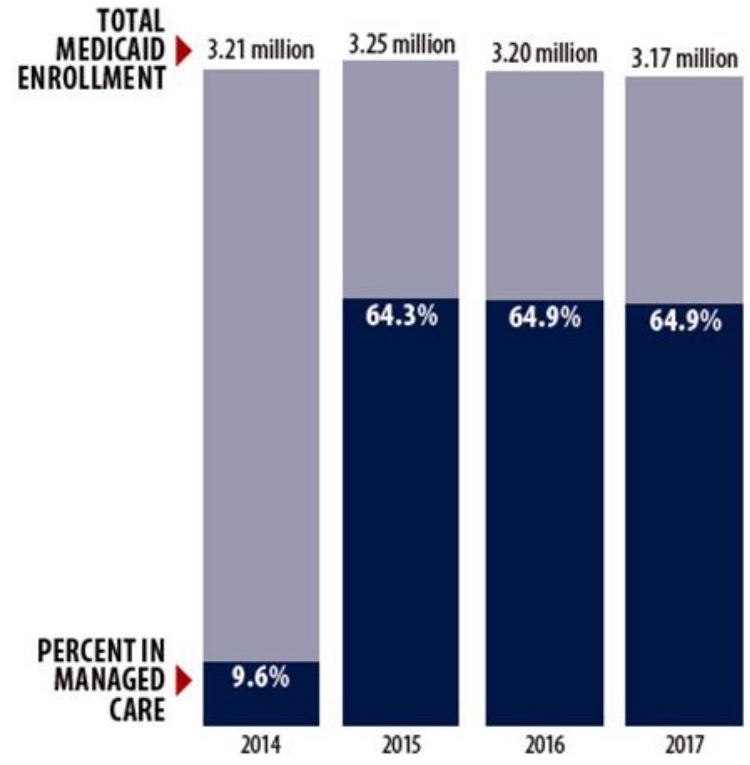
- ✓ Builds on established patient relationships with primary care medical homes
- ✓ Drives shared incentives and alignment

- × Challenges with telephonic method of engaging patients
- × Challenges engaging PCPs
- × Limited access to EMR data

