

AMH Tier 3: High-Need Care Management
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Dr. Nancy Henley

(Slide 1) This is Dr. Nancy Henley. I'm the chief medical officer for North Carolina Medicaid. Thank you for joining today's webinar AMH Tier 3 High-Need Care Management. This is our sixth in our series of training focused on Advanced Medical Homes or AMH, which will launch when North Carolina transitions its Medicaid program from a fee-for-service structure to managed care beginning of November of 2019. This webinar is the second of three focused specifically on AMH Tier 3. AMH Tier provides an opportunity for primary care practices participating in North Carolina Medicaid to establish a uniformed local care management platform by taking on additional management responsibilities at the practice level. In return, Tier 3 practices may receive additional payments from prepaid health plans or PHPs. As we discussed in the last webinar, AMHs will be required to risk stratify their empaneled patients and deliver ongoing care management to those categories as "high-need." Today, we will focus on the requirements of AMH Tier 3 around delivering care management to these patients. I'll talk through what these will look like for practices on the ground.

For today's presentation, I will be joined by Dr. Carrier. Dr. Carrier is a senior manager with Manatt Health, the State's technical assistance provider for Medicaid transformation. Dr. Carrier is physician and has over 15 years of experience including direct patient care, policy research in developing new payment and delivery model during her time in the centers for Medicare and Medicaid services. If you wish to see additional background of AMH program, we encourage you to visit the AMH webpage on the DHHS website which contains slide decks and recordings from previous webinars, the AMH provider manual, FAQs, information on future training and other resources. The AMH webpage is linked in the back of this presentation and you can also just google it, DHHS Advanced Medical Home.

(Slide 2) Slide 2 has our agenda for today, so I'll walk through that quickly for you. We'll start with a brief of high level overview of North Carolina's Medicaid transformation and AMHs program generally and talk a bit about why one of the department designed the program in this way and its goals for the program then I'll turn it over to Dr. Carrier, who will walk through AMHs requirements around high-need care management. This will include a discussion of care management staffing requirements, as well as other requirements relating to developing care plans, monitoring admission, discharge and transfer data and coordinating with other care management programs. Dr. Carrier will then conclude with a few real life examples, which will show several scenarios from which AMHs would be expected to provide care management to Medicaid enrollees. Time permitting, we will follow this up with some Q&A. We encourage you to enter your questions in the Q&A box at the bottom right of your screen. You can do this at any time. We will conclude with some key next steps and direct you to other training resources that may be of interest.

(Slide 3) Our next section looks at care management through the AMH program. For those of you who have been on other webinars, this will look very familiar, but we want to give a high-level overview for those who may be here for the first time.

(Slide 4) On slide 4, we'll consider what is care management, so our definition here that care management is team-based person-centered approach to effectively managing patients' medical, social, and behavioral needs. The goal of care management is to ensure that patients are receiving the right care at the right place at the right time. Robust care management includes a range of different activities. These include development of comprehensive assessment, care plans and the deployment of prevention and population health programs. Second, management of enrollee needs during transitions of care as well as those with rare diseases or high-cost procedures. And, last care management for care management for special populations, including individuals at high-risk and those that require chronic care. To remind you how AMH fits in with all this, AMHs are designed to serve as the primary vehicle for robust, local care management in the State's managed care transition. The State recognizes that many of these features already exists in Carolina Access, the State's current primary care case management program. AMH intends to leverage the existing Carolina Access infrastructure and build on its successes going forward.

(Slide 5) Moving on to slide 5, the State has also strongly encouraging the provision of care management at the local level. The reason for this is that there is a significant body of evidence that patients prefer that care management be delivered locally using caregivers they know and trust and that these type of programs lead to better outcomes. In keeping with this, under managed care, PHPs must ensure a robust system of local care management that is performed at the site of care, in the home or in the community with face-to-face interaction, wherever possible.

