NC AHEC

RECRUIT
TRAIN
RETAIN

North Carolina AHEC Practice Support

Presenters

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North Carolina AHEC

The aim is to support practices in the "medical neighborhood" as they transition on the road to value-based care.

Value-based care connects provider payment to the quality, cost and equity of services.

We help practices

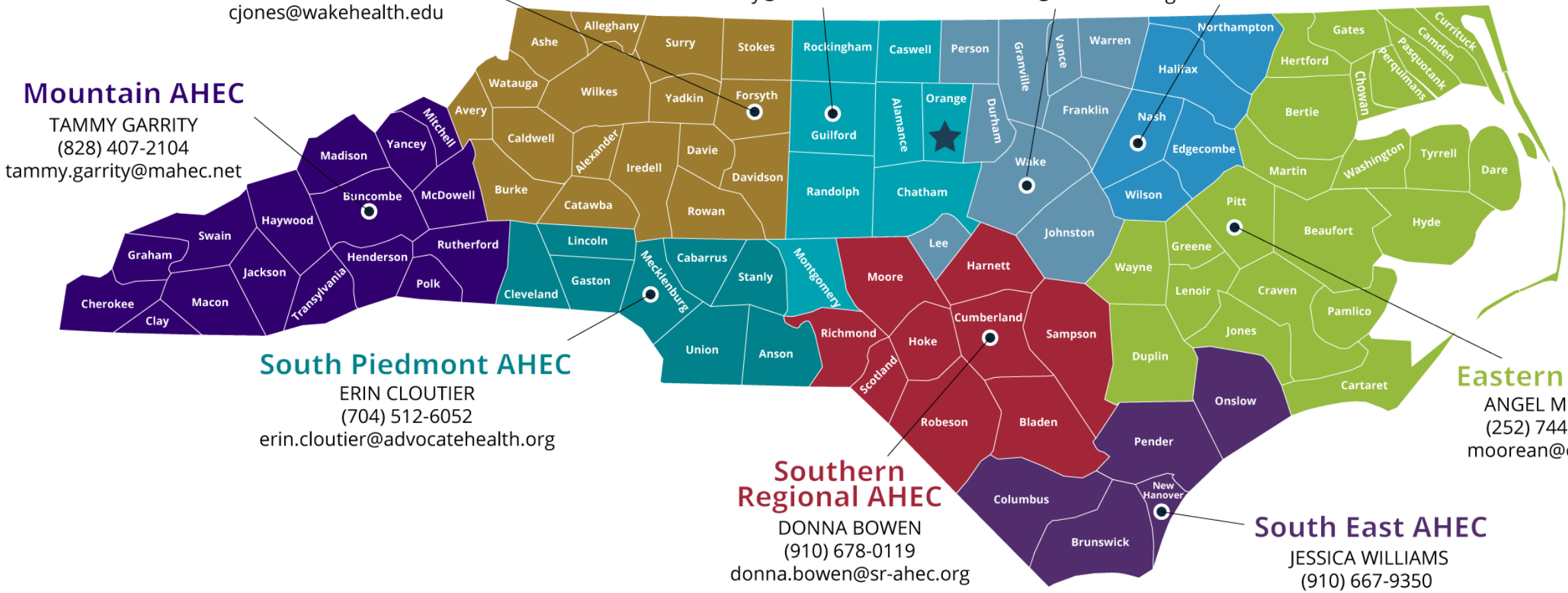
- **stand on their own two feet**
- **maximize performance with FFS and value based care models**
- **have healthier patients**
- **remain economically viable**
- **improve the skills & knowledge of their workforce**

Mission is to recruit, train and retain the state's health workforce.

North Carolina born, trusted and nationally recognized program since 2005.

Coaches work 1:1 with independent primary care practices and specialists, FQHCs, rural health centers, health departments with primary care services, behavioral health providers, and some health system primary care/specialist practices.

NORTH CAROLINA AHEC REGIONAL PRACTICE SUPPORT CONTACTS



NC AHEC PROGRAM OFFICE PRACTICE SUPPORT TEAM

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NC AHEC Practice Support covers 1,072 practices serving 100 counties

Includes FQHCs and Rural Health Clinics!

Partnerships with NCCHCA, NC Office of Rural Health & NC DHHS and Medicaid

Practice Satisfaction Survey 2024 Results

✓ Recommend NC AHEC PS?	**100%**
✓ Satisfied with Quality of Information & Assistance by NC AHEC PS Coach?	**99%**

Practice Support Services

- Quality Improvement (Medicaid, Medicare QPP/MIPS, All Payors)
- Medicaid managed care education & issue resolution
- Clinical workflow redesign & process improvement
- Behavioral health integration (including Collaborative Care Model)
- Financial Health & Human Resources Best Practices
- Operational assessments
- EHR optimization, telehealth integration
- HIE training and optimization
- Revenue cycle management, billing & coding guidance
- Practice Manager Academy
- Advanced Medical Home (AMH) tier education and support
- Tailored Care Management (AMH+/CMA) support
- Community Health Worker integration and training
- Social Drivers of Health Workflow, Healthy Opportunities & NCCARE 360 Optimization
- Virtual Collaboratives & Educational Programming

Practice Support Team

- 42 experienced and knowledgeable practice support coaches in physical and behavioral health across 9 regional teams
- 1 embedded health science librarian and digital library resource
- Clinical Advisor- Dr. Adam Zolotor, Family Physician
- Program Office with expertise in program management, fiscal and contract operations, quality improvement, Medicaid managed care, behavioral health integration, health information technology and communications

Change

How You

Approach

Value-Based

Care

Practice Support Financial Health Scorecard

Why do we need another tool?

You do not. However, consider the benefits of productive analysis and data capture in one place.

- **Customizable for each FQHC and easy to adapt - Excel**
- **Benefit is to have all contracts and related focus areas in one tool to monitor, report and analyze monthly , quarterly or as needed.**
- **Efficient for Board and provider/administrator meetings and through the year budget adjustments.**
- **Helps you prioritize opportunities and do some strategic planning.**
- **All payor or by single payor which useful for situational variations**
- **Great for contracting data negotiations and to “tell your story”.**
- **Added benefit will be with accountant and financial institutions as needed.**
- **Optimize your visit with your NC AHEC Practice Support Coach.**

Sections of the PS Financial Health Scorecard

- **CY MIPS Promoting Interoperability Guide & Scoring Tool** - Note this pertains to Medicare and does not apply to Pediatrics.
- **NCAHEC section** - to promote bi-directional communication and questions before/after visits and maintain practice specific resource.
- **Practice Dashboard** - to monitor monthly all various sections, Financial, Operating Income, AR Aging, Revenue based on patient visits, Claims data and Payor Mix collections in one dashboard.
- **Fiscal Health Worksheet** – Usage is two-fold and allows for comparison of budgeted totals and actual revenue vs costs.
- **Revenue Overview** – Monthly revenue, expenses, AR buckets, claims processed, claims denials and patient visits.

Sections of the Scorecard continued

- **Claims Data** - designed to monitor from clearinghouse, payor and clean claims (unique) level of monthly detail.
- **2025 All Payor Quality Measure** - Easy to use by payor to align your Pediatric Measures relevant to each payor and align with incentives. One place for your incentives and performance tracking using your EHR or can input claims level data if the practice has access based on contract and accessibility on a payor level.
- **CY Calendar Measure Resources** - in one place.
- **Reporting Cadence** -tool and resource based on best practice.

