WEBVTT

1
00:00:24.240 --> 00:00:27.000
Mario Schiavi: Thank you for joining today's program will begin shortly.

2
00:01:26.070 --> 00:01:38.970
Mario Schiavi: hello, and welcome to today's webinar a Mario and i'll be in the background answering any zoom technical questions experienced difficulties during this session, please type your question into the Q amp a section and a producer will respond.

3
00:01:40.020 --> 00:01:52.350
Mario Schiavi: We will be holding a Q amp a session during today's webinar we encourage you to submit written questions at any time, using the Q amp a panel located at the bottom of the zoom webinar viewer please type your questions in the text field and click thing.

4
00:01:53.730 --> 00:02:08.340
Mario Schiavi: Should you wish to view closed captioning during the program please click CC at the bottom of your zoom window to enable or hide subtitles during today's event all participants main and listen only mode with that would like to get started, we hope you enjoyed today's presentation.

5
00:02:09.360 --> 00:02:20.040
Mario Schiavi: And now like to introduce our first speaker for today Kelly crosby chief quality officer in North Carolina medicaid quality and population health Kelly, you know the floor.

6
00:02:21.060 --> 00:02:26.160
Kelly Crosbie: Thank you so much, Maria hi everyone and welcome to another one of our tailored care management trainings.

7
00:02:26.610 --> 00:02:37.230
Kelly Crosbie: today's training is on quality measurement and improvement, which is a really big and really important topic and we're also going to spend some time talking about some misconceptions about the tailored career management model.

8
00:02:38.460 --> 00:02:39.090
Kelly Crosbie: So.

9
00:02:40.740 --> 00:02:48.510

Kelly Crosbie: we've had a lot of topics, so far, and again this is our presentation today on quality and misconceptions our speakers today or myself.

10
00:02:49.830 --> 00:02:58.980
Kelly Crosbie: And Oh, I have some housekeeping first sorry I skipped two speakers so remember, we have Q amp a session at the end time permitting so we're going to try to make sure that we leave some time at the end.

11
00:02:59.640 --> 00:03:03.780
Kelly Crosbie: You can hold your questions until the end, because sometimes we cover the things that you wanted to ask.

12
00:03:04.230 --> 00:03:09.210
Kelly Crosbie: But it's just we're getting towards the end we're not covering it please feel free to put put questions in the chat at any point.

13
00:03:09.510 --> 00:03:14.760
Kelly Crosbie: we'll do our very best to answer those and remember, we are going to create an faq document at the end of all the sessions.

14
00:03:15.660 --> 00:03:25.770
Kelly Crosbie: So those will be on our website as well in a recording of today's presentation and the deck will be available at our tailored career management webinar series web page and the links are here.

15
00:03:28.470 --> 00:03:38.190
Kelly Crosbie: presenter so i'm your first presenter today had the pleasure of meeting with you all on some of the sessions so far i'm the chief quality officer here at North Carolina medicaid.

16
00:03:38.670 --> 00:03:46.290
Kelly Crosbie: i'll also be joined by crystal Hilton you've talked with crystal many times now she's our associate director of pop health here at North Carolina medicaid.

17
00:03:46.710 --> 00:03:55.530
Kelly Crosbie: And I don't know if you've met hoped, yet, but hope is hope is a wonderful member of our team she's our tailored plan lead in our quality management team so since we're talking about quality.

18
00:03:56.130 --> 00:04:00.480
Kelly Crosbie: It was really cool to have hope come and talk with you today, but I bet you've seen her on other trainings.

19
00:04:02.370 --> 00:04:11.490
Kelly Crosbie: So here's our agenda first we're going to talk about quality so we're going to do a little level setting it's really important that you understand if you're doing Taylor care management.

20
00:04:11.940 --> 00:04:17.070
Kelly Crosbie: The universe, the quality universe, in which you live so we're going to talk about that high level universe.

21
00:04:17.400 --> 00:04:23.010
Kelly Crosbie: And where your places so we're gonna talk a lot about a lot of things that aren't necessarily something you're going to do today.

22
00:04:23.400 --> 00:04:30.510
Kelly Crosbie: But again, you do have a big role in quality, but we want to understand that you don't understand the universe, in which you are.

23
00:04:30.810 --> 00:04:38.460
Kelly Crosbie: we're going to talk about quality measures and reporting so we're going to talk a little bit about what we measure at the state but tailored plans will measure.

24
00:04:38.760 --> 00:04:44.670
Kelly Crosbie: And then maybe what you're going to be responsible for as a tailor care Management Agency and it's much smaller and magnitude.

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00:04:45.300 --> 00:04:54.540
Kelly Crosbie: we're absolutely going to talk about how we use quality measurement to promote health equity both hope and I are going to talk about kind of the measurement and the action on the measure that we do.

26
00:04:54.990 --> 00:04:57.540
Kelly Crosbie: and hopes going to talk a lot about provider support so.

27
00:04:57.840 --> 00:05:06.510
Kelly Crosbie: We know that quality is just not about measuring a bunch of things it's being able to use the data and make appreciable changes, based on the data so she's going to talk about our provider supports Program.

28
00:05:06.990 --> 00:05:20.880
Kelly Crosbie: And crystal is going to come on and talk about our Taylor Commission misconceptions and again we're going to try to leave some time

for Q amp a there's lots of things in the appendix, including a whole bunch of measures, so I will reference some of those as we go through the presentation.

29
00:05:23.160 --> 00:05:27.450
Kelly Crosbie: So let's talk about a really high level overview of medicaid managed care quality.

30
00:05:29.970 --> 00:05:31.800
Kelly Crosbie: we're going to do a little level setting like I said.

31
00:05:33.810 --> 00:05:41.250
Kelly Crosbie: So today we really want you to understand a couple of things medicaid has a quality strategy and a quality management Program.

32
00:05:41.760 --> 00:05:56.460
Kelly Crosbie: It requires reporting have lots of measures, analysis and evaluation of those quality measures and performance at many levels So how are we doing as a state, how are we doing as a tailored plan our different populations within a tailor plan doing.

33
00:05:57.720 --> 00:06:04.260
Kelly Crosbie: And we're all involved in quality there's things we do things tentative plans will do things providers will do things to have a care management agencies will do.