So what are PHP requirements around local care management? PHPs must have an established system of local care management through AMHs, Local Health Departments (LHDs) as well as care management provided by the PHP that delivers high quality care. That is to say, if the care needed cannot be delivered by the AMH or the local health department then it is the PHPs responsibility to deliver that care management. PHPs will be required to submit a "local Care Management plan." This will include the plan approach for identifying high-need members, the approach for ensuring local care management and the PHPs plan for working for AMHs, local health departments and other entities performing care management. PHPs can delegate care management responsibilities to AMHs Tier 3 practices, but are ultimately responsible for ensuring that members receive needed services. Finally, as Medicaid enrollees receive care management from more than one entity, the PHP must ensure that Care Plans document the roles and responsibilities of all local care managers in order to avoid duplication. So if a patient has been flagged as needing care management through both an AMH and through one of the State's local health department programs, it is the responsibility of PHP to ensure that roles and responsibilities are clear. For example if a woman whose had significant diabetes and hypertension becomes pregnant, she may need management under the pregnancy care management in the local health department and need to continue care management through

her AMH. In order to ensure that PHPs are providing truly local care management to Medicaid enrollees, the State will require standard contract terms and PHP contracts with AMHs. It also plans to conduct ongoing monitoring to ensure that PHPs are complying with their local management plan.

One final note here is that the AMH program is intended as a minimum initial framework and PHPs and practices are encouraged to innovate around payment and delivery models to support local care management in ways that go beyond minimum requirements.

(Side 6) Moving to slide 6, Care Management Approach Tier 3. Some of you may have seen this slide before. It's really the foundation slide for us in discussing this. This slide provides an overview of the universe of care management functions that the State envisions under managed care. It shows how the State will ensure that high-need individuals and those transitioning out of the hospital will receive appropriate local care management. I will briefly walk through this to provide context for today's discussion. The care management process you see in this diagram is divided into three separate categories. The yellow arrows are functions that will generally be formed by the PHP. Blue boxes will generally be performed by the Tier 3 AMH and the crosshatched boxes will be shared responsibilities between the PHP and the AMH. The top row of this diagram displays the process for flagging high-need individuals and routing them to appropriate care management. We focus on this session in our last presentation, but I will briefly recap the key elements.

The first component in the top left is the care needs screening, which will generally be done by the PHP within 90 days and we'll screen for things like chronic and acute conditions, behavior health needs, medications and unmet health related resources needs.

The second component is risk scoring and stratification. This will generally involve each PHP using proprietary methodology to assign a risk score to each member. This data will then be transmitted to Tier 3 AMHs or to their CIN. Tier AMHs will then be required to take in this information and use it to stratify their patient panel.

The third is comprehensive assessment. This is a more in-depth person-centered assessment of a beneficiary health and non-health related needs. These will only be performed on individuals that are identified by the practice base risk stratification as having high-needs.

And, finally this leads to the actual development of care management for patients identified as high-needs. This step is what we will focus on for the majority of today's presentation. Simultaneously, with the top row, there is a set of ongoing care management and related pathways for individuals that are not identified as high-need by practice based risk stratification. You'll find those toward the middle of the slide. We will not focus on these today, but they are important and they are as follows: transitional care management for individuals who are discharged for in-patients stays or the emergency room. General care coordination for all patients that are between different care settings and various preventative and population health management efforts.

(Side 7) Moving to slide 7, we will look at the type of care management to be performed by Tier 3 AMHs. The AMH model envisions two different approaches of care management. These include care management for high-need enrollees and transitional care management. Care management for high-need enrollees is only for patients identified as high-need by the PHPs care needs screening risk score or the AMH risk stratification. High-need care management is characterized by longitudinal, ongoing care management and it is guided by the care plan, but we'll talk about this in greater depth on subsequent slides, but the care plan is intended to identify key patient needs and interventions to address those needs. The other type of care management under AMH is transitional care management. This type of care management should be available to all empaneled patients who have an emergency department visit or who are discharged from hospitals or other in-patient settings and who are at risk for readmission or other poor outcomes. Traditional care management is characterized by short term care management coupled with medication management.

One key note here is that these types of care management have different requirements under the AMH program. Today's presentation will focus only on high-need care management, but we will spend time on our next webinar discussing transitional care management. I'm going to turn it over to Dr. Emily Carrier who will walk us through the high-need care management requirements. Thank you Dr. Carrier.