NC AHEC RECRUIT TRAIN RETAIN

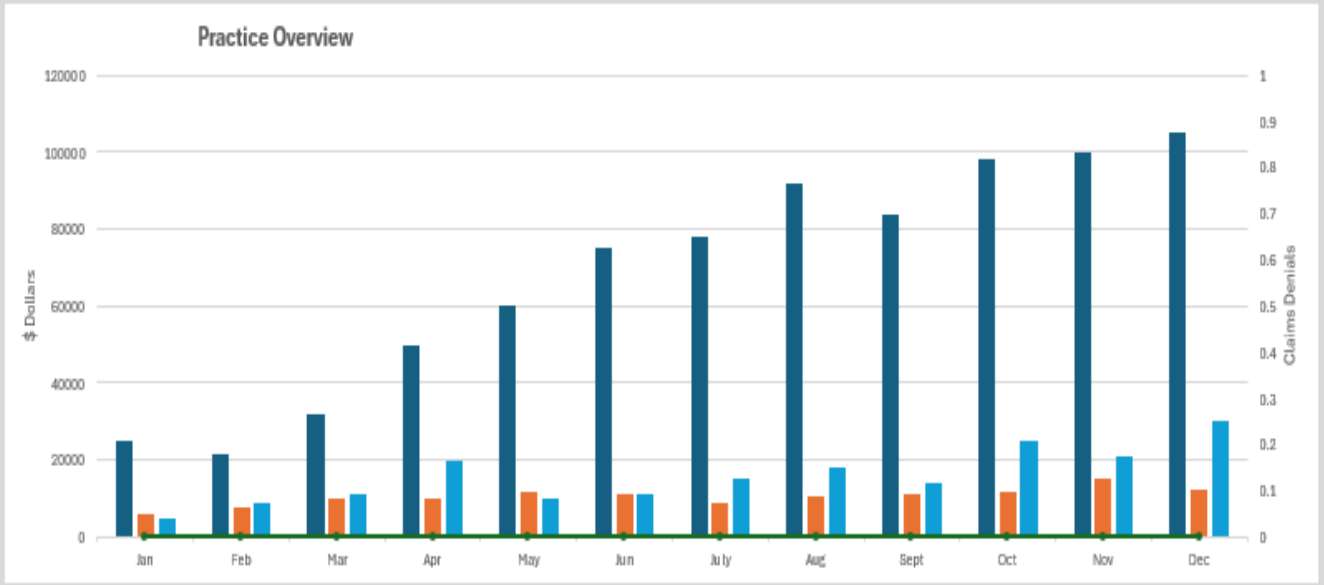
Practice Dashboard

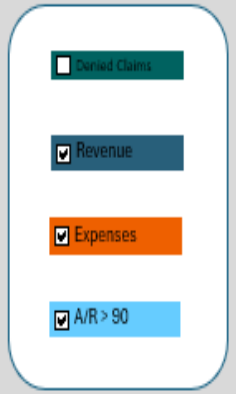
- Dashboard
- Fiscal Health Worksheet
- Revenue
- Payor Mix & Collections
- Reimbursement Analysis
- Front Desk Operations
- Claims Data

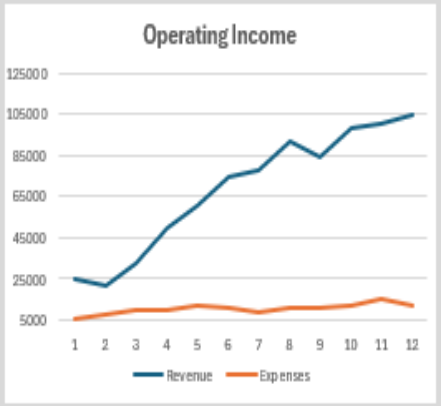
Reference Pages

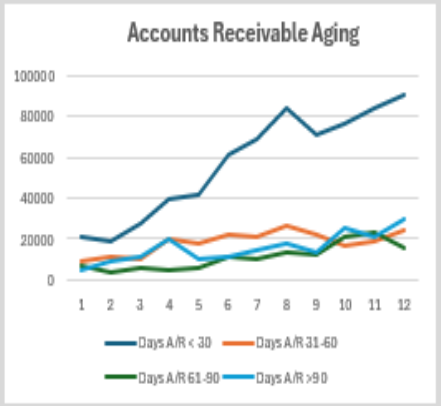
- All-Payor Quality Measures
- CY Quality Measure Resources
- CY MIPS PI Guide & Scoring Tool
- Reporting Cadence

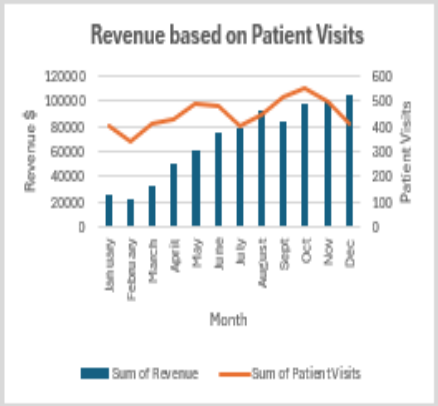
Financial Data











Payor Mix & Collections

Reimbursement Analysis

Front Desk Operations

Claims Data

Reference Pages

All Payer Quality Measures

CY Quality Measure Resources

CY MIPS PI Guide & Scoring Tool

Reporting Cadence

Quality Measure	National Quality Forum Measure Reference	Medicaid AMH Measure Set	2025 State Target	Practice Baseline Performance	Practice Target	Practice YTD Performance	Aledade MSSP	Practice Baseline Performance	Practice Target	Practice YTD Performance	Blue Premier	Practice Baseline Performance	Practice Target	Practice YTD Performance	PHP 1	Practice Baseline Performance	Practice Target	Prac Perf
PEDIATRIC MEASURES																		
Child and Adolescent Well-care Visits (WCV)	NQF 1516	X	54.09%															
Childhood Immunization Status (Combination 10) (CIS)	NQF 0038	X	36.77%															
Immunization for Adolescents (IMA) - Combo 2	NQF 1407	X	31.22%															
Well-child Visits in the First 30 Months of Life (W30)	NQF 1392 - First 15 Months of Life	X	66.72%															
	NQF 1392 - 15-30 Months	X	72.43%															
Chlamydia Screening in Women Ages 16-20	NQF 0033	X	58.88%															
Screening for Depression and Follow-Up Plan (CDF) Ages 12 to 17	NQF 0418	X	N/A															
<Insert Other>																		
ADULT MEASURES																		
Cervical Cancer Screening (CCS)	NQF 0032	X	44.80%															
Chlamydia Screening in Women (Ages 21-24) (CHL)	NQF 0033	X	67.12%															
Chlamydia Screening in Women (Total Rate - All ages) (CHL)	NQF 0033	X	62.48%															
Hemoglobin A1c Control for Patients with Diabetes (HBD)	NQF 0575 - A1c Control (<8%)	X	N/A															
	NQF 0059 - A1c Poor control (>9%)	X	N/A															
Controlling High Blood Pressure (CBP)	NQF 0018	X	52.93%															
Screening for Depression and Follow-Up Plan (CDF) - Ages 18+	NQF 0418/0418e	X	N/A															
Screening for Depression and Follow-Up Plan (CDF) - Total (All Ages)	NQF 0418/0418e	X	N/A															
<Insert Other>																		