34
00:06:04.620 --> 00:06:12.750
Kelly Crosbie: Things members will do things external evaluation will do to look at our work so there's a lot of folks involved in the quality program in North Carolina medicaid.

35
00:06:13.320 --> 00:06:21.480
Kelly Crosbie: we're really focused today on reviewing the measures and reporting of tailor plans in particular and measures that might be.

36
00:06:21.930 --> 00:06:35.850
Kelly Crosbie: In particular, important to tailor care management agencies, I understand that's what you're all wanting to know right, thank you for all this quality, but what do I have to care about the most so we're going to explore two measures that we want you to think about a lot today.

37
00:06:37.470 --> 00:06:43.020
Kelly Crosbie: All right here, hopefully, this is not the first time you're seeing this, this is our quality strategy.

38
00:06:43.650 --> 00:06:50.370
Kelly Crosbie: We have three main quality goals here in North Carolina medicate we want better care we want healthier people in communities.

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00:06:50.790 --> 00:06:57.960
Kelly Crosbie: And we want to be really smart about what we're spending our money on so under each of those names, we have particular goals.

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00:06:58.410 --> 00:07:06.060
Kelly Crosbie: and objectives, if you look at all those objectives we actually have measures for each and every one of those objectives.

41
00:07:06.420 --> 00:07:16.650
Kelly Crosbie: And the measure might come from a survey of Members a survey of providers, it might come from a measure that we calculate using claims information, it might be information we.

42
00:07:17.250 --> 00:07:21.330
Kelly Crosbie: calculate using clinical information so information actually from charts.

43
00:07:21.750 --> 00:07:28.380
Kelly Crosbie: Are from North Carolina hae so we measure, a lot, but when you think about the north Carolina medicaid program it's really complex.

44
00:07:28.710 --> 00:07:33.990
Kelly Crosbie: But at the end of the day, we're trying to make sure that our Members feel confident satisfied in the care that they're getting.

45
00:07:34.320 --> 00:07:42.810
Kelly Crosbie: They feel their cares organized they feel like people are listening to them and that they're a partner in their care so we measure, a lot in the Member space we want to make sure our providers feel satisfied.

46
00:07:43.200 --> 00:07:49.380
Kelly Crosbie: They were taking care of them and medicaid that our plans for taking care of them, because obviously we want providers to stay engaged in medicaid.

47
00:07:50.040 --> 00:07:55.680
Kelly Crosbie: And then remember thinking about who medicaid serves medicaid serves a lot of children we serve a lot of pregnant women.

48
00:07:55.950 --> 00:08:05.100
Kelly Crosbie: We serve individuals with physical disabilities, we serve individuals with intellectual and developmental disabilities with mental health and behavioral health substance use disorders.

49
00:08:05.700 --> 00:08:12.780
Kelly Crosbie: With long term services support needs, so we need to think about measures that measure, the quality of care that all of these individuals are getting.

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00:08:13.410 --> 00:08:19.110
Kelly Crosbie: And then, when you talk about smarter spending, we need to talk about making sure that we're spending our money in the right place right.

51
00:08:19.440 --> 00:08:32.910
Kelly Crosbie: So people are getting good preventative Community based care that's where we're spending the bulk of our money and we're not spending a lot of our money on things like preventable hospitalizations or out of home placement, so when you think about measurement just.

52
00:08:34.200 --> 00:08:42.480
Kelly Crosbie: it's it's it's just makes sense, actually, when you take all the measurement out of it we're just trying to make sure that the people were taking care of.

53
00:08:42.870 --> 00:08:55.620
Kelly Crosbie: are getting healthier and better and care in the right place Members feel satisfied engaged and respected and provider stay with us and they feel respected and they still feel valued so that's kind of what we're trying to achieve with this big old quality strategy.

54
00:08:57.840 --> 00:09:06.090
Kelly Crosbie: So let's talk about quality measures like I said we've aims goals and objectives and we've got to measure all those objectives right they're just words on a paper unless you have.

55
00:09:06.390 --> 00:09:13.980
Kelly Crosbie: Measures that tell you, if you're getting better or worse on those particular objectives so let's talk about measure reporting for a bit.

56
00:09:15.390 --> 00:09:24.150

Kelly Crosbie: So the Taylor plans themselves have a big old measure set we measure, a lot of things for Members in tailored placements.

57
00:09:24.990 --> 00:09:29.310
Kelly Crosbie: That you'll see in the appendix when you look at this slide all this, many measures.

58
00:09:29.670 --> 00:09:36.930
Kelly Crosbie: So, think about who's in a tailor plan you've got women, children, people with intellectual developmental disabilities traumatic brain injury.

59
00:09:37.290 --> 00:09:44.130
Kelly Crosbie: People with substance use disorders, people with behavioral health issues and all of those people have physical bodies.

60
00:09:44.550 --> 00:09:52.110
Kelly Crosbie: So we care about their physical health care to so we measure, a lot right we measure, a lot we're going to make sure people's physical needs behavioral needs.

61
00:09:52.470 --> 00:09:57.630
Kelly Crosbie: are being met, so we measure tons of things again you'll find those things in the appendix.

62
00:09:58.110 --> 00:10:07.650
Kelly Crosbie: So we measure those things, and then we try to gauge how we're doing how we doing and all those things, so we use measures that are consistent nationally.

63
00:10:07.980 --> 00:10:19.140
Kelly Crosbie: So we use national measure set so we can say how's our medicaid program doing against other medicaid programs so try not to have a lot of homegrown or customized measures because we want to make sure that we are.

64
00:10:19.620 --> 00:10:25.110
Kelly Crosbie: Doing as well as other states will hopefully better than other states, every time and then we set.

65
00:10:25.590 --> 00:10:32.310
Kelly Crosbie: benchmarks, so we set targets so we say this is where we are right now we're implementing managed care, which is quite complex.

66

00:10:32.700 --> 00:10:48.270
Kelly Crosbie: How do we expect managed care to work with providers work with to care management work with Members to improve quality of Members lives and experiences over time as we're aiming for, so we have to say we're going to set targets for me to say aggressive targets, so we can help.

67
00:10:49.710 --> 00:10:52.410
Kelly Crosbie: tailor Taylor plans drive performance over time.