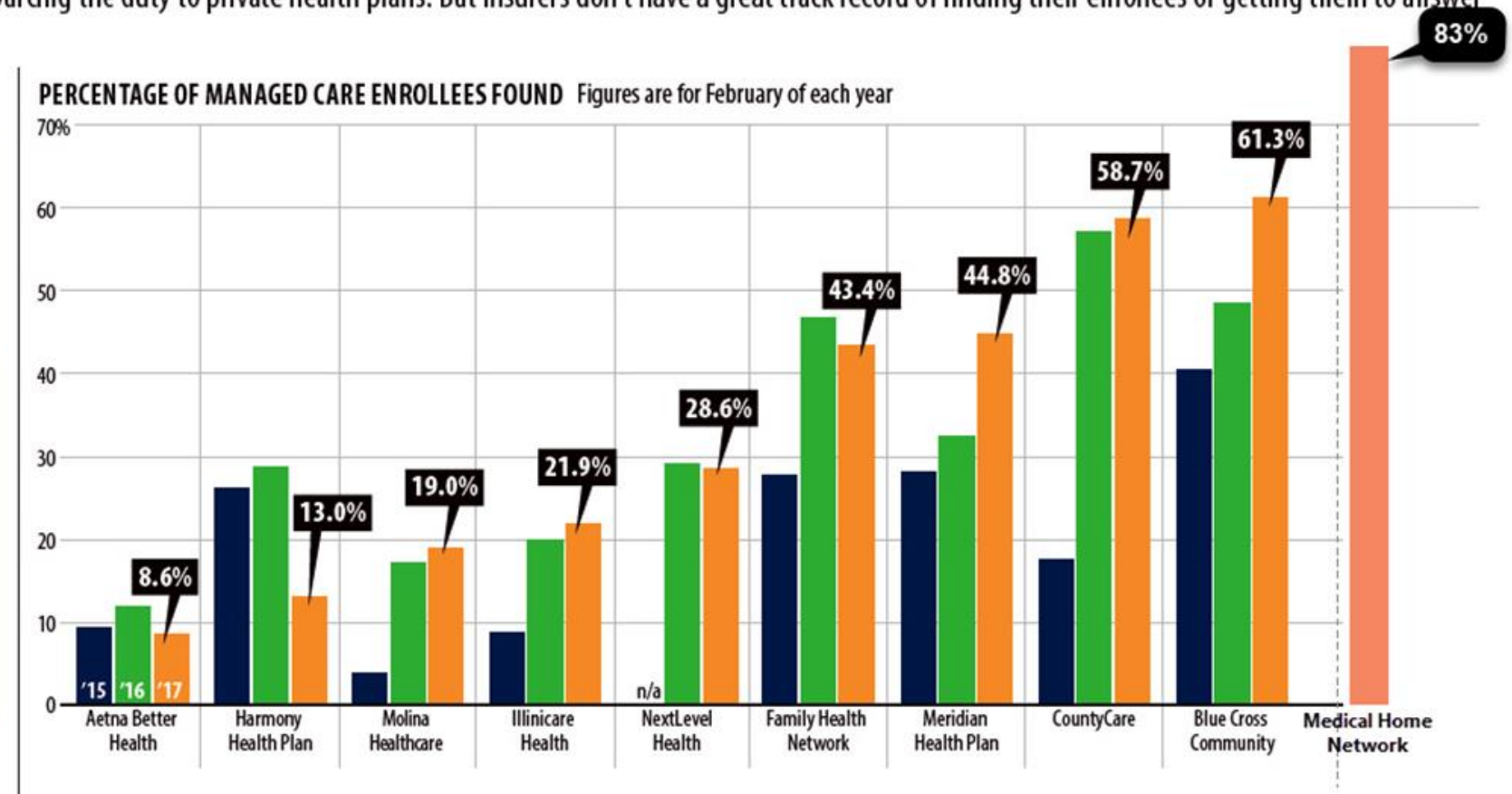
Medical Home Network:
The Impact of Delegating Care Management to Practices

MISSING MEDICAID

Enrollment in Illinois Medicaid managed care programs swelled after a state law mandated that at least 50 percent of all Medicaid recipients enroll by Jan. 1, 2015. Managed care is meant to be a cost-saving initiative for the state, which is increasingly outsourcing the duty to private health plans. But insurers don't have a great track record of finding their enrollees or getting them to answer basic questions about their health.



Note: 2017 enrollment as of March 31. Illinois' fiscal year ended June 30.
Source: Illinois Department of Healthcare & Family Services



Sources: Illinois Department of Healthcare & Family Services; Crain's analysis

MEDICAL HOME NETWORK

Medical Home Network | ©2020 All Rights Reserved | Proprietary & Confidential

MHN: Identify Rising Risk Through Addressable Medical, Behavioral & Social Factors