Dr. Emily Carrier

(Slide 8) Thanks Dr. Henley. So I'm moving forward to slide 8 for those who are following outside the webinar. So, we're going to talk about staffing requirements for high-need care management and we know that everyone is going to have specific situations that they might have questions about. The goal of these next couple of slides is to provide some sort of high-level principles that can kind of get you acquainted with the general thinking and then if you have very detailed questions about particular individuals, you're welcome to reach out.

So the goal—and this is something Dr. Henley mentioned and we'll keep mentioning again and in subsequent presentations because we think it's really important—is to provide as much care management as we can locally understanding that every practice is going to have different challenges in terms of local care management and we want to give some flexibility to make sure that people can implement that local concept and that it makes sense to them.

(Slide 9) So I'm moving ahead to slide 9, let's talk about the care manager training and qualifications. So who are we talking about for these teams? So for every high-need patient, the Tier 3 AMHs are expected to assign a care manager who really has accountability for that patient and again, the care management we're talking about is the ongoing care management that Dr. Henley mentioned from an earlier slide, not the transitional care management that might be over after a needed visit. So this would be a care manager who really has an ongoing relationship with them and thinks holistically about them beyond their immediate medical needs and each high-need patient needs to be assigned a care manager with a minimum credential of RN or LCSW and that means that's the person who should be leading and overseeing the care manager process and you've had questions in the past and there are

probably other questions that there now about this specific subsets of some of these requirements of some of these licensures. The general sort of theme to follow on here is that since this person is going to be leading the care management process and potentially overseeing others, we would expect this person to have kind of the full version of their credentials rather than being someone who is still in training before they can work independently and supervised. There are some social work designations that are kind of training designations. There are other non-licensed staff. Those individuals would be welcomed to participate in the delivery of care management, but we would think that they probably wouldn't be the people to lead the care team and in particular, there are some elements of the care management visits that have the care management interaction in particularly the very specific assessment that have more clinical aspects. For example, medication reconciliations that may happen either initially or after a Tier 3 transition and we would really like to have those local license fully credential staff members to be able to weigh in there.

So the comprehensive assessment, which is one of those times, can be performed as part of a clinician's visit. So if the lead clinician, an LCSW or an RN whose seeing the patient as part of their regular medical care would like to lead the comprehensive assessment, they can do that or can also be led separately by the care management team—again led by a clinician with the minimum credential of the RN or LCSW. The additional staff that may participate on the care management team can definitely participate in other tasks, both in terms of the less clinical parts of the comprehensive assessment or also there are many other things as you know that needs to be done in care management, scheduling after-care appointments, conducting follow-up outreach after a discharge, things like that. There just needs to be a care manager with those minimum credentials who is accountable for the patient and understands what's going on and is regularly informed by the team.

So, we've been talking a lot about locality and care management. What does that mean? We don't think it means that care managers need to be physical embedded at a practice location, you know, physically present full time in the practice. We understand that it is sort of challenging and it doesn't necessarily meet the most efficient use of care manager time, but we do think that as much care management as possible needs to be local. There's good literature to suggest that local care management and lots of face-to-face interaction is more effective and yield better results and also patients like it more, which is important. So, we think generally that the care manager has to allow as much face-to-face interaction with patients as possible, understanding that this might not involve being physically present at a practice all the time. We are happy to sort of take questions about that. These expectations is that practices will each need to interpret that in their own way, understanding their specific challenges in terms of their location and the needs of the patients that they serve.

(Slide 10) So moving onto slide 10 now. This is talking about the care team. So we talked about the care manager leader and how they would fit in. They would be part of multi-disciplinary care team and this is a list of people who could be care team members. This is definitely not a minimum set of care team members. These are just the kinds of people who could be included in the care team. We do expect obviously that the patient should be on the care team to the

extent that they have a caretaker or a legal guardian. It should be on the care manager and care coordinator and the primary care provider and then other folks who will need to be on the team—really depend on the patient’s needs and we understand that not every practice could employ someone like this. You know, on a full or even part time basis, but we do hope that practices would do their best to sort of tailor the construction of each patient’s care team to their specific needs. So, you know, even if you can’t access a nutritionist full time if you have a patient with diabetes and food insecurities for whom managing their diet is really the primary challenges keeping them from the health that they want. This might be a chance for a care manager to try to do some outreach, engaged with a partner and have access to someone who could join that care team and support that patient and we encourage practices to think about partners and CINs who could help them access additional resources for enhancing their care management and addressing those non-medical needs. We don’t expect that any single professional could tackle all the challenges of a high-needs patient.