68
00:10:55.350 --> 00:11:11.790
Kelly Crosbie: So we measure, a lot of things at this date lots and lots of things so everything that you'll find not appendix on the measures we measure, so we measure everything we measure everything for medicaid direct for standard plans for Taylor plans, but of course we also ask Taylor plans to.

69
00:11:12.930 --> 00:11:18.900
Kelly Crosbie: calculate and report their own quality measures it's just an important thing to do in quality, you got to own your data you got to create your measures.

70
00:11:19.140 --> 00:11:26.640
Kelly Crosbie: You got to look at your own measures you got to think about them and you got to make sure that you're improving, so we do that as a state, we ask all of our plans to also calculate their own measures.

71
00:11:26.910 --> 00:11:36.210
Kelly Crosbie: And, by and large, as I said, most of the data we get from measures comes from surveys, it comes from claims information, sometimes it comes from clinical information.

72
00:11:36.510 --> 00:11:43.680
Kelly Crosbie: That we might get from the health information exchange, so will calculate them Taylor clients will calculate them and in the future.

73
00:11:44.160 --> 00:11:53.580
Kelly Crosbie: So today we're going to talk about how we here's your measure here's your target hopes going to talk to you about how we stratify or break up the measure by race, ethnicity gender county.

74
00:11:53.850 --> 00:11:59.220
Kelly Crosbie: So we're really digging deep on the data she's going to talk about that, and then we set targets for improvement.

75

00:12:00.060 --> 00:12:09.540
Kelly Crosbie: In about the third year of managed care will do something called with results so actually hold tailored plans financially accountable for performance on particular measures.

76
00:12:09.990 --> 00:12:19.050
Kelly Crosbie: And we can reward good performance it's not necessarily that penalties, it could be about rewarding or earning a reward for good quality, performance I think about that because.

77
00:12:20.160 --> 00:12:25.080
Kelly Crosbie: That also pertains to tailor care management agencies will talk about that a little bit more.

78
00:12:28.140 --> 00:12:35.580
Kelly Crosbie: So we have a similar program in the senior plans it's called advanced medical homes now it's a primary care medical home, but it has.

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00:12:37.050 --> 00:12:45.720
Kelly Crosbie: It has a heavy care management component, much like this tailored care management model, and in that program we've set a standard set of measures.

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00:12:46.260 --> 00:12:52.350
Kelly Crosbie: That we want those advanced medical homes to be working on because they're measures, we think that advanced medical home can actually impact.

81
00:12:52.800 --> 00:13:03.090
Kelly Crosbie: So it's a primary care office we think they can impact child well visits we think they can impact adolescent wealth is it's an child immunization so we think your primary care office.

82
00:13:03.390 --> 00:13:07.560
Kelly Crosbie: Your primary care you've got care management, you can help impact these things, for your Members.

83
00:13:07.920 --> 00:13:16.950
Kelly Crosbie: we're going to do the same thing for tailored care management right so we're going to say have as many measures that we're going to measure for Taylor plans and ask them to be accountable for.

84
00:13:17.760 --> 00:13:23.820

Kelly Crosbie: Which specialist we actually think a Taylor care management agency can help with and you'll see on the next slide we're going to.

85
00:13:24.300 --> 00:13:32.220
Kelly Crosbie: play around with a couple and see what you think so we haven't established measure set yet we're working hard on it, but we also want to talk with our.

86
00:13:32.820 --> 00:13:38.190
Kelly Crosbie: Taylor care management technical advisory group and get some of their feedback as well, we want to get Taylor fan feedback.

87
00:13:38.610 --> 00:13:44.010
Kelly Crosbie: On what they think the right measures that are that we asked Taylor career management agencies to be accountable for.

88
00:13:44.760 --> 00:13:55.290
Kelly Crosbie: And in the first year, the emphasis really is on letting Taylor care management know how they're doing on those quality members for their measures it's not to penalize.

89
00:13:55.890 --> 00:14:02.070
Kelly Crosbie: There won't even be an incentive in your one of you for good performance but we'll start doing that very soon.

90
00:14:02.730 --> 00:14:13.350
Kelly Crosbie: The incentive part we're not all about penalties were about incentivizing good behavior so we're going to say hey in the first year we're going to pick a couple of quality measures that we think a tailor K management can help improve.

91
00:14:14.100 --> 00:14:24.780
Kelly Crosbie: And and you're too if you're improving on those we'd like to think through an incentive program if you're helping your Members do do better you're helping the Taylor plan do better on that particular measure, we would like to reward you.

92
00:14:25.170 --> 00:14:32.550
Kelly Crosbie: So again, the offices, going to be have all these many things that we measure right which of these things could a care manager actually impact and effect.

93
00:14:33.420 --> 00:14:38.070

Kelly Crosbie: And so, the last thing is also really important to write, how do you know.

94
00:14:38.820 --> 00:14:45.210
Kelly Crosbie: One of the things that Taylor plan needs to do for providers so let's do this for their primary care providers will do this for their Taylor career management writer.

95
00:14:45.570 --> 00:14:55.110
Kelly Crosbie: Is they do things like send care alerts or care gap alerts, so they will send a notice to a practice that said, someone is overdue for wealth is it or an immunization.

96
00:14:55.590 --> 00:15:01.230
Kelly Crosbie: A practice might know that themselves, of course, right a care Management Agency might know themselves to write.

97
00:15:01.770 --> 00:15:14.130
Kelly Crosbie: But that's one way to tailor print can help you they can send you notices to say hey someone is like for a well visit let's look at the next slide and you'll see why i'm talking so much about what was it, so this is a really busy slide.

98
00:15:15.150 --> 00:15:24.780
Kelly Crosbie: But this is one of the things that we measure right, and please remember challenging adolescence or the bulk of medicaid they are the bulk of medicaid.

99
00:15:25.320 --> 00:15:31.590
Kelly Crosbie: There are children and adolescents and standard plans in tailored plans in medicaid direct.

100
00:15:32.010 --> 00:15:39.720
Kelly Crosbie: So, making sure that our children and adolescents get to well visits is incredibly important, no matter what plan you work in.