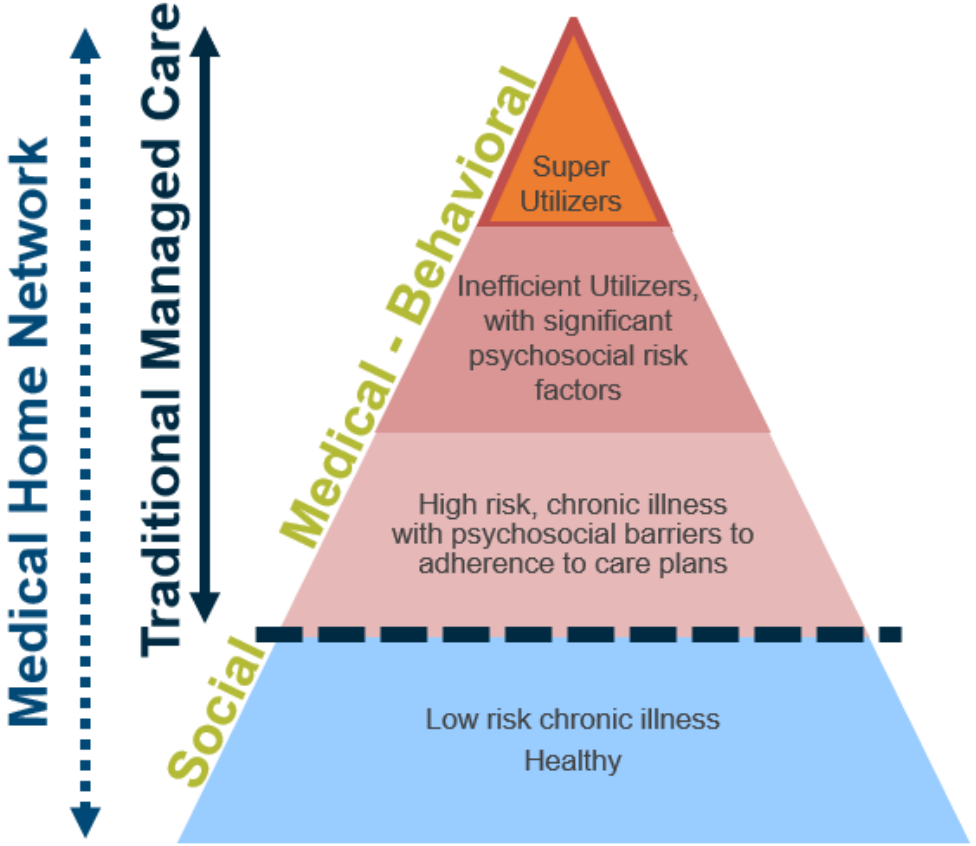


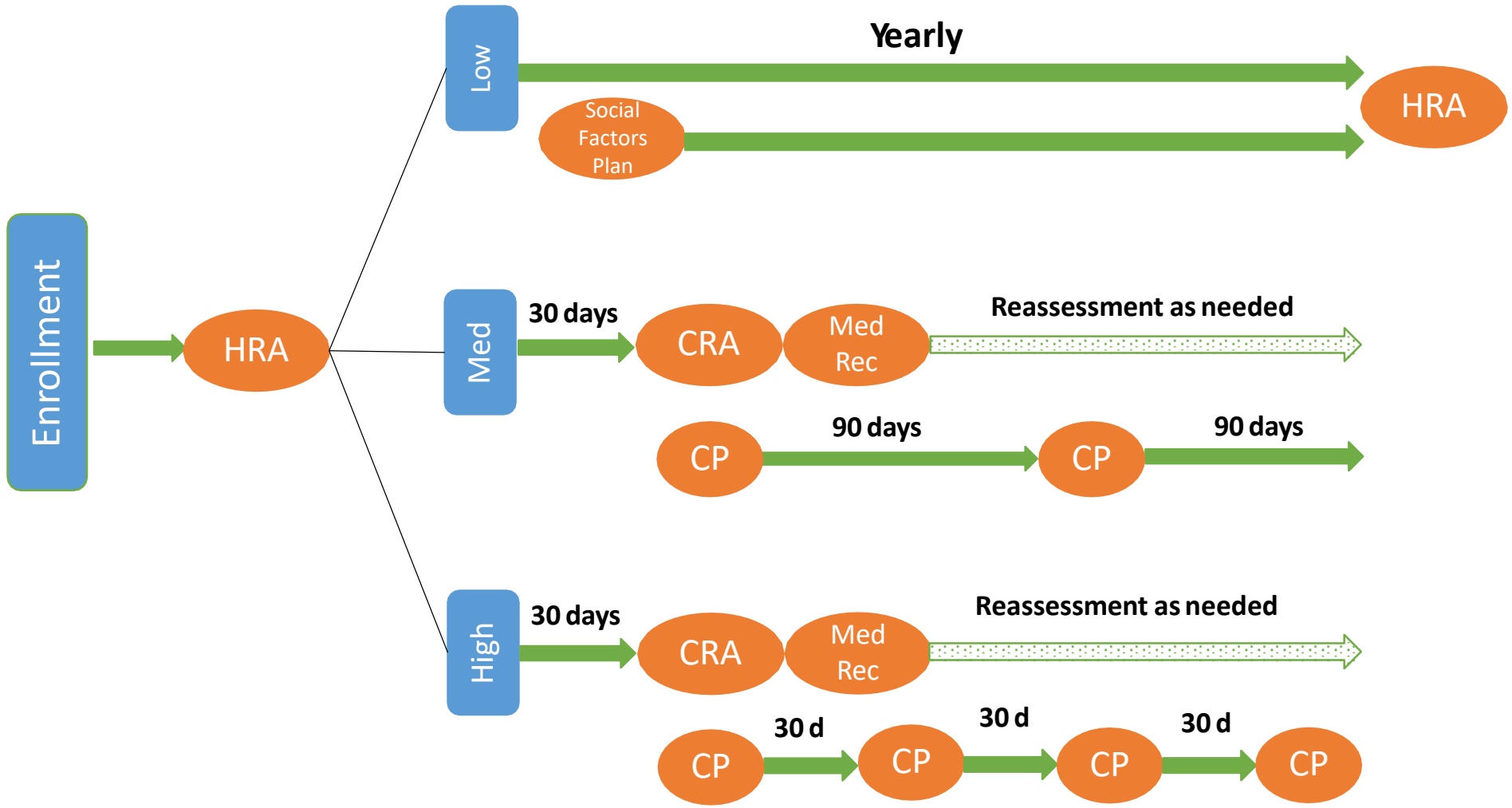
Table 2.1 Member, Cost, and Utilization by Risk Level – Medicaid Expansion