(Slides 11 and 12) So let’s move on to the next slide. We have our care team in place. Now let’s talk about delivering that high-need care management. And, again just as a reminder to orient folks. This is not something that all of your patients will need. This is really for patients who have been identified as high-need through the AMH risk stratification, which is what we talked about on our last webinar and we expect that in addition to the risk stratification, we’d be keeping in mind that the comprehensive assessments, which is something else that we talked about on our last webinar the AMH Tier 3 Practices would approach.

So now, we’ve decided that someone is high-need. We have our care team in place and so now we’re talking about what the care team would be doing when they’re working with the patient. So the first thing we’ll talk about is the care plan. This is kind of a core function of the care management team. Once you’ve done the comprehensive assessment and you decided your patient is high-needs, there AMH Tier 3 practice is expected to develop a care plan for each high-need member and it’s supposed to be individualized and in person centered and that’s one thing that we always say about primary care. What does it really mean? So, we do want it to be really tailored to the individual patient and involved some measureable goals that reflect the specific issues that the patient or depending on the situation, the patient and their caregiver may have and this is critical because we are expecting the practice to evaluate the care plan and sort of see how it’s doing and may be do a first correction. If the care plan isn’t meeting the needs of the patient in the practice, so that does require that you have to have some input that you look at and say are we working—are we going in the right direction or not? We would expect the care plan would address medical needs, which we think behavior health needs should be very closely integrated into all of this and particular early identification of the behavior health condition. So even if this is something that you would within your AMH Tier 3 practice wouldn’t treat directly—if this is something that you would expect to work with another practice to work—this is something where the care manager should be able to identify and have a plan in place to make the appropriate referrals or if there is another channel, other than a behavior health provider who you think with your knowledge of the patient is the best entity to deal with trying to figure out how to get the patient down that path to early treatment. So, interventions of the patients currently have going on, the kinds of treatment and therapy that

they are currently getting with a particular emphasis on medication management. A lot of your high-needs patients are going to be seeing multiple prescribers and this is something in particular where care managers and care management teams can add a lot of value by helping the patient avoid potentially dangerous interaction and ensuring that someone is really taking a holistic look at their medications regime. We want to understand the outcome. How are you going to know if the care plan isn't been successful? This is sort of related to what their goals are. How are you going to know when you get there? And, then this is on the bottom of the list as a bullet point, but we think it's really important and kind of permeates all of the other bullet points, understanding the social and educational and other services that the patient needs. The care plan definitely should not be limited to the patient's medical issues. As we mentioned, it should really take a holistic look at the patient and their needs.

(Slide 13) So moving on to the next slide. We're going to talk a little more about the care plan. So this—as we mentioned the care plan is going to be updated. It first needs to be completed within 30 days of the comprehensive assessment and then at least every year. A practice should be taking another look at it for sort of that right check, what changed and then there are other times when we would expect that the care plan may be reevaluated. For example, if the patient has a big change in their circumstances or their needs, that would be a good time. The care plan needs to be documented, stored and shared. Sharing is really important. It should be stored in a clinical systems of records. We would expect that this in the EHR but we understand that not all practice that's not where all practices are in right now. So the HER elements is not a program requirement. We understand that putting the care plan together in a thoughtful way, including all of these elements could take time, but we do expect that practices would go ahead and try to get patients their needed services even if they're still putting together the care plan or even if there in a period where the care plan is being reevaluated and new patients can get the treatment they need for their immediate needs and the care plan can be updated or modified to affect that. There may be a time when the patient doesn't need a care plan anymore, which is probably a sign that the practice has been delivering excellent care. So if the practice is intending to take a patient out of that high-need category and close out their care plan, this is something that the practice should have a kind of policy and procedure in place and one component of that policy should be that the patient should be aware of what's going on and they should know that they are not going to have a care plan anymore.