Payor Mix & Collections	Quality Measure	Q1 Target	Practice Target	Practice YTD Performance	Availity WellCare	Inovalon UHC CP	NaviNet AmeriHealth Caritas	Vaya	<Inser Pay
Reimbursement Analysis	**PEDIATRIC MEASURES**				**$100**	**$100**	**$40**		
All-Payor Quality Measures	Asthma Medication Ratio		91%						
CY Quality Measure Resources	BMI Percentile				X	X	X		
Reference Pages	BMI Counseling for Nutrition				X	X	X		
All-Payor Quality Measures	BMI Counseling for Physical Activity				X	X	X		
CY Quality Measure Resources	Chlamydia Screening in Women Ages 16-20								
Reporting Cadence	Immunization for Adolescents (IMA) - Combo 10		66%	16%	X		X		
	Immunization for Adolescents (IMA) - Combo 2		46%	10%	X		X		
	Screening for Depression and Follow-Up								

... | Front Desk Admin | Claims Data | 2025 All Payor Quality Measures | Care Gap Submission | CY (...

Supporting FQHCs

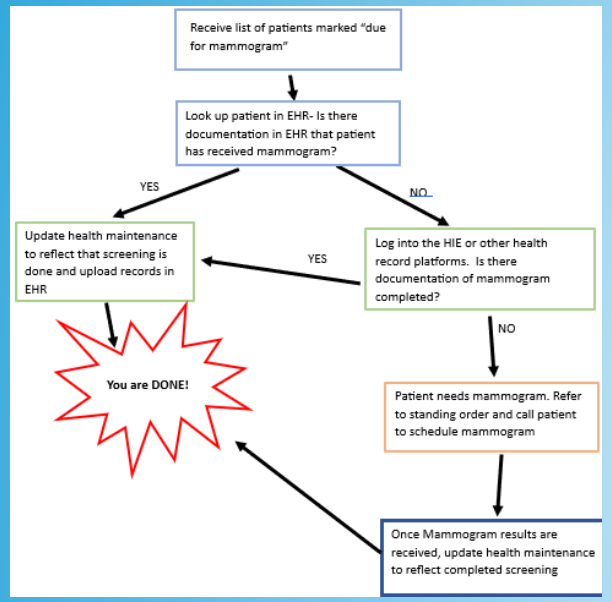
- FQHCs represent the front lines of equitable, community-based care
- FQHC support is unique in that it focuses on a comprehensive scope of services that you all provide—medical, dental, behavioral health, and enabling services
- We also help support the rigorous standards for quality and service to maintain federal HRSA designation

Clinical Quality Improvement Support

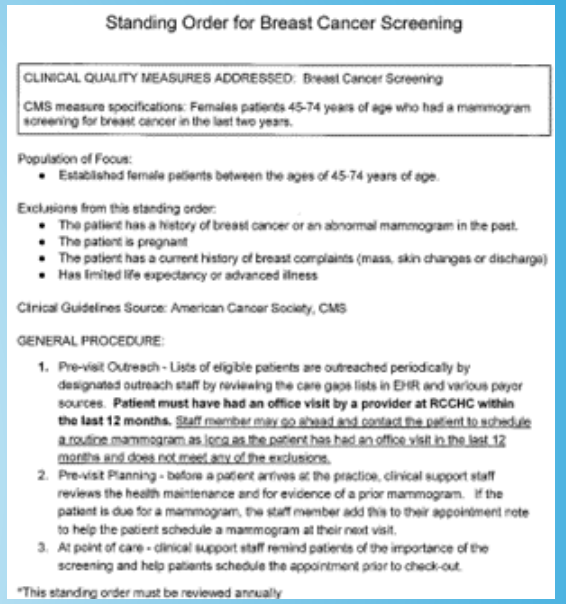
EXAMPLE:

- Large multisite FQHC
- Focusing on 3 sites and 3 priority measures at each site
- Measures focused on: Breast cancer screening, blood pressure control, colorectal cancer screening, and uncontrolled diabetes

Clinical Quality Improvement Support



- Focused staff trainings
- Developed best practice workflows
- Created and provided tip sheets
- Developed standing orders
- Celebrated wins!



Standing Order for Breast Cancer Screening

CLINICAL QUALITY MEASURES ADDRESSED: Breast Cancer Screening

CMS measure specifications: Females patients 45-74 years of age who had a mammogram screening for breast cancer in the last two years.

Population of Focus:
- Established female patients between the ages of 45-74 years of age.

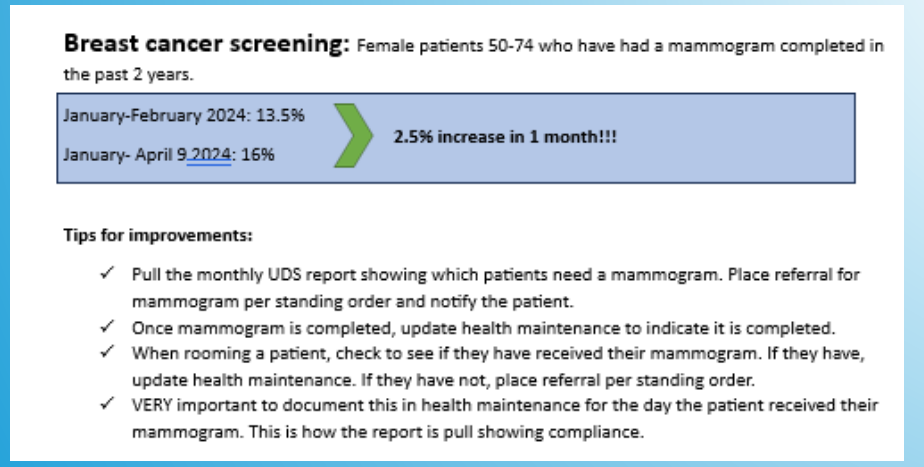
Exclusions from this standing order:
- The patient has a history of breast cancer or an abnormal mammogram in the past.
- The patient is pregnant
- The patient has a current history of breast complaints (mass, skin changes or discharge)
- Has limited life expectancy or advanced illness

Clinical Guidelines Source: American Cancer Society, CMS

GENERAL PROCEDURE:

1. Pre-visit Outreach - Lists of eligible patients are outreached periodically by designated outreach staff by reviewing the care gaps lists in EHR and various payor sources. **Patient must have had an office visit by a provider at RCCHC within the last 12 months.** Staff member may go ahead and contact the patient to schedule a routine mammogram as long as the patient has had an office visit in the last 12 months and does not meet any of the exclusions.
2. Pre-visit Planning - before a patient arrives at the practice, clinical support staff reviews the health maintenance and for evidence of a prior mammogram. If the patient is due for a mammogram, the staff member add this to their appointment note to help the patient schedule a mammogram at their next visit.
3. At point of care - clinical support staff remind patients of the importance of the screening and help patients schedule the appointment prior to check-out.

*This standing order must be reviewed annually



Breast cancer screening: Female patients 50-74 who have had a mammogram completed in the past 2 years.