HRA Risk Profile	Member Count	% Members Total	ER Visits / 1000	Inpatient Admits / 1000	Medical + Rx Cost PMPM	Relative Cost
Low	1,606	21%	415.3	56.66	$217.1	100%
Low-CHW	4,181	54%	620.2	96.39	$349.4	161%
Medium by Social Factors	663	9%	742.1	143.29	$423.3	195%
Medium by Utilization	320	4%	1,856.3	281.25	$479.9	221%
High by Social Factors	127	2%	834.6	125.98	$404.7	186%
High by Utilization	865	11%	1,653.2	679.77	$821.4	378%
Total	**7,762**	**100%**	**757.8**	**165.29**	**$387.2**	**178%**

** Note: This analysis includes ACA adults who were continuously enrolled for twelve months post Health Risk Assessment (7,762 observations) and their associated claims cost during that period.*

***Source: Jones A, et al., J Community Med Public Health Care 2017, 4: 030**

NC AMH TIER 3 COMPLIANT MODEL OF CARE



MHN ACO's Care Management Model:

Demonstration

MEDICAL HOME NETWORK™

Building Partnerships for Better Health

COMPREHENSIVE RISK ASSESSMENT REQUIREMENTS

1. Patient's immediate care needs and current services
2. Other State or local services currently used
3. Physical health conditions
4. Current and past behavioral and mental health and substance use status and/or disorders
5. Physical, intellectual developmental disabilities
6. Medications
7. Priority domains of social determinants of health (housing, food, transportation, and interpersonal safety);