101
00:15:40.320 --> 00:15:50.430
Kelly Crosbie: So every year in medicaid we measure the percentage of our kids getting in on time for all their child and adolescent well care visits so right now.

102
00:15:51.090 --> 00:15:57.900
Kelly Crosbie: for children and adolescents and standard plans about 46% of them get in for chatting and less than what was it's on time.

103
00:15:58.770 --> 00:16:09.510
Kelly Crosbie: Members who were entailed plans actually do a little bit better so about closer to 48% of them get in for children and adolescent well care visits and our overall rate is about 45%.

104
00:16:11.160 --> 00:16:21.120
Kelly Crosbie: If you look at the charts on the side, just to orient you a little bit the really small but the light blue our members in standard plans and the dark blue are Members in tailored plants.

105
00:16:21.810 --> 00:16:36.660
Kelly Crosbie: And the four boxes represent different age groups, so the first box is actually our overall all children and adolescents, the second box is children 15 to 30 months i'm sorry it's it's the first 13 months of life.

106
00:16:38.550 --> 00:16:39.930
Kelly Crosbie: it's so small i'm having a hard time.

107
00:16:40.950 --> 00:16:48.000
Kelly Crosbie: Oh that's right, I was right it's 15 to 30 months is the second block the third block is well visits in the first 30 months of life.

108
00:16:48.960 --> 00:16:55.470
Kelly Crosbie: And the third I think it's 15 but don't don't hold my poor is correct, we do that, but the point is, we break it down write.

109
00:16:56.280 --> 00:17:04.140
Kelly Crosbie: children's birthday 30 months there's evidence based care when they should come in 311 there's evidence based times should come in 12 to 17 there's evidence based tend to should come in.

110
00:17:04.620 --> 00:17:13.800
Kelly Crosbie: And so we look at all of those indicators and you can see, with some age groups, actually children and Taylor plans, who are currently or will be enrolled and Taylor plans in the future.

111
00:17:14.070 --> 00:17:21.060
Kelly Crosbie: are getting in higher for child and adolescent well visits, but the thing is 4546 47% is not really great right.

112
00:17:22.140 --> 00:17:27.150

Kelly Crosbie: Why am I talking about this measure we care, we have a lot of kids and medicaid kids are in every kind of plan.

113
00:17:28.410 --> 00:17:36.090
Kelly Crosbie: And we think care managers can make a difference in this measure So what do you think we think your managers can impact this.

114
00:17:36.570 --> 00:17:39.120
Kelly Crosbie: or care managers are going to provide the primary care Of course not.

115
00:17:39.600 --> 00:17:47.640
Kelly Crosbie: But can they engage with our Member and say hey Well, this is a really important hey do you know who your primary care physician is hey can I help you get in for a while visit.

116
00:17:48.300 --> 00:17:52.560
Kelly Crosbie: Oh, you have barriers to getting in you don't know your primary care physician is, let me help you.

117
00:17:53.040 --> 00:18:02.670
Kelly Crosbie: Can I send you a reminder that we're getting close to time for a well visit, can the Taylor plan, send a tailored care management agency or reminder that it's time for a child to go in for Watson absolutely.

118
00:18:03.120 --> 00:18:07.560
Kelly Crosbie: So, again we don't think Taylor care management agency can provide the world visit.

119
00:18:08.130 --> 00:18:15.870
Kelly Crosbie: But we absolutely think they can be really great care manager and help people get in for child and adolescent well so that's just one example of a measure.

120
00:18:16.200 --> 00:18:28.860
Kelly Crosbie: we're thinking hard about that we're going to talk to our technical advisor group about to say is this a good measure for Taylor career management agencies to really focus on to focus on helping us improve next one, and this is the last one.

121
00:18:29.880 --> 00:18:37.350
Kelly Crosbie: follow up after hospitalization for mental illness, most of you are very familiar with this venture because Jeff Kelly has been trying to move this measure for a really long time.

122
00:18:38.610 --> 00:18:46.800
Kelly Crosbie: Look at our rates not great, so this is the measure it's a national measure is based on evidence based care and the notion is that when people are hospitalized.

123
00:18:47.100 --> 00:18:57.870
Kelly Crosbie: For mental health or behavioral health issue, they should have a follow up with a behavioral health specialist in seven days in 30 days that's just standard of care, I didn't make it up that's the national measure based on experts.

124
00:18:59.430 --> 00:19:07.500
Kelly Crosbie: We struggle with this mightily and there's so many reasons right, and most of the reasons are reasons that probably a care manager can help.

125
00:19:07.890 --> 00:19:13.290
Kelly Crosbie: Right, not all of them i'm saying it's complex it's very complex when you actually break down the session you'll notice.

126
00:19:13.890 --> 00:19:22.860
Kelly Crosbie: Why, it can it be hard to get someone to get engaged in in with the behavioral health provider within seven days of a mental health hospitalization.

127
00:19:23.280 --> 00:19:28.860
Kelly Crosbie: So how can a care manager help, so this is measure measure when we think about we think we think care managers could probably help.

128
00:19:29.310 --> 00:19:35.220
Kelly Crosbie: It could probably help connect with a member, help them get to be a behavioral health provider do with transportation issues.

129
00:19:35.550 --> 00:19:44.460
Kelly Crosbie: pharmacy issues helps them understand why a follow up visit is helpful they might be struggling with a housing issue, so there are all kinds of things that they.

130
00:19:45.450 --> 00:19:54.510
Kelly Crosbie: Care manager might potentially be able to help someone with and again the light and blue light blue or members and standard plans, because they too are hospitalized for mental health reasons.

131

00:19:54.930 --> 00:20:00.450
Kelly Crosbie: And dark blue are our Taylor pin number so as you can see it's an area where we struggle, a little bit.

132
00:20:00.900 --> 00:20:05.160
Kelly Crosbie: This one in particular I do want to point out the dark orange line if you see the dark orange line across the top.

133
00:20:05.610 --> 00:20:14.370
Kelly Crosbie: that's the national media and it's not great we're close to 40% of Members nationally, who get up visit in seven days and 60% nationally, those who get to visit in 30 days.

134
00:20:14.940 --> 00:20:23.130
Kelly Crosbie: were really far below that really far below that so that's this isn't measured consistently, we want to do better and better and better on because.