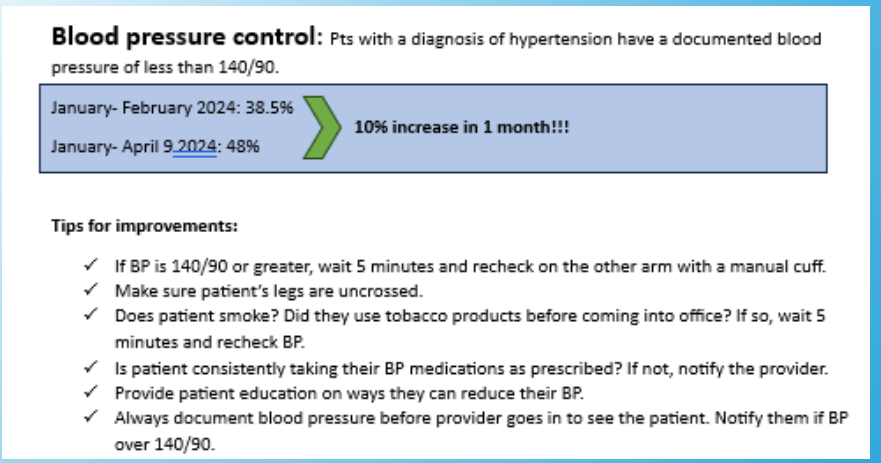
January-February 2024: 13.5%

January- April 9 2024: 16%

2.5% increase in 1 month!!!

Tips for improvements:

- ✓ Pull the monthly UDS report showing which patients need a mammogram. Place referral for mammogram per standing order and notify the patient.
- ✓ Once mammogram is completed, update health maintenance to indicate it is completed.
- ✓ When rooming a patient, check to see if they have received their mammogram. If they have, update health maintenance. If they have not, place referral per standing order.
- ✓ VERY important to document this in health maintenance for the day the patient received their mammogram. This is how the report is pull showing compliance.



Blood pressure control: Pts with a diagnosis of hypertension have a documented blood pressure of less than 140/90.

January- February 2024: 38.5%

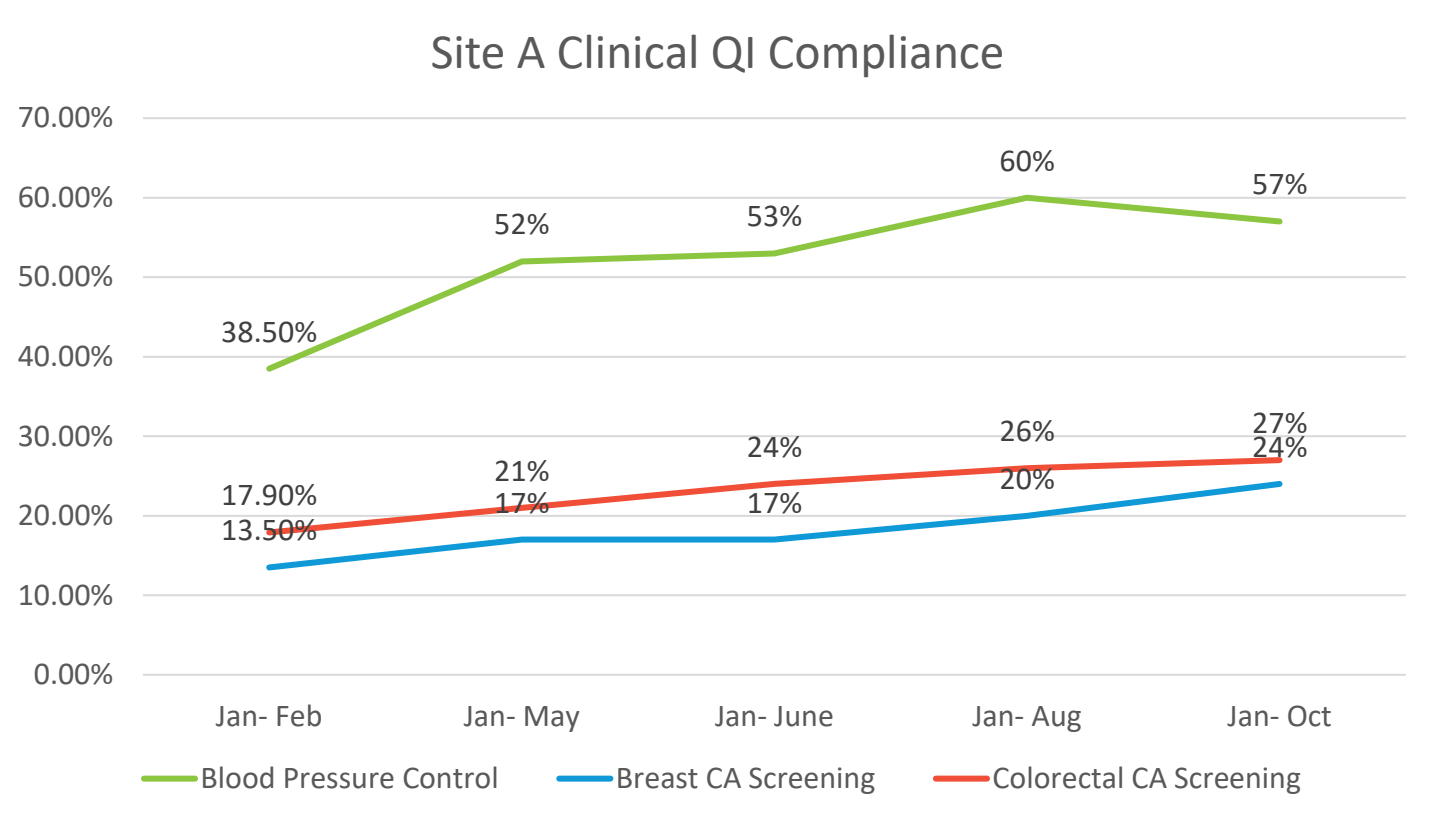
January- April 9 2024: 48%

10% increase in 1 month!!!

Tips for improvements:

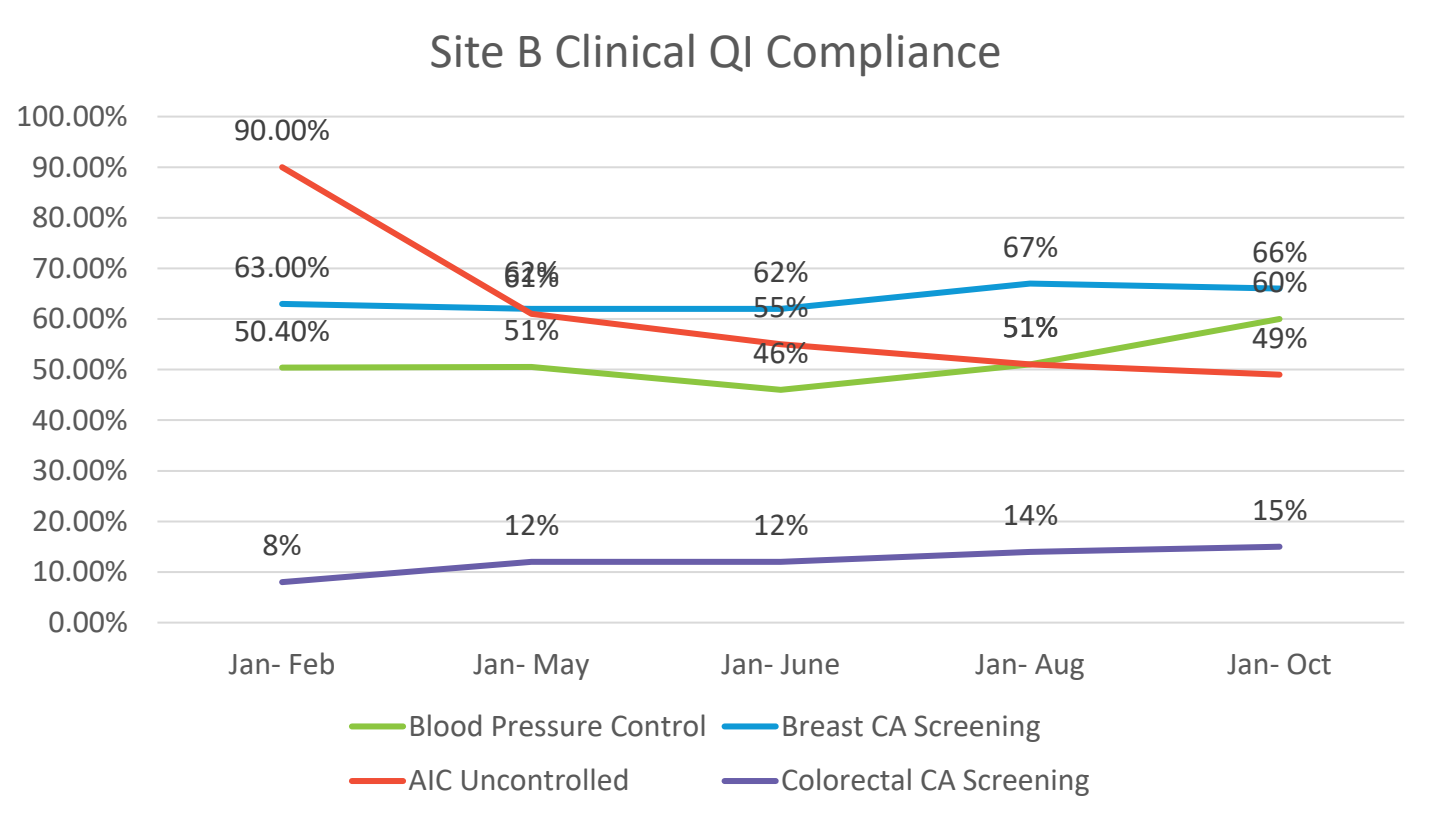
- ✓ If BP is 140/90 or greater, wait 5 minutes and recheck on the other arm with a manual cuff.
- ✓ Make sure patient's legs are uncrossed.
- ✓ Does patient smoke? Did they use tobacco products before coming into office? If so, wait 5 minutes and recheck BP.
- ✓ Is patient consistently taking their BP medications as prescribed? If not, notify the provider.
- ✓ Provide patient education on ways they can reduce their BP.
- ✓ Always document blood pressure before provider goes in to see the patient. Notify them if BP over 140/90.

Clinical Quality Improvement Support



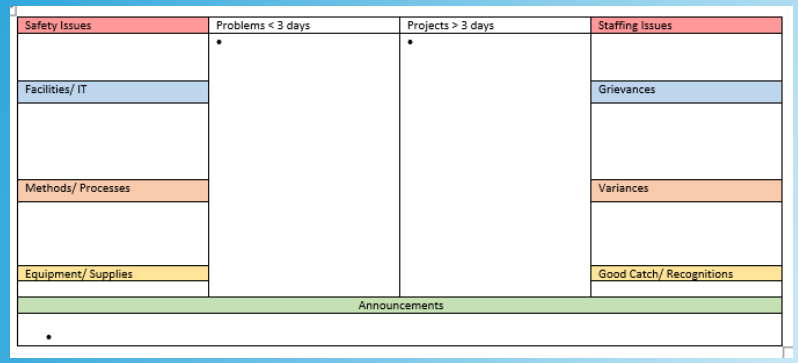
- **48% increase in Blood Pressure Control**
- **50% increase in Colorectal Cancer Screening**
- **78% increase in Breast Cancer Screening**

Clinical Quality Improvement Support



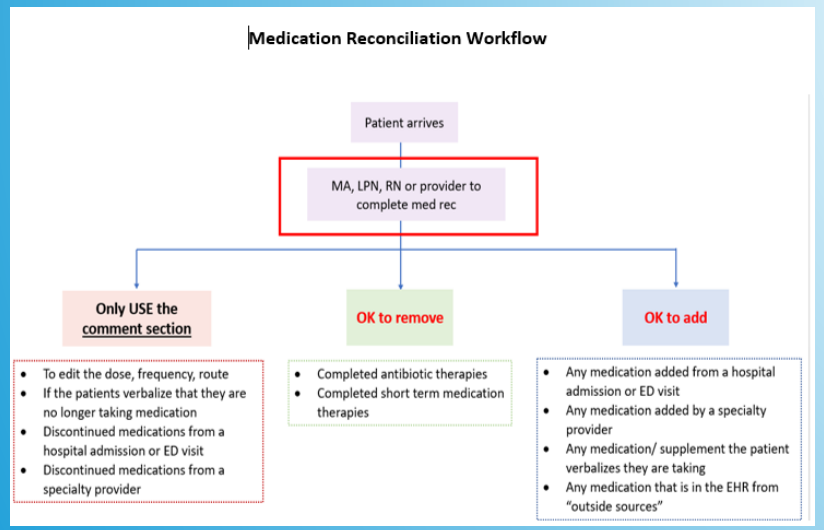
- **20% increase in Blood Pressure Control**
- **88% increase in Colorectal Cancer Screening**
- **5% increase in Breast Cancer Screening**
- **84% decrease in uncontrolled AIC**

Operational/ Workflow Support



Safety Issues	Problems < 3 days	Projects > 3 days	Staffing Issues
	•	•	
Facilities/ IT			Grievances
Methods/ Processes			Variances
Equipment/ Supplies			Good Catch/ Recognitions
Announcements			
•			

- Previsit planning workflows
- Organizational huddle implementation
- Developing workflows
- Practice Assessments



Medication Reconciliation Workflow

Patient arrives

MA, LPN, RN or provider to complete med rec

Only USE the comment section

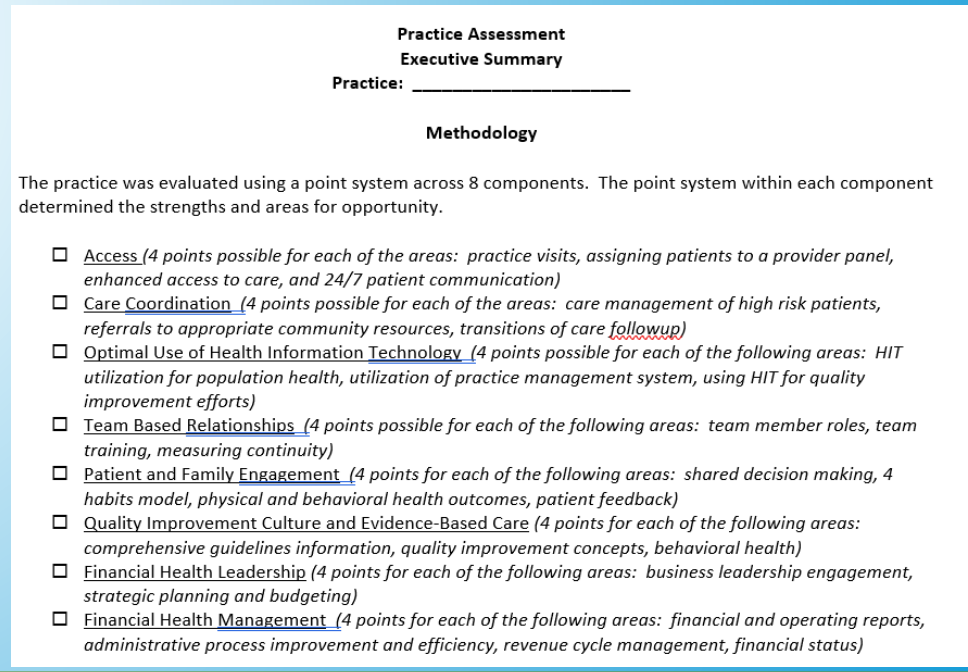
- To edit the dose, frequency, route
- If the patients verbalize that they are no longer taking medication
- Discontinued medications from a hospital admission or ED visit
- Discontinued medications from a specialty provider