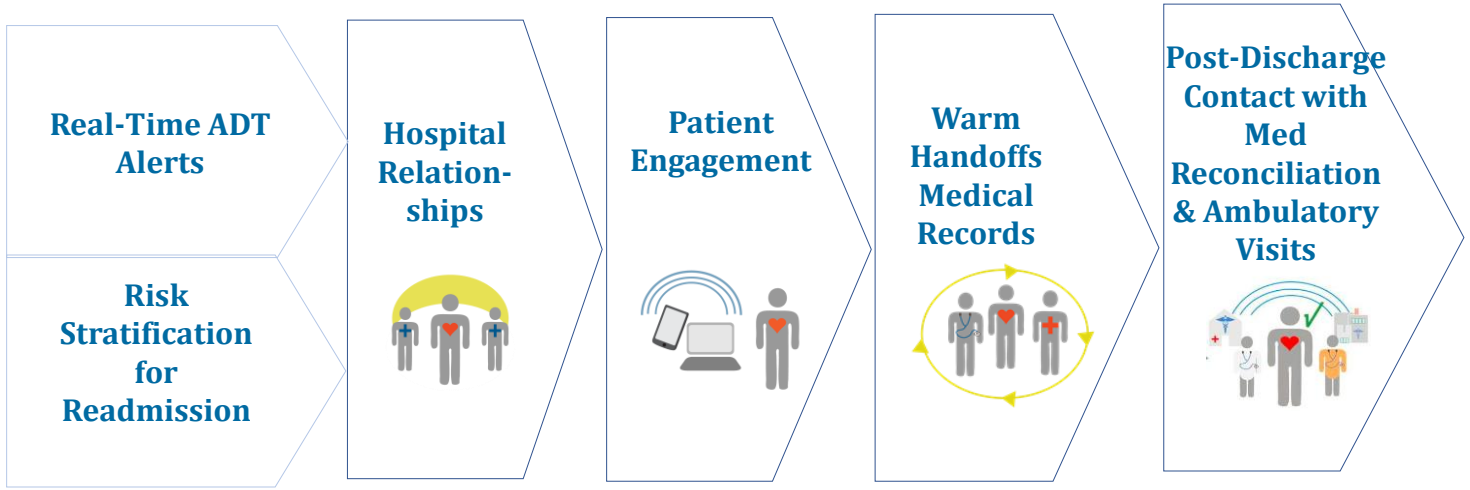
CARE PLAN REQUIREMENTS

1. Measurable patient (or patient and caregiver) goals
2. Medical needs including any behavioral health needs
3. Interventions
4. Intended outcomes
5. Social, educational, and other services needed by the patient.

CARE PLAN UPDATES

1. Review hospital activity (ED/Inpatient)
2. Review current medications
3. Review Care Manager Action Steps and progress
4. Review Care Gaps
5. Review self-management goals and progress
6. Reassess identified behavioral health issues
7. Review any other concerns the patient may have
8. Review upcoming PCP appointments, subspecialist appointments and external community referrals
9. Set up next care management encounter
10. Risk adjust as necessary using HRA and/or manual risk adjustment

NC AMH TIER 3 COMPLIANT TRANSITIONS OF CARE



HEALTH MANAGEMENT ASSOCIATES

TRANSITIONS OF CARE WORKFLOWS

Bundle Step	Description
Care Manager contacts the patient during hospitalization	1. Ask patient why they came to the hospital 2. Reinforce existing care plan 3. Reinforce relationship with the medical home 4. Document in MHNConnect
Care Manager call: • Within 48 hours of discharge • Notifies care team of patient discharge • Consults with care team on frequency of up to 4 weekly calls following discharge	1. Provide patient with customized information and instructions 2. Address short term needs 3. Reinforce signs and symptoms; where/when to call for help
7-Day Follow-up Appointment with PCP or BH Provider	1. Attempt to schedule the appointment before the patient is discharged 2. Confirm that the patient has attended
Medication Review post-discharge	1. Perform Medication Review and/or medication reconciliation