135
00:20:23.490 --> 00:20:30.840
Kelly Crosbie: It really helps people to get to an aftercare visit, so they aren't rehospitalized it's just treatment, you all know that so.

136
00:20:31.590 --> 00:20:37.740
Kelly Crosbie: Again members and standard plans Taylor plans numbers with add Members with tbi are hospitalized for mental health reasons.

137
00:20:38.100 --> 00:20:47.670
Kelly Crosbie: So it's a mission to fix a lot of people, and so we think this is something potentially the care managers could help again we'll talk to the tech and get their feedback on it alright next slide.

138
00:20:49.320 --> 00:20:54.300
Kelly Crosbie: So i'm going to talk a week super quick and permitting health equity because hope is going to talk about smart.

139
00:20:54.750 --> 00:21:03.960
Kelly Crosbie: So, remember, I said we're going to measure, a lot of things, but we're also going to set targets for that we will set targets at the Taylor plan level we won't set them at the provider level.

140
00:21:04.290 --> 00:21:09.720
Kelly Crosbie: We will set them at the Taylor plan level right, so what we will do we already know.

141

00:21:10.470 --> 00:21:21.480
Kelly Crosbie: The baseline for our tailored plan measures Members how well they're doing on all the quality measures will give those to the tailor plans and will say in the first few years we want each.

142
00:21:21.990 --> 00:21:26.880
Kelly Crosbie: measure to improve and we'll set a target it's a 5% relative target there's a lot of math.

143
00:21:27.870 --> 00:21:39.870
Kelly Crosbie: it's not five percentage points it's 5% relative so in a measure like we just looked at where our rate is 30% 5% relative is 1.5 points so we're saying is 30% now.

144
00:21:40.080 --> 00:21:46.050
Kelly Crosbie: Next year we want us to be at 31.5% so they're reasonable logical targets, where we think folks can improve.

145
00:21:46.800 --> 00:21:53.970
Kelly Crosbie: So in successive years that in the first couple years after we get our feet wet that's when we'll think about Okay, so our methodology right.

146
00:21:54.390 --> 00:22:04.800
Kelly Crosbie: Do we need to have regional targets or higher targets and so we'll have to you know think through you always have to be making sure that your targets are cracked and they're really driving improvement.

147
00:22:06.300 --> 00:22:08.490
Kelly Crosbie: So the next slide.

148
00:22:10.590 --> 00:22:22.710
Kelly Crosbie: it's just an example of how that looks right, so you can study this slide when you look at it and the takeaway is the blue covered lives are people that did get.

149
00:22:24.240 --> 00:22:32.790
Kelly Crosbie: Oh, this is a chlamydia screening measure, very important for all of our measures right chlamydia screening, so the blue are folks who did receive their chlamydia screening in the orange aren't.

150
00:22:33.420 --> 00:22:45.000
Kelly Crosbie: And with our 5% target is, you can see, over three years, the number of blue Members with this 5% target it seems small but it builds on itself so over time, in the course of about three years.

151
00:22:45.300 --> 00:22:49.830
Kelly Crosbie: We have far more people getting this important chlamydia screenings that are not getting this woman do screening.

152
00:22:50.970 --> 00:22:56.370
Kelly Crosbie: So here's what I really want to say i'm really excited about the next slide because it's about equity targets.

153
00:22:57.780 --> 00:23:05.430
Kelly Crosbie: So we do have disparities, we know that we have disparities in some of our measures, we know that in some cases i'm.

154
00:23:07.020 --> 00:23:17.250
Kelly Crosbie: black and African American children aren't getting in for well visits the same high higher rate that may be wider Caucasian people are, that is a persistent issue we see in medicaid today.

155
00:23:17.790 --> 00:23:34.830
Kelly Crosbie: So we're saying that's not good enough right so yeah overall 5% we want the whole measure to get better, but in a group that's that low, we need 10% relative improvement on that particular group so that's just what this demonstrates, so we are showing an example on this side.

156
00:23:36.360 --> 00:23:45.030
Kelly Crosbie: of where we look at a measure, where there is a particular disparity and where there was a group that has a disparity, we said a 10% relative target next time.

157
00:23:48.810 --> 00:24:01.860
Kelly Crosbie: This just shows you how that looks This is very dense I think it's actually really important takeaway, but this is something you probably just want to read, but this is just an example of how over time in about three years time with that aggressive 10% target.

158
00:24:02.340 --> 00:24:09.660
Kelly Crosbie: We are actually closing closing the gap between the two groups, so, if you look at the blue and orange covered lives that's what this is illustrating.

159
00:24:12.060 --> 00:24:12.600
Kelly Crosbie: Next slide.

160

00:24:14.100 --> 00:24:19.380
Kelly Crosbie: And this is just a slide putting the both together so overall we expect 5% of improvement.

161
00:24:19.770 --> 00:24:26.940
Kelly Crosbie: But you never want improvement to happen in a way that furthers a disparity, because that can happen if you don't have both right.

162
00:24:27.420 --> 00:24:31.110
Kelly Crosbie: 5% relative improvement could be great, because in that example that I gave you.

163
00:24:31.770 --> 00:24:43.650
Kelly Crosbie: We could just improve the rate for children getting a wealth, as it birth of 15 Caucasian children, we can improve that by 20% but still have a group, maybe black or African American children lagging significantly behind.

164
00:24:44.040 --> 00:24:48.960
Kelly Crosbie: So we can't do that we need to balance both and make sure that we're closing that gap so again.

165
00:24:49.290 --> 00:25:01.080
Kelly Crosbie: If you look at the diagram that we have here we show an example of how we close the disparity both groups, improve they improve at different rates, but in the end we're closing that gap for closing despair in that measure.

166
00:25:03.690 --> 00:25:10.800
Kelly Crosbie: Alright, so the last thing I want to say before I turn it over and hope is that was a lot of dense Stefan measures, measures actually aren't that scary.

167
00:25:11.400 --> 00:25:21.870
Kelly Crosbie: They just measure, health care or behavioral health care they measure Member experience your provider experience that's a lot of data, but that's great because there's really there's quality experts who do all that stuff all day.

168
00:25:22.380 --> 00:25:24.930
Kelly Crosbie: And they give us the results and they work on.