(Slide 14) So moving onto the next slide. We are on slide 14 now for folks who are following along. Another requirement that we expect people to have questions on is the way that we think that Tier 3 practices should work with admissions, discharge and transfer data fees. This is an opportunity for Tier 3 practices or the CINs or other partners that they work with to try to track their empaneled patients' utilizations and their local EDs and hospitals through after access to an ADT feed. And, again for folks who may not familiar with this, this is admission, discharge and transfer so if you're patient has an ED, gets admitted to a hospital, they get discharge from a hospital and transfer to another hospital that creates sort of paying notification for you to know who the patient is and where they went.

As of June 1, 2018, hospitals, physicians and nurse practitioners basically if you have currently have any EHR systems you are expected to be connection to the NC Health Connection as part of participating on North Carolina Medicaid and North Carolina Health Care Services. And, health connect is a state and health information exchange. There are planning to provide access to ADP information for all advanced medical home care practices that are participating in the HIE at no additional charge, so we think this is potentially a really helpful resource for you, but AMH practice are free to access ADT information through another channel if they prefer to do that, so we are expecting practices to have the capacity to respond to ADT alerts in real time or near real time, so again what does that mean? It definitely does not mean that a practice needs to have someone either directly or through their partner's kind of sitting on the feed and staring at all times, particularly for a practice that's working on the phone. We are not expecting that they necessarily you have the capacity to do that, but we do expect practice to have a process in place so that they can determine which notification merit a response within a particular timeframe and ensure the response occurs. And again, the sort of thinking behind the rationale for one we would expect practices to be able to respond is to capture that special value that a primary care package and advanced medical home practice can offer in guiding the care of the patient in a way that just—having access to a patient's problem list is never going to be able to match so we would expect the practice—the AMH practice to have some kind of thinking about which patient they would want to respond on right away. So for example, if you have a patient whose particularly high complexities who hit the ED all the time and you just know that every time the patient hits the ED, the practitioners there are kind of busy trying to move everyone through and they're going to miss a really important nuance. You might want to able to know right away where the patient is in the EDs, so you just call in to make sure, for example, they don't get admitted if you know from your long relationship with them then an admission is not what they need, so that may be a group of—and again this is sort of an example. We really expect practices to look through their panel and think about their resources and come up with their own policy, but this is an example of the kind of patients where would think you would want to have some kind of policy in place by identifying those patients and thinking about how you can get that timely response to add the kind of the value of your feedback and your contribution.

And, there may be another category of patients for whom you would want to be able to reach out to them the same day or next day. For example, someone who you know has been—you just need to know that if they been discharged from the hospital so you can get them settled in at home to avoid problems. And, then there are other patients for who might be most appropriate for you to reach out within a couple of days. You know patients who might be—who, you know might have high risk for poor outcomes but it doesn't have to be same day. They have a little bit of time for you to get settled in. So again, this isn't, you know, that your policy has to look like. We just expect that you think through your patient's panel and you have a policy and there would be some way for an external observer to come in and look at your material and look at the documentation of your care team outreach and understand what the policy is and whether it is being followed or not. We really do think that practices—we understand that practices have different resources and there panels have different needs and you want to provide flexibility while ensuring that the Medicaid program can really take

advantage of that special value you provide in knowing your patients really well. So that's kind of the basic thinking about ADT and we're happy to take questions about this both now or if you want to reach out offline, we're happy to talk through specific scenarios, but again the answer maybe we'd want you to have flexibility to figure out what works for best for your practice.

(Slide 15) So I'm going to move onto the next slide. I'm slide 15 working with the CIN and other partner to provide high-need care management. So we know that many AMH practices may elect to work with within a CIN or to work with another partner. Some practices sort of—you know—in terms of staffing—the state recognizes that a lot of AMH Tier 3 practices may want to do the work, but may not be able to justify just financially hiring an FTE care manager. So a CIN or another partner may be able to provide an option using care managers that are located in the community and can come in for the face-to-face interaction and can reach out the patient directly for that face-to-face interaction as needed but are not bound to that specific practice only. The CIN staff—we expect that the CIN staff would be able to be in terms of function pretty much interchangeable with AMH staff. We would expect that a CIN staff would be permitted to take on any component of care management that you the AMH are comfortable with them doing. And again, sort of the primary goal here is that the care is sufficiently local. So, it would not be sufficient for an AMH to outsource their care management staff to a purely telephonic CIN service, but it would be fine if CIN staff took care of all the care plan development and care management from a position of being embedded locally in the community and being able to have that face-to-face interaction as often as possible. So, some other things that they can do, you know, in terms of developing a care plan, staff from other partners could develop the clinical workflows that could help the practice build their care plans and update them. They could try to work with the data flows that will be coming into you from PHP and in other sources to identify what the most action will be to inform the care plan development. We just talk about ADP data feeds. That's going to be probably a big source of data for your practice, so they could be well positioned to follow that feed and help identify those particular high priority and help provide the solutions and protocols for responses particularly in case when you know when somebody might need a response outside of your practices in normal business hours. So we expect that there will be as practices decide if they are going to work with CINs or other partners. This is an area where there may be a lot of questions and again folks are welcome to reach out, but again that principle is that we do want to provide a certain amount of flexibility, so the answer to your question may be that we want to practice and the CIN to figure out what's works best for the panels and just have some way to sort of explaining the policies that they have made.