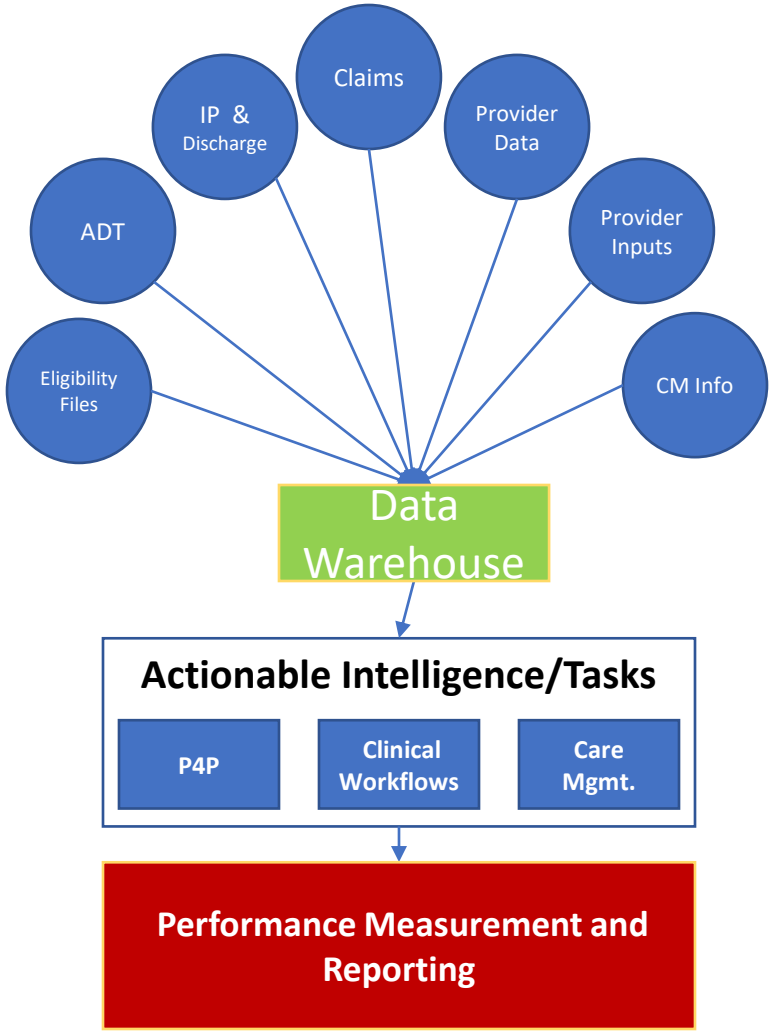
PREPARATION FOR AMH TIER 3 CARE MANAGEMENT

1. Care management model of care
2. Care management budgeting
3. Risk stratification algorithm
4. Care management tools
5. Performance metrics and targets
6. Care management platform solution
7. Recruiting and training care management staff

CARE MANAGEMENT BUDGETING

Care Management Tasks	Time allocated (hours)	Frequency per year			Care Coordinator time/yr (hrs)			Care Manager time/yr (hrs)		
		Low Risk	Mod Risk	High Risk	Low Risk	Mod Risk	High Risk	Low Risk	Mod Risk	High Risk
Onboarding new members within 30 days of enrollment	0.5	0.5	0.5	0.5	0.25	0.25	0.25	0	0	0
Outreach to members who have not been seen in the health center in the previous twelve months	0.25	0.25	0.25	0.25	0.0625	0.0625	0.0625	0	0	0
Initial or annual health risk screen (includes PHQ, assumes multiple attempts are sometimes required)	0.5	1	1	1	0.5	0.5	0.5	0	0	0
Community -based organization referrals	0.25	0.5	1	2	0.125	0.25	0.5	0	0	0
Closing gaps in care and wellness messaging	0.5	1	2	2	0.5	1	1	0	0	0
Outreach to members with four or more emergency department visits in the previous six months	0.5	0	0.4	0.6	0	0.2	0.3	0	0	0
Post-ED visit contact**	0.25	0	0	0	0	0	0	0	0	0
Comprehensive risk assessment and initial/major revision of care plan	1.5	0	1	2	0	0	0	0	1.5	3
Telephonic care plan review	0.5	0	2	8	0	0	0	0	1	4
Face-to-face care plan update	0.5	0	1	2	0	0	0	0	0.5	1
Post-hospitalization transition of care (low risk)	1	0.07			0	0	0	0.07	0.00	0.00
Post-hospitalization transition of care (medium and high risk)	4		0.25	1.50	0	0	0	0.00	1.00	6.00
Disease management/health coaching	0.5	0	3	6	0	0	0	0	1.5	3
Manage electronic alerts**	0.25	0	0	0	0	0	0	0	0	0
Hours PMPY					1.44	2.26	2.61	0.07	5.50	17.00

