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

<table>
<thead>
<tr>
<th>Testing Capacity</th>
<th>NC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Centers with COVID-19 Testing Capacity</td>
<td>100%</td>
</tr>
<tr>
<td>Health Centers with COVID-19 Drive-Up/Walk Up Testing Capacity</td>
<td>80.95%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average Turnaround Time for COVID-19 Test Results</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 Hour</td>
<td>14.29%</td>
</tr>
<tr>
<td>12 Hours or Less</td>
<td>0%</td>
</tr>
<tr>
<td>24 Hours</td>
<td>23.81%</td>
</tr>
<tr>
<td>2-3 Days</td>
<td>42.86%</td>
</tr>
<tr>
<td>4-5 Days</td>
<td>19.05%</td>
</tr>
<tr>
<td>More than 5 Days</td>
<td>0%</td>
</tr>
</tbody>
</table>

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

Latest Data from September 4th
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

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

Number of Patients Tested for COVID-19 | NC |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Tested</td>
<td>3409</td>
</tr>
<tr>
<td>Patients Tested Positive</td>
<td>327</td>
</tr>
</tbody>
</table>
CHC Task Force Meeting
September 18, 2020
Zoom Help

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

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

**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

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

**Tier 3**
- Medical Homes Fees Remain the Same ($2.50/$5.00)
- PHPs must offer incentive pgms
- NEW Care Management Rate
<table>
<thead>
<tr>
<th>AMH Tier 3 Requirements</th>
<th>AMH Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Risk stratify all empaneled patients</td>
<td>PHPs will verify that AMHs can meet Tier 3 requirements</td>
</tr>
<tr>
<td>• Provide care management to high-need patients</td>
<td>PHPs will look for evidence of:</td>
</tr>
<tr>
<td>• Provide short-term, transitional care management along with medication reconciliation to all empaneled patients who are discharged from the ED or an inpatient setting</td>
<td>• Care management policy, assessment/care plan tools,</td>
</tr>
<tr>
<td>• Demonstrate active access to an ADT</td>
<td>• care management workflows,</td>
</tr>
<tr>
<td>• Receive claims data feeds and meet State-designated security standards for their storage and use</td>
<td>• risk scoring methodology,</td>
</tr>
<tr>
<td></td>
<td>• staffing plans/job description,</td>
</tr>
<tr>
<td></td>
<td>• care management documentation system,</td>
</tr>
<tr>
<td></td>
<td>• technology system capable of capturing and using encounter data, member data, ADT data</td>
</tr>
</tbody>
</table>

PHPs are responsible for on-going oversight
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)
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
“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

Health Management Associates
“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
CMS HEALTH HOME PROGRAM REQUIREMENTS

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care
- Individual and family support
- Referral to community and support services
Practice-Level vs. Centralized Care Management

Practice-level Care Management

- Payor
- MHN ACO
- Medical Homes
  - Care Management & Coordination in the Medical Homes
  - Complex Care

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

Centralized Care Management

- Payor
- Centralized Network
- Medical Homes

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

120 community based created jobs

THIS DOCUMENT IS PROPRIETARY & CONFIDENTIAL. YOU MAY NOT REVEAL THE CONTENTS WITHOUT THE EXPRESS WRITTEN CONSENT OF MEDICAL HOME NETWORK.
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.


PERCENTAGE OF MANAGED CARE ENROLLEES FOUND  Figures are for February of each year

Sources: Illinois Department of Healthcare & Family Services; Crain's analysis
Table 2.1 Member, Cost, and Utilization by Risk Level – Medicaid Expansion

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

*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**

THIS DOCUMENT IS PROPRIETARY & CONFIDENTIAL. YOU MAY NOT REVEAL THE CONTENTS WITHOUT THE EXPRESS WRITTEN CONSENT OF MEDICAL HOME NETWORK.
NC AMH TIER 3 COMPLIANT MODEL OF CARE

- **Enrollment**
  - **Low**
    - Social Factors Plan
  - **Med**
    - CRA
    - Med Rec
    - CP
    - Reassessment as needed
    - 30 days
    - 90 days
    - 90 days
    - 30 d
    - 30 d
    - 30 d