(Side 16) I'm going to move on the next slide. We're on slide 16 now. Let's talk about care management overlap. This is something that Dr. Henley had alluded to earlier. What do you do in situations where you patient's high-needs and that AMH in their advanced medical home definitely needs to be involved in their care management and play a really important accountability of role, but the patient also has other needs that are being overseen by other care managers and we really want to avoid that situation where patient is being boxed between local care managers and there's not good clarity on what their goals are and who has ball and

whose helping the patient meet their goals. We've flagged some particular situations—a particular scenario that we think is worth talking about the local health department. These local health departments looking to play a role under managed care. They have a critical role right now in the provision of care management services for high-risk pregnant women and at-risk children. In some cases an LHD (local health department) may actually elect to participate as an AMH if they meet AMH criteria but in other cases, the AMH practices will be overseeing the care management from AMH perspective but the patient will be seen by a local health department, kind of acting, in its LHD capacity and we expect that PHPs will contract with LHDs to administer care management for high-risk pregnant woman and at-risk children and the PHP will be responsible for ensuring that the roles and responsibilities are not overlapping so we mention that there would need to be some type of documentation of whose playing what role and the PHP are accountable for ensuring that documentation of care plans and roles and responsibilities for all of the various parties who may be involved but we do expect that this is something an AMH practice will want to pay special attention and sort of from your feed in the process make sure that the patient is getting the care that they need, but there is not undue confusion or mixed messages that are going to them about what they need to best manage their health. So, we walked through kind of the theory behind this. What we wanted to provide a schematic—kind of realistic example of how high-need care management might play out on the grounds of some of the parties themselves. So this is as you know, individual clinical scenarios are very personal and complex. This is just meant to be sort of one example of how practice might choose to do it understanding again that practices choosing the individual solutions that meet their panel's needs is most important.

(Slide 17 through 19) So let's take our hypothetical patient among slide 18 now. So let's say we have a mom and her son who are enrolled in a standard plan PHP. Let's say the mom is very low income so the PHP is covering them both and the PCP who the mom selects—maybe there a family practice so they are seeing both the mom and the child is participating in a Tier 3 AMH and maybe they have some issues that they are dealing with where that makes the practice think that they would be a high-needs patient appropriate for high-needs care management. So let's say the child has poorly controlled asthma for which they frequently visit the ED and they have—they are missing school a lot—maybe this is affecting their school performance and keeping them from achieving the way they can. And let's say the mom has a lot going on in her life too. She's really challenged managing her child's treatment plan and one of her big issues is that they can't find stable housing. They are kind of crashing with some friends in their home because they don't have their own housing and among their friends there are a lot of smokers in the house and that's really not helping her son's asthma and so she's, you know, struggles to deal with his asthma at this point and now they have this trigger in their new housing situation. And so let's say, in this scenario, what could high-need care management do. So in this scenario let's say that the AMH practice has also decided to partner with a CIN to support the delivery of local care management. So the AMH is really relying on the CIN to do a lot of the care management work with them. So in this scenario there is this kind of back and forth between the two entities. The AMH is doing the care planning and the local care management with the help of the CIN and the CINs role is—so they are pulling all the data together from the PHP—they've sort of flagged this patient, this family as high risk. They are watching the ADT to

check for emergency department visits for the son and they are conducting the care planning and they are working on that sort of local care management. They are helping to write the care plan and figure out ways to update it as the family situation evolves.