NC AMH TIER 3 COMPLIANT CONNECTIVITY & ANALYTICS



Data Feed	Type	Frequency
Health Plan Member Attribution	Flat File/Excel	Monthly
Eligibility Terminations	Flat File/Excel	Weekly
ED Visit and Inpatient Admissions	ADT Direct Connect	Near Real Time
Inpatient Census	Flat file/Excel	Daily
Hospital Discharge Data	ADT Direct Connect	Near Real Time
Attributed Member Claim History (MCO)	Flat file/Excel	Weekly
PCP EHR Data	Flat file/Excel	Weekly
Case Management Data	Flat File/Excel	Weekly

MHN ACO: Driving Health Outcomes by Reducing Social Determinants

MHN OUTCOME 37.4% reduction in total social risk factors impacting health

Social Risk Factor Reduction of High Risk and Medium Risk Adults in Care Management
3,315 members, July 2014 – June 2018

Social Risk Factor	Initial HRA	Latest HRA	% Change	Predictive of Future Cost and/or Utilization*
Total Social Factors	**11,124**	**6,963**	**-37.4%**	
Rates overall health as Fair or Poor	**2,019**	**1,578**	**-21.8%**	✓
Difficulty making appointments	685	396	-42.2%	✓
Difficulty getting to appointments or filling prescriptions	1,396	885	-36.6%	✓
Untreated Depression	1,172	511	-56.4%	
Untreated Drug/Alcohol Use	304	156	-48.7%	✓
Difficulty securing food, clothing, or housing	1,717	868	-49.4%	✓
Currently homeless or living in a shelter	126	68	-46.0%	✓
Difficulty paying for meds	1,000	270	-73.0%	✓
Does not feel physically or emotionally safe at home	213	143	-32.9%	
Refused Smoking Cessation program	607	226	-62.8%	

The Impact of Social Risk

The presence of even one social risk factor dramatically increases a patient's cost & utilization*

Evaluation criteria: Most recent HRAs for ACO members with 12+ months continuous enrollment and minimum of 2 HRAs at least 30 days apart.

NCCHCA Updates: Readiness to Train Assessment,

Josie Lane-Kuzniar, NCCHCA Training Coordinator

HRSA's Health Professions Education and Training (HP-ET) Initiative

Readiness to Train Tool (RTAT) to gauge health center readiness to engage in Health Professional Training Programs

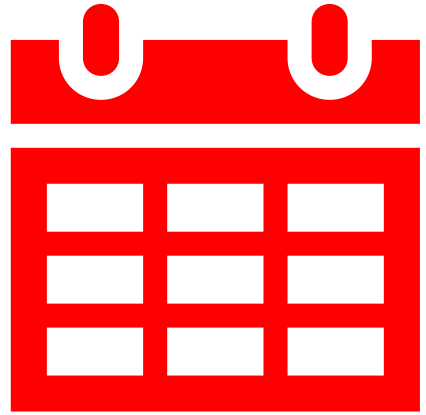
Overview of RTAT Initiative

- HRSA national initiative
- Goal of RTAT
- Readiness to Train Tool (RTAT)
- NC Health Center's participation
- Target Goal
- Kick Off Call
  - Please join the **Webinar: Readiness to Train Assessment Tool** next week on September 23, 2020 from 3:00 - 4:30 PM ET to learn more!

Upcoming FQHC Task Force Calls

October 9, 10:00-11:30am

October 23, 10:00-11:30am



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covid19@ncchca.org