OK to remove

- Completed antibiotic therapies
- Completed short term medication therapies

OK to add

- Any medication added from a hospital admission or ED visit
- Any medication added by a specialty provider
- Any medication/ supplement the patient verbalizes they are taking
- Any medication that is in the EHR from "outside sources"



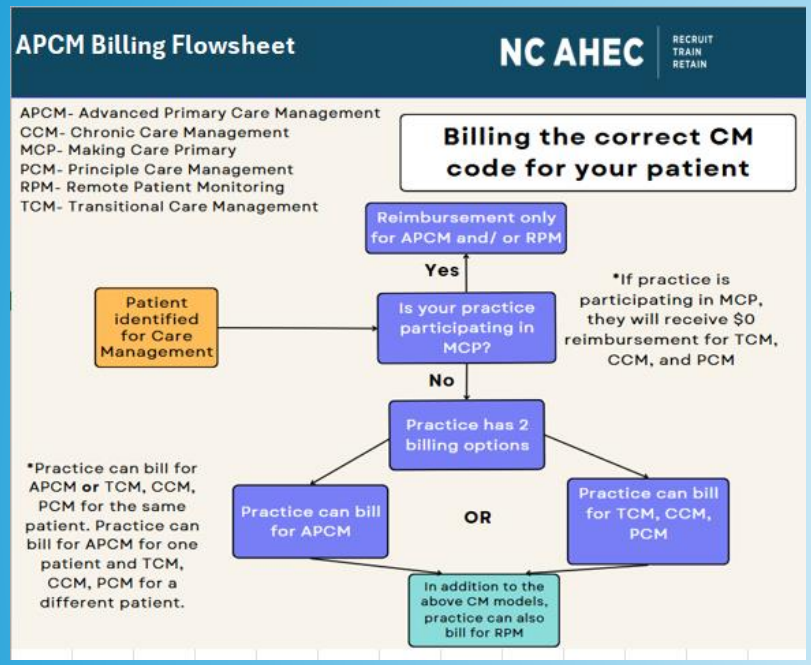
Practice Assessment
Executive Summary
Practice: _____

Methodology

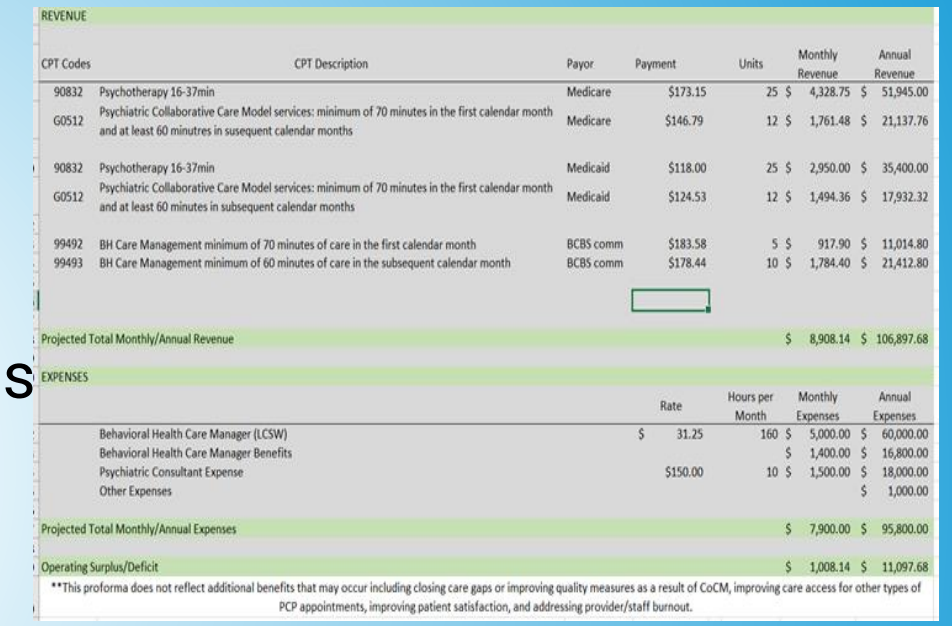
The practice was evaluated using a point system across 8 components. The point system within each component determined the strengths and areas for opportunity.

- ☐ Access *(4 points possible for each of the areas: practice visits, assigning patients to a provider panel, enhanced access to care, and 24/7 patient communication)*
- ☐ Care Coordination *(4 points possible for each of the areas: care management of high risk patients, referrals to appropriate community resources, transitions of care followup)*
- ☐ Optimal Use of Health Information Technology *(4 points possible for each of the following areas: HIT utilization for population health, utilization of practice management system, using HIT for quality improvement efforts)*
- ☐ Team Based Relationships *(4 points possible for each of the following areas: team member roles, team training, measuring continuity)*
- ☐ Patient and Family Engagement *(4 points for each of the following areas: shared decision making, 4 habits model, physical and behavioral health outcomes, patient feedback)*
- ☐ Quality Improvement Culture and Evidence-Based Care *(4 points for each of the following areas: comprehensive guidelines information, quality improvement concepts, behavioral health)*
- ☐ Financial Health Leadership *(4 points for each of the following areas: business leadership engagement, strategic planning and budgeting)*
- ☐ Financial Health Management *(4 points for each of the following areas: financial and operating reports, administrative process improvement and efficiency, revenue cycle management, financial status)*

Financial Analysis Support



- Financial proformas
- Cost/benefit analysis
- Billing flow sheets
- All specialized for FQHCs