(Slide 20) So here kind of now we sort of have our players assembled in this scenario. So now let's sort of see how we think the data and services would flow in real time. So here we have in our upper right corner we have our PHP that's sort of spitting out data on what the family is doing in both their historical utilization and, you know, any other information the PHP has from screening that they've conducted that data might flow into the CIN because of the particular role that the AMH has assigned to their CIN in this case, again we expect that every AMH will make their own choice about how to best use CINs and their other partners. So they make the data a little more user friendly and give it to the AMH and the AMH together with the CIN engage in this sort of care planning and management for the family. And the AMH might delegate to the CIN to work with the PHP to help solve this big problem that they have identified which is the housing situation. And the PHP might facilitate some sort of a linkage to a housing CBO that might support that family's search for housing to get them out of that trigger, that sort of trigger home environment which is really causing problems for the child's asthma. So that's how we think it would work. How the care management process could work at a very sort of high level conceptual kind of picture understanding that every individual patient is going to bring their own challenges and complications and needs.

(Slide 21) So now let's look at slide 21. Let's see what happens when something comes up, let's say over the weekend the boy has an asthma exacerbation, he's taken to the ED and so let's say that we have in our lower right corner now, we talk to ED and they ED creates an ADT ping. They sort of create a ping when the boy gets registered for the emergency department, that ping generates an ADT alert that gets sent to the CIN and the CIN does two different things in this scenario. Number one they decided that this is a family and because of everything this family has going on, they are really in the category of people who need rapid follow-up. They are worried about sort of losing touch with the mom. They want to make sure that the kid doesn't—the boy doesn't bounce back. And they are concerned that the mom might not fill her prednisone or her steroid script. So they think that they need same day follow-up. And so the CIN staff gives a call to the mom to make sure that she is able to fill the script. Gives her any kind of help that she needs. And then they also provide the information to the practice and update the care plan and then the AMH practice works with mom on an ongoing basis and has sort of leader time when they are able to all sit down together, talk to mom about the asthma action plan, figure out what works for her. What didn't? Were there things that she's worried about doing or she feels challenged to do given that she's not in her own home and kind of help with the long-term optimization. So that's, again, this is a very high level schematic. Real patients in real life are always more complicated but this is an example of how we think all the different players might work together.

(Slide 22 – Q&A)

So that really takes us to our Q&A. If anyone has a question we would encourage you to enter it into the bottom right. And we haven't gotten any questions so far. We know this is complicated and it takes a while to digest so folks are welcome to reach out afterwards if they have any questions and we'll be releasing FAQ documents on an ongoing basis. So it looks like we did get a question. But people should feel free to jump in with anything. So I'm going to take one second for the question to pop up.

Okay. So the question is about—in the mother and child scenario, what if the mom is seeing an AMH Tier 2 or 3 PCP and the child is linked to a AMH Tier 3 pediatrician, who coordinates efforts for the PHP?

That's a great question. We think that—so, for simplicity sake, let's say that both of these are Tier 3 because we think that that is kind of the scenario where would be the greatest potential for multi-care manager conflict. If the AMH is a Tier 2 then we expect the PHP would be doing a lot of this, on the mom's side. So if a family has two family members in an AMH Tier 3 practice—sorry, two family members in two different AMH Tier 3 practices—I don't think we expect, you know, like a specific hierarchy, like the care manager always trumps or something like that. We expect that different practices may work in different ways and may be that they feed into the same CIN or they may be working with different CINs. We think there are a lot of different permutations. So again, in terms of, you know, who should be coordinating we would probably want the practices to in the CIN or the CIN or other partners or PHPs to develop an individual solution that works best for everyone. If this is an issue that keeps coming up, we could develop more specific guidance, but I think currently we're thinking that this is something where the scenarios are going to be specific enough to each practice's resources and that there might be different solutions that work in different areas. The PHP is account for making sure that someone is coordinating—that someone has the ball. But that someone may not always be the PHP, if that makes sense.

So CIN—so we had a question about finding the slides. So the slides are going to be updated to the AMH training page later this week and we have links that I think we can send out. So that was another question that we got.