169
00:25:25.920 --> 00:25:32.430

Kelly Crosbie: we're going to be really transparent about performance we publish a lot of things today we actually publish our medicaid rates will continue.

170
00:25:32.730 --> 00:25:39.150
Kelly Crosbie: to publish our medicaid rates on a whole host of measures, all those indicators that I mentioned all those measures that are in Appendix of the slide.

171
00:25:39.750 --> 00:25:48.570
Kelly Crosbie: And we will measure with them by standard plan and tailored plan will measure them by each tailored plan So you see how they're performing against one another.

172
00:25:50.040 --> 00:25:50.580
Kelly Crosbie: and

173
00:25:51.990 --> 00:25:55.920
Kelly Crosbie: So we'll share those will share them with plans will share them publicly.

174
00:25:56.220 --> 00:26:04.050
Kelly Crosbie: And remember, part of the role of the Taylor plan is to share that data with providers and tailored care Management Agency so they understand how their members are performing.

175
00:26:04.530 --> 00:26:16.950
Kelly Crosbie: And they think about and talk about ways they can improve so i'm actually a tournament hope and hopes team really spends a lot of time taking that analyze data and talking about ways we can help improve the quality measures.

176
00:26:18.570 --> 00:26:22.020
Hope Newsome: Thanks Kelly, and thanks for laying that all out so beautifully.

177
00:26:23.160 --> 00:26:30.270
Hope Newsome: Again we'll talk a little bit more about promoting health equity and how we make that actionable on our team.

178
00:26:32.880 --> 00:26:42.600
Hope Newsome: So health equity is a key priority for our quality program the department is committed to promoting health equity in all aspects of the managed care Program.

179
00:26:42.990 --> 00:26:54.630
Hope Newsome: Including and not limited to the quality program So what does that exactly look like, so the department expects tailored plans to ensure improvements and quality, performance.

180
00:26:54.960 --> 00:27:01.050
Hope Newsome: or equitably distributed across race and ethnicity and we'll talk a little bit more about that in a moment.

181
00:27:01.590 --> 00:27:07.200
Hope Newsome: As described and ally, did the department's quality strategy tailored plans are expected to collect.

182
00:27:07.560 --> 00:27:20.520
Hope Newsome: And report quality measures to support activities aimed at promoting health equity, so we want to see what are some of those activities that are specifically going to address and for mediate health equity.

183
00:27:21.240 --> 00:27:30.750
Hope Newsome: And, as mentioned in previous slides that Kelly stated, beginning in the third year of the contract the department will hold Taylor plants financially accountable for ensuring.

184
00:27:31.110 --> 00:27:42.330
Hope Newsome: equity and improvement have selected measures so more to come on that down the road, but we just wanted to quickly highlight some of the ways that we're addressing and are committed to health equity.

185
00:27:45.330 --> 00:28:03.720
Hope Newsome: So again, we want to talk a little bit more about the stratification Taylor plants are required to capture a report and metrics on disparities, to inform targeted health equity intervention, so we have a whole host of stratification said that Taylor plans are directed to report on.

186
00:28:05.250 --> 00:28:15.420
Hope Newsome: Most are the quality measures, using the chart listed below so or senior right so in the table one those certifications are.

187
00:28:15.960 --> 00:28:32.280
Hope Newsome: Age race, ethnicity gender primary language long term services and supports need status disability status, one of the good service region geography and for 2022 we will be adding transitions to community living.

188
00:28:33.120 --> 00:28:41.940
Hope Newsome: And this data will inform the development of our health equity report that identifies trends and variations in health services and outcomes.

189
00:28:43.230 --> 00:28:58.200
Hope Newsome: Of stratified variables over time, so we want to make sure that we are providing this information will be able to look at it, over a period of time and look at those trends and be able to provide a comprehensive report, for you and our health equity report.

190
00:29:01.290 --> 00:29:16.890
Hope Newsome: Some additional things that will be required of tailor plans is that thing must development and implement health equity interventions So what does that look like the department will monitor stratified measures which we just discussed.

191
00:29:18.570 --> 00:29:27.750
Hope Newsome: That will report identify disparities and over time again we will develop or require the plans to developed targeted interventions and our strategies.

192
00:29:28.050 --> 00:29:35.700
Hope Newsome: to identify disparities, so we want to look at how are you going to address those disparities that were identified.

193
00:29:36.390 --> 00:29:51.780
Hope Newsome: And so, some of these interventions may include but certainly aren't limited to the development of disparity specific quality measurement improvement targets that could be on a program wide or statewide level or very plan specific.

194
00:29:53.100 --> 00:30:05.460
Hope Newsome: And it may include, for example, the development of modification or addition to the performance Improvement Plan requirements so that's those are things that will be looking for over time.

195
00:30:06.300 --> 00:30:17.520
Hope Newsome: And then, on an annual basis, the department will review the plan strategy to actively address and respond to opportunities to improve health disparities in collaboration with the department developed.

196
00:30:18.480 --> 00:30:29.700

Hope Newsome: Cross plan interventions so again here you'll see that we want to respond to any opportunities that we can that will be for improving health disparities.

197
00:30:30.840 --> 00:30:35.370
Hope Newsome: So what does that mean for providers so some of the implications for providers.

198
00:30:36.420 --> 00:30:48.870
Hope Newsome: could just mean that you will have increased communication from the Taylor plan so hopefully and we'll talk about that in a moment you'll see more opportunities to collaborate with Taylor plants.

199
00:30:50.940 --> 00:30:58.890
Hope Newsome: So, again here we're going to look at providers support, and what that looks like in our quality improvement efforts.

200
00:30:59.370 --> 00:31:06.660
Hope Newsome: We really want to continue to build upon IT infrastructure to drive clinical improvement through our selected Taylor plans.

201
00:31:07.050 --> 00:31:19.200
Hope Newsome: We will provide work to provide additional resources and supports to providers and efforts to achieve quality improvement goals so some of those efforts will be required, and some of them.

202
00:31:19.800 --> 00:31:28.020
Hope Newsome: may be things that the Taylor plan initiate on their own, but more specifically Pacific specifically excuse me with the department.