- **Yearly**
  - HRA

- **High**
  - CRA
  - Med Rec
  - CP
  - Reassessment as needed
  - 30 days

- **HRA**
MHN ACO’s Care Management Model:
Demonstration
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

- Real-Time ADT Alerts
- Risk Stratification for Readmission
- Hospital Relationships
- Patient Engagement
- Warm Handoffs Medical Records
- Post-Discharge Contact with Med Reconciliation & Ambulatory Visits
<table>
<thead>
<tr>
<th>Bundle Step</th>
<th>Description</th>
</tr>
</thead>
</table>
| 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 |
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
<table>
<thead>
<tr>
<th>Care Management Tasks</th>
<th>Time allocated (hours)</th>
<th>Frequency per year</th>
<th>Care Coordinator time/yr (hrs)</th>
<th>Care Manager time/yr (hrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Low Risk</td>
<td>Mod Risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Low Risk</td>
<td>Mod Risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Low Risk</td>
<td>Mod Risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Low Risk</td>
<td>Mod Risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Low Risk</td>
<td>Mod Risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Low Risk</td>
<td>Mod Risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Low Risk</td>
<td>Mod Risk</td>
</tr>
<tr>
<td>Onboarding new members within 30 days of enrollment</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>0.25</td>
</tr>
<tr>
<td>Outreach to members who have not been seen in the health center in the previous twelve months</td>
<td>0.25</td>
<td>0.25</td>
<td>0.25</td>
<td>0.0625</td>
</tr>
<tr>
<td>Initial or annual health risk screen (includes PHQ, assumes multiple attempts are sometimes required)</td>
<td>0.5</td>
<td>1</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Community -based organization referrals</td>
<td>0.25</td>
<td>0.5</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Closing gaps in care and wellness messaging</td>
<td>0.5</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Outreach to members with four or more emergency department visits in the previous six months</td>
<td>0.5</td>
<td>0</td>
<td>0.4</td>
<td>0.6</td>
</tr>
<tr>
<td>Post-ED visit contact**</td>
<td>0.25</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Comprehensive risk assessment and initial/major revision of care plan</td>
<td>1.5</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Telephonic care plan review</td>
<td>0.5</td>
<td>0</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Face-to-face care plan update</td>
<td>0.5</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Post-hospitalization transition of care (low risk)</td>
<td>1</td>
<td>0.07</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Post-hospitalization transition of care (medium and high risk)</td>
<td>4</td>
<td>0.25</td>
<td>1.50</td>
<td>0</td>
</tr>
<tr>
<td>Disease management/health coaching</td>
<td>0.5</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Manage electronic alerts**</td>
<td>0.25</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hours PMPY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NC AMH TIER 3 COMPLIANT CONNECTIVITY & ANALYTICS

<table>
<thead>
<tr>
<th>Data Feed</th>
<th>Type</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan Member Attribution</td>
<td>Flat File/Excel</td>
<td>Monthly</td>
</tr>
<tr>
<td>Eligibility Terminations</td>
<td>Flat File/Excel</td>
<td>Weekly</td>
</tr>
<tr>
<td>ED Visit and Inpatient Admissions</td>
<td>ADT Direct Connect</td>
<td>Near Real Time</td>
</tr>
<tr>
<td>Inpatient Census</td>
<td>Flat file/Excel</td>
<td>Daily</td>
</tr>
<tr>
<td>Hospital Discharge Data</td>
<td>ADT Direct Connect</td>
<td>Near Real Time</td>
</tr>
<tr>
<td>Attributed Member Claim History (MCO)</td>
<td>Flat file/Excel</td>
<td>Weekly</td>
</tr>
<tr>
<td>PCP EHR Data</td>
<td>Flat file/Excel</td>
<td>Weekly</td>
</tr>
<tr>
<td>Case Management Data</td>
<td>Flat File/Excel</td>
<td>Weekly</td>
</tr>
</tbody>
</table>
MHN ACO: Driving Health Outcomes by Reducing Social Determinants

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

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

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
Stay connected!

www.ncchca.org/covid-19/

covid19@ncchca.org