We had a question about what CIN stands for and what qualifications are needed to be a CIN. CIN stands for Clinically Integrated Network. So this is a network of practice—sorry, it could be a network of providers who are all kind of coming together because it might make more sense to get these resources in a group form and a CIN might elect to work with other partners like an outside organization that could provide some of the data analytics or some of the care manager staffing or things like that. And we can provide links to more information about CINs. There's probably more than I can talk about right now but I think we have some other slides on those that we can point you to as well.

We have some questions about consent for care management. Can a patient opt out of care management? And I think the patient needs to consent to the additional periods of care on an ongoing basis for care management. Let me get back to you with that in the FAQs.

Let's see, we have a question about—let's see, since the AMH must assign a care manager who is either an LCSW or RN can LCSW-As work under the LCSW? So yes, they could. So we would think of the LCSW-A as just like any other team member who is working under the LCSW or RN supervision.

How much variability will there be within each PHPs definition of high-needs? So this speaks to a larger question, I think, about sort of how much variability there is in PHP risk stratification and I think we're not proscribing, we have broad parameters for what PHPs should specify as high-needs. And when I say broad, I mean their pretty specific about which categories of information they could consider but it is possible that a patient would be deemed high-needs by one PHP but not high-needs if they were seen by a different PHP. We are expecting that the PHPs will be convened. There is sort of a technical group around AMHs that will be convened and the goal is to make sure that the practices have the consistency that they need to do their work without too much confusion and complication. But we want to make sure that practices—and this is sort of an opportunity for the Tier 3 practices to take in the PHP information and develop their own kind of classifications and organization to make sense of them. Because if you are Tier 3 you are also going to be making that designation. But we expect that PHPs might not have the cases where PHPs are making that definition of whose high-needs and who is not. They might come to different conclusions. And by the same token, different AMH Tier 3 practices may have different rationales that they use.

Will the PHPs be using the same risk stratification methodology? So again, the PHPs have parameters about what their risk stratification methodology needs to include but the PHPs we don't expect will be using—or we don't know—if they will be using the same exact risk stratification methodology. So one of the sort of opportunities of the Medicaid transformation is the opportunity for different entities to come in and be innovative and do different things. So one of the potential benefits of allowing PHPs some flexibility is the opportunity to generate and learn from new best practices. However, we want to make sure that we can balance that against practices' needs for consistency and understanding and, you know, making sure that they have clear signals that come to them. So there will be sort of an ongoing effort to convene PHPs and to the extent that we learn best practices, to disseminate those and have some consistency around the processes. The practices—one of the things that practices will need to do is to take the different PHP data flows of risk stratification and pull them together in a way that makes sense to you. And this is something that a practice might elect to do on its own or it's another opportunity for a CIN or another partner to get involved.

So we had a question. Is same day ED follow-up expected to occur on weekends and holidays? So this really goes back to the idea that this is—we expect the practice to come up with a policy and then be able to share some of the rationale behind the policy and stick to it. So I think the expectation would be that if the practice has identified someone who you think clinically needs same day follow-up, that need would still hold on a weekend or holiday. So if the practice has designated a person as needing that sort of rapid touch, to help support them in an important care transition, keep them out of the hospital, keep out of the ED, something like that, then the expectation would be that that touch would happen. So we understand that not all practices

may have the staffing or the infrastructure to do this, again this would probably be an opportunity for a CIN or for another partner to get involved and help to share in some of that effort.

Let's see. We have a question about licensed professional counselors, so again I think those would fall into the category of entities of choice. Both who could be on the care team but again for leading the care team, the requirement is that it be an RN or an LCSW.

(Slide 24)

So we're just looking for—so we have a couple more questions that I think we're going to take to the FAQ so folks should keep an eye for more information coming out but I think we will close out. There are some next steps we just want to take a couple minutes to discuss. We have some upcoming webinars. On December 18 we have a webinar on transitional care management and then in the New Year on January 10 we have a webinar on IT needs and data sharing capabilities. We think that these are both going to be—have a lot of interest for you. So we would encourage folks to register. And then for more information, to register and then for some of the follow-up information that we talked about. This is a link to the Advanced Medical home page that has a lot of useful documents and other information.

And so, with that, we will sign off. And again, look for follow-up on the Advanced Medical homepage. You should see the link in front of you. Thanks very much!