203
00:31:28.320 --> 00:31:36.750
Hope Newsome: We will offer, and we have been offering new real estate much on trainings and feedback sessions, hopefully you've had an opportunity to join, some of those.

204
00:31:37.440 --> 00:31:46.620
Hope Newsome: They include webinars virtual office hours fireside chats which later became big back porch checks and we're feasible.

205
00:31:47.280 --> 00:31:54.690
Hope Newsome: Those trainings will be in person, but obviously we've been having those state led trainings in a virtual setting.

206
00:31:55.110 --> 00:32:03.780

Hope Newsome: But we've seen so much great success and participation with those trainings that we have implemented through North Carolina a heck.

207
00:32:04.560 --> 00:32:18.060
Hope Newsome: Just as an example with our virtual office hours we've had well over 4000 participants with that, and so we will continue to look for ways that we can integrate and support our providers across the state.

208
00:32:19.080 --> 00:32:27.000
Hope Newsome: Currently, just to kind of give you a little heads up, we are working on our quality forms that are stateless and.

209
00:32:27.630 --> 00:32:36.810
Hope Newsome: Stay organized, if you will, for both standard plans and tailored plans so we're working on our calendar for 2022 as we speak so more to come on that.

210
00:32:37.110 --> 00:32:41.970
Hope Newsome: But we do really want to make sure that we are addressing the needs and interests of our providers.

211
00:32:42.840 --> 00:32:59.940
Hope Newsome: In addition to that, the tailor plants will be responsible for providing trainings on plan specific policies and programs, and they must develop a specific provider support plan that will be reviewed by us at the department and we review that on an annual basis.

212
00:33:01.230 --> 00:33:12.420
Hope Newsome: Just quickly to highlight some of the things that are included in that provider support plan, it must include technical support activities, it must include detailed information on how.

213
00:33:13.920 --> 00:33:27.600
Hope Newsome: it's going to support activities to advance it and goals and objectives within our quality strategy, they must include an overview of which metrics that Taylor plan will use to evaluate is provided engagement over time.

214
00:33:32.760 --> 00:33:43.320
Hope Newsome: So again, one of the things that we want to make sure that we provide opportunity for and make sure that we communicate that with that Taylor plan is, we want to support.

215
00:33:43.830 --> 00:33:54.000

Hope Newsome: provider dialogue and information sharing providers will have an opportunity, through a number of forums, with the in person online routine or.

216
00:33:54.480 --> 00:34:13.830
Hope Newsome: or on an ad hoc basis to raise local challenges and exchange of best practice, ideas and services and and supports all related to quality and population health within tailored plans so let's look a little bit about what that may look like and what you may see.

217
00:34:15.840 --> 00:34:29.850
Hope Newsome: From where you sit, so we will have clinical leadership at the regional level some meet with plan leadership at least quarterly to discuss implementation of quality improvement activities that are aligned with our quality strategy.

218
00:34:30.240 --> 00:34:39.330
Hope Newsome: And in those quarterly meetings clinical leadership should include our active network of CMO and quality directors.

219
00:34:39.840 --> 00:34:47.040
Hope Newsome: And it may also include our quality staff at the department and medical leadership will also be invited to participate.

220
00:34:47.820 --> 00:34:54.090
Hope Newsome: So I talked to at the last slide about the state offerings of quality forms, but we were also.

221
00:34:54.810 --> 00:35:06.390
Hope Newsome: require Taylor plants to implement quality form so on a regional level, and some of the invitees might be primary care physicians are best medical homes all tears are invited.

222
00:35:06.840 --> 00:35:14.100
Hope Newsome: obstetrics and gynecology local providers behavior health local health departments school based health services hospitals.

223
00:35:14.610 --> 00:35:33.900
Hope Newsome: don't CSS agencies clinical integrated networks and local DSS offices and then obviously it may be some variation with stakeholders, depending on the topics and the goals of that particular form but those are some of the things that you can expect to see in terms of provider supports.

224
00:35:36.720 --> 00:35:38.790

Hope Newsome: crystal i'm going to hand it over to you.

225
00:35:42.810 --> 00:35:43.140
Krystal Hilton: Thank you.

226
00:35:44.220 --> 00:35:45.360
Krystal Hilton: Good afternoon, everyone.

227
00:35:47.910 --> 00:35:57.330
Krystal Hilton: I would like to share a little bit of information to help with some of them here take care management misconceptions that have been flying around in the atmosphere next slide please.

228
00:36:01.110 --> 00:36:13.800
Krystal Hilton: The Department fully understands that there are some areas of confusion and we would like to take just a brief moment to help walk through and clarify those points so that it will be.

229
00:36:15.360 --> 00:36:18.960
Krystal Hilton: So that we can directly clarify those issues next slide.

230
00:36:20.640 --> 00:36:25.380
Krystal Hilton: Our first misconception is related to the electronic health record certification.

231
00:36:27.600 --> 00:36:35.460
Krystal Hilton: The misconception, is that H plus practices and cma will need to have electronic electronic health records ehr.

232
00:36:35.790 --> 00:36:52.140
Krystal Hilton: That meet the office of national coordinator for health information technologies criteria for certified ehr technology, this is a misconception, but department does not require that ehr be certified for the purposes of Taylor care management.

233
00:36:53.880 --> 00:36:54.270
Krystal Hilton: The.

234
00:36:55.410 --> 00:37:07.500
Krystal Hilton: providers clinical record clinical system of record or ehr must possess the capability to electronically record store and transmit remember clinical information.

235

00:37:09.180 --> 00:37:09.990
Krystal Hilton: Next slide please.

236
00:37:11.550 --> 00:37:20.550
Krystal Hilton: I second misconception is related to the relationships between that telecom management provider certification and billing for other medicaid services.

237
00:37:22.500 --> 00:37:34.620
Krystal Hilton: Organizations providing behavioral health and add services must be certified as an AMA plus or cma in order to continue billing medicaid for these services, this too is a misconception.

238
00:37:35.700 --> 00:37:43.560
Krystal Hilton: The color correct information is that providers do not need to be certified as a tale of care management provider.

239
00:37:44.130 --> 00:38:03.960
Krystal Hilton: As, then that will be an H plus or a cma in order to build for medicaid cover behavioral health ID or tbi services, only the providers that are interested in delivering tailored care management services would go under the H plus or the cma certification process.