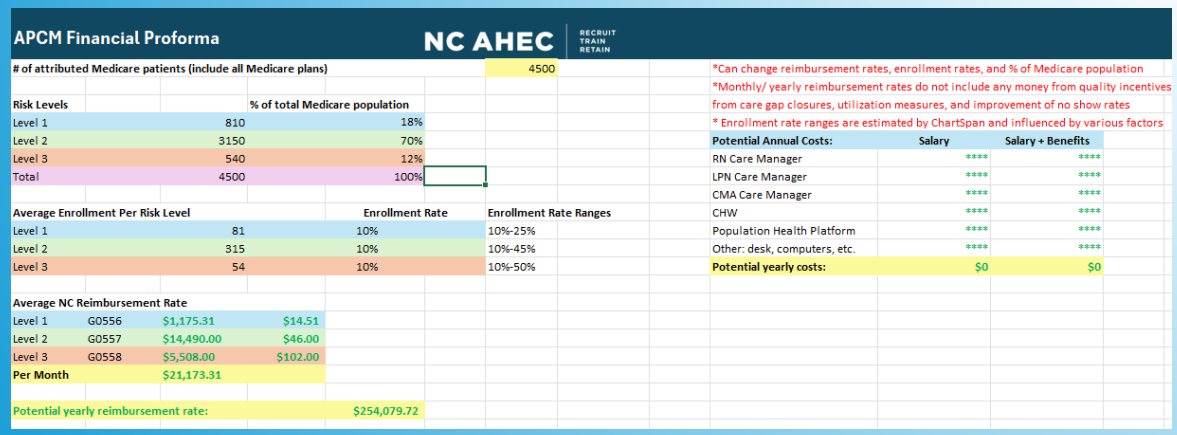
REVENUE

CPT Codes	CPT Description	Payor	Payment	Units	Monthly Revenue	Annual Revenue
90832	Psychotherapy 16-37min	Medicare	$173.15	25	$ 4,328.75	$ 51,945.00
G0512	Psychiatric Collaborative Care Model services: minimum of 70 minutes in the first calendar month and at least 60 minutres in susequent calendar months	Medicare	$146.79	12	$ 1,761.48	$ 21,137.76
90832	Psychotherapy 16-37min	Medicaid	$118.00	25	$ 2,950.00	$ 35,400.00
G0512	Psychiatric Collaborative Care Model services: minimum of 70 minutes in the first calendar month and at least 60 minutes in subsequent calendar months	Medicaid	$124.53	12	$ 1,494.36	$ 17,932.32
99492	BH Care Management minimum of 70 minutes of care in the first calendar month	BCBS comm	$183.58	5	$ 917.90	$ 11,014.80
99493	BH Care Management minimum of 60 minutes of care in the subsequent calendar month	BCBS comm	$178.44	10	$ 1,784.40	$ 21,412.80
	Projected Total Monthly/Annual Revenue				$ 8,908.14	$ 106,897.68

EXPENSES

	Rate	Hours per Month	Monthly Expenses	Annual Expenses
Behavioral Health Care Manager (LCSW)	$ 31.25	160	$ 5,000.00	$ 60,000.00
Behavioral Health Care Manager Benefits			$ 1,400.00	$ 16,800.00
Psychiatric Consultant Expense	$150.00	10	$ 1,500.00	$ 18,000.00
Other Expenses				$ 1,000.00
Projected Total Monthly/Annual Expenses			$ 7,900.00	$ 95,800.00
Operating Surplus/Deficit			$ 1,008.14	$ 11,097.68

**This proforma does not reflect additional benefits that may occur including closing care gaps or improving quality measures as a result of CoCM, improving care access for other types of PCP appointments, improving patient satisfaction, and addressing provider/staff burnout.



APCM Financial Proforma — NC AHEC — RECRUIT TRAIN RETAIN

# of attributed Medicare patients (include all Medicare plans)	4500

*Can change reimbursement rates, enrollment rates, and % of Medicare population
*Monthly/ yearly reimbursement rates do not include any money from quality incentives from care gap closures, utilization measures, and improvement of no show rates
* Enrollment rate ranges are estimated by ChartSpan and influenced by various factors

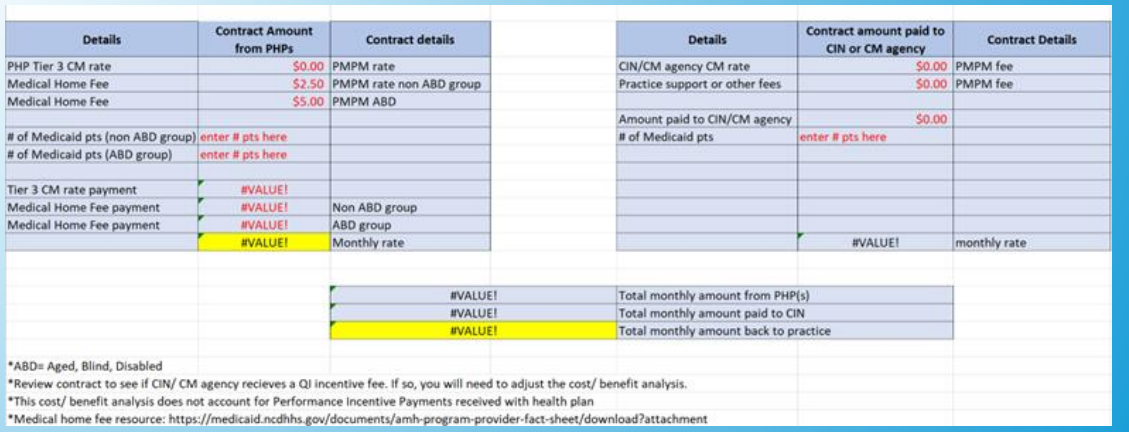
Risk Levels		% of total Medicare population
Level 1	810	18%
Level 2	3150	70%
Level 3	540	12%
Total	4500	100%

Average Enrollment Per Risk Level		Enrollment Rate	Enrollment Rate Ranges
Level 1	81	10%	10%-25%
Level 2	315	10%	10%-45%
Level 3	54	10%	10%-50%

Potential Annual Costs:	Salary	Salary + Benefits
RN Care Manager	****	****
LPN Care Manager	****	****
CMA Care Manager	****	****
CHW	****	****
Population Health Platform	****	****
Other: desk, computers, etc.	****	****
Potential yearly costs:	$0	$0

Average NC Reimbursement Rate			
Level 1	G0556	$1,175.31	$14.51
Level 2	G0557	$14,490.00	$46.00
Level 3	G0558	$5,508.00	$102.00
Per Month		$21,173.31	

Potential yearly reimbursement rate: $254,079.72



Details	Contract Amount from PHPs	Contract details
PHP Tier 3 CM rate	$0.00	PMPM rate
Medical Home Fee	$2.50	PMPM rate non ABD group
Medical Home Fee	$5.00	PMPM ABD
# of Medicaid pts (non ABD group)	enter # pts here	
# of Medicaid pts (ABD group)	enter # pts here	
Tier 3 CM rate payment	#VALUE!	
Medical Home Fee payment	#VALUE!	Non ABD group
Medical Home Fee payment	#VALUE!	ABD group
	#VALUE!	Monthly rate

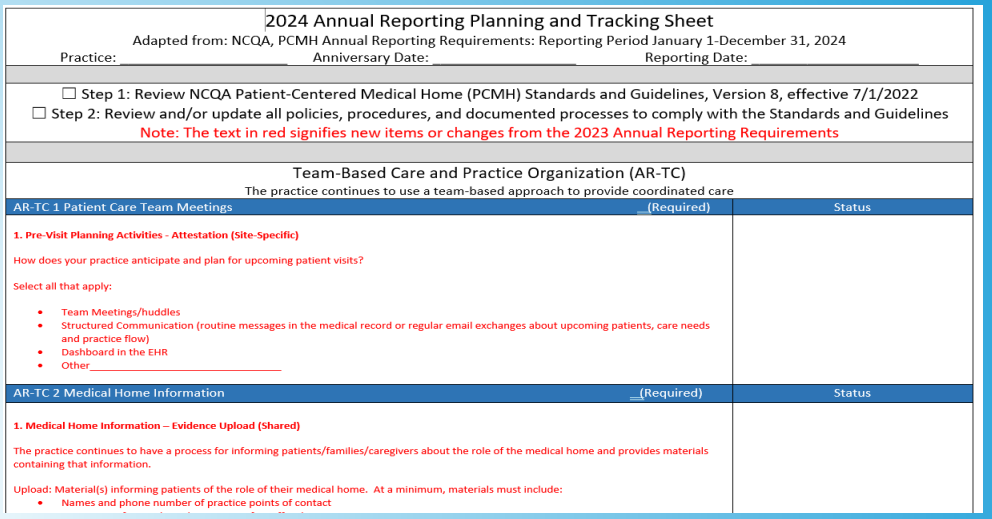
Details	Contract amount paid to CIN or CM agency	Contract Details
CIN/CM agency CM rate	$0.00	PMPM fee
Practice support or other fees	$0.00	PMPM fee
Amount paid to CIN/CM agency	$0.00	
# of Medicaid pts	enter # pts here	
	#VALUE!	monthly rate

#VALUE!	Total monthly amount from PHP(s)
#VALUE!	Total monthly amount paid to CIN
#VALUE!	Total monthly amount back to practice

*ABD= Aged, Blind, Disabled
*Review contract to see if CIN/ CM agency recieves a QI incentive fee. If so, you will need to adjust the cost/ benefit analysis.
*This cost/ benefit analysis does not account for Performance Incentive Payments received with health plan
*Medical home fee resource: https://medicaid.ncdhhs.gov/documents/amh-program-provider-fact-sheet/download?attachment

Regulatory Support

- **PCMH**
  - Initial transformation and annual reporting
- **HRSA OSV**
- **Safety/ Infection Control Audits and Support**
- **Emergency Preparedness Preparation**
  - Emergency plans
  - Policies and procedures
- **UDS Reporting Support**



2024 Annual Reporting Planning and Tracking Sheet

Adapted from: NCQA, PCMH Annual Reporting Requirements: Reporting Period January 1-December 31, 2024

Practice: _____ Anniversary Date: _____ Reporting Date: _____

☐ Step 1: Review NCQA Patient-Centered Medical Home (PCMH) Standards and Guidelines, Version 8, effective 7/1/2022

☐ Step 2: Review and/or update all policies, procedures, and documented processes to comply with the Standards and Guidelines

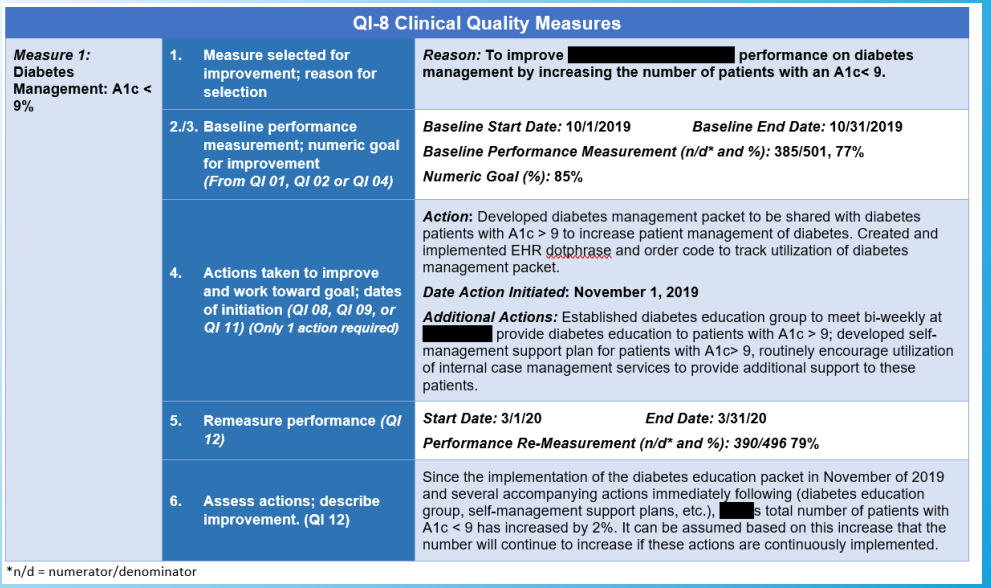
Note: The text in red signifies new items or changes from the 2023 Annual Reporting Requirements

Team-Based Care and Practice Organization (AR-TC)

The practice continues to use a team-based approach to provide coordinated care

AR-TC 1 Patient Care Team Meetings (Required)	Status
1. Pre-Visit Planning Activities - Attestation (Site-Specific) How does your practice anticipate and plan for upcoming patient visits? Select all that apply: • Team Meetings/huddles • Structured Communication (routine messages in the medical record or regular email exchanges about upcoming patients, care needs and practice flow) • Dashboard in the EHR • Other_____	

AR-TC 2 Medical Home Information (Required)	Status
1. Medical Home Information – Evidence Upload (Shared) The practice continues to have a process for informing patients/families/caregivers about the role of the medical home and provides materials containing that information. Upload: Material(s) informing patients of the role of their medical home. At a minimum, materials must include: • Names and phone number of practice points of contact	



QI-8 Clinical Quality Measures

Measure 1: **Diabetes Management: A1c < 9%**	**1. Measure selected for improvement; reason for selection**	***Reason:*** **To improve [redacted] performance on diabetes management by increasing the number of patients with an A1c< 9.**
	2./3. Baseline performance measurement; numeric goal for improvement ***(From QI 01, QI 02 or QI 04)***	***Baseline Start Date:*** **10/1/2019** ***Baseline End Date:*** **10/31/2019** ***Baseline Performance Measurement (n/d* and %):*** **385/501, 77%** ***Numeric Goal (%):*** **85%**
	4. Actions taken to improve and work toward goal; dates of initiation ***(QI 08, QI 09, or QI 11) (Only 1 action required)***	***Action*****:** Developed diabetes management packet to be shared with diabetes patients with A1c > 9 to increase patient management of diabetes. Created and implemented EHR dotphrase and order code to track utilization of diabetes management packet. ***Date Action Initiated*****: November 1, 2019** ***Additional Actions:*** Established diabetes education group to meet bi-weekly at [redacted] provide diabetes education to patients with A1c > 9; developed self-management support plan for patients with A1c> 9, routinely encourage utilization of internal case management services to provide additional support to these patients.
	5. Remeasure performance ***(QI 12)***	***Start Date:*** **3/1/20** ***End Date:*** **3/31/20** ***Performance Re-Measurement (n/d* and %): 390/496*** **79%**
	6. Assess actions; describe improvement. (QI 12)	Since the implementation of the diabetes education packet in November of 2019 and several accompanying actions immediately following (diabetes education group, self-management support plans, etc.), [redacted]s total number of patients with A1c < 9 has increased by 2%. It can be assumed based on this increase that the number will continue to increase if these actions are continuously implemented.

*n/d = numerator/denominator

Continuing Professional Development Offerings within Practice Support

- Safe Vaccine Administration for Pediatric Patients: Best Practices, Guidelines, and Safety Measures
- CME credits for monthly provider meetings
- Motivational Interviewing offered with nursing and CME credits
- Medicaid Managed Care education for care management staff
- Quality Improvement basics for leadership staff
- QI Course within virtual Practice Manager Academy Bootcamp

Questions & Discussion

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