240
00:38:05.400 --> 00:38:14.670
Krystal Hilton: When Taylor plans launch in order to continue providing medicaid services beyond or outside of Taylor care management or state funded.

241
00:38:15.030 --> 00:38:25.950
Krystal Hilton: behavioral health it do tbi services, the providers must be in network with the Taylor plane we're sharing an example, hopefully to help with a little more clarity on that.

242
00:38:26.640 --> 00:38:41.160
Krystal Hilton: But if a provider does not obtain the telecom management certification does not need to obtain the so Taylor care management certification to provide substance abuse comprehensive outpatient treatment services.

243
00:38:42.240 --> 00:38:48.180
Krystal Hilton: tailored care management certification is only to provide Taylor care management service.

244
00:38:49.920 --> 00:38:50.580
Krystal Hilton: Next likely.

245
00:38:52.200 --> 00:39:01.650
Krystal Hilton: I third misconception is related to care management take care manager, excuse me caitlin's organizations, providing Taylor care management.

246
00:39:02.430 --> 00:39:22.770
Krystal Hilton: That will be our am H plus practices our cms or Taylor plans must maintain specific care manager to Member caseload This is also a misconception, the correct information is where we really want to share that the department has not yet established care manager to Member caseload.

247
00:39:24.630 --> 00:39:27.990
Krystal Hilton: That must be maintained, just not establish those at this time.

248
00:39:29.040 --> 00:39:38.790
Krystal Hilton: providers have that flexibility to be real care teams, as they see fit, and that is through the use of extenders adjusting caseload size those types of activities.

249
00:39:39.330 --> 00:39:50.760
Krystal Hilton: But they but their flexibility would have to assure that they are meeting certain programmatic requirements, and that is establishing a multi disciplinary care team with care manager.

250
00:39:51.030 --> 00:40:06.420
Krystal Hilton: supervisor and care manager primary care provider behavioral health provider ID and tbi providers as applicable or other specialists and individuals identify in the provider manual and the rfa, that is what the care team could look like.

251
00:40:08.160 --> 00:40:12.720
Krystal Hilton: and also within that flexibility of building the care teams provide.

252
00:40:13.350 --> 00:40:21.960
Krystal Hilton: The providers would ensure regular communication and information sharing across the care TEAM members, they all have to talk to each other, and all of the systems must communicate.

253
00:40:22.620 --> 00:40:34.230

Krystal Hilton: there's also that requirement that the care manager to supervisor ratio cannot exceed more than a two, one that has to be cannot be more than eight to one ratio.

254
00:40:36.060 --> 00:40:50.910
Krystal Hilton: The department is released information at the providers request about caseload assumptions This information was to perform rates, but the caseload assumptions that were released are not programmatic requirements.

255
00:40:51.930 --> 00:40:56.400
Krystal Hilton: As we've shared the those requirements have not been.

256
00:40:57.840 --> 00:40:59.070
Krystal Hilton: have not been established today.

257
00:41:00.240 --> 00:41:09.030
Krystal Hilton: For more details on caseload assumptions and forming the rate development process we've provided a link at the bottom of this slide which you will have access to the.

258
00:41:10.200 --> 00:41:11.040
Krystal Hilton: Next slide please.

259
00:41:12.690 --> 00:41:18.630
Krystal Hilton: Our fourth misconception about Taylor care management relates to care management comprehensive assessments.

260
00:41:21.360 --> 00:41:28.710
Krystal Hilton: tailored care management comprehensive assessment is the same as a comprehensive clinical assessment, this is also a misconception.

261
00:41:29.730 --> 00:41:35.340
Krystal Hilton: The tailor care management comprehensive assessment is a person centered assessment of.

262
00:41:35.910 --> 00:41:52.590
Krystal Hilton: Healthcare needs functional and accessibility needs strengths and supports goals and other characteristics that inform the care plan or the individual support plan and treatment of the beneficiary This assessment is performed by the care manager.

263
00:41:54.240 --> 00:42:10.530

Krystal Hilton: Conversely, the comprehensive clinical assessment is a clinical evaluation and this provides the necessary and relevant clinical data and offers recommendations that are used when developing the person centered plan or the service plans with the individual.

264
00:42:11.880 --> 00:42:19.980
Krystal Hilton: This comprehensive clinical assessment is performed by a licensed professional or associate level licensed professional.

265
00:42:21.270 --> 00:42:31.560
Krystal Hilton: And also, noting that the information in from the comprehensive clinical assessment can be used as an input to the tailor care management comprehensive assessment.

266
00:42:33.300 --> 00:42:34.200
Krystal Hilton: Next slide please.

267
00:42:36.750 --> 00:42:40.620
Krystal Hilton: Our fifth misconception is related to conflict free care management.

268
00:42:43.740 --> 00:42:55.800
Krystal Hilton: prevailing thought is to meet conflict free requirements cma can set of firewalls that separate home and community based service delivery and Taylor care management.

269
00:42:57.390 --> 00:43:14.250
Krystal Hilton: And that will be having a separate reporting structures for Taylor care management and service delivery would separate the care plan development function from the direct service provider function, this is also a misconception, the department has explored.

270
00:43:15.630 --> 00:43:22.680
Krystal Hilton: Allowing home Community based service providers and cma to develop firewalls particular care management services.

271
00:43:23.400 --> 00:43:37.080
Krystal Hilton: telecare management and service delivery, however cms has strongly prohibited this and they've inform the state that this type of approach is not compliant with federal conflict free rules.

272
00:43:37.740 --> 00:43:49.830
Krystal Hilton: want to just restate that we are not able to establish any possibility of firewalls between the provision of telecare management services of telecare management and other service deliver.

273
00:43:50.850 --> 00:44:01.200
Krystal Hilton: In order to comply with the conflict free rules behavioral health ID or TV provider cannot deliver both take care management.

274
00:44:02.220 --> 00:44:14.550
Krystal Hilton: And the see innovation tbi or the 1950s 1915 I home and community based services at me sorry to the same individual.

275
00:44:15.690 --> 00:44:22.800
Krystal Hilton: federally we cannot have that delivery to the same same individual excuse me.

276
00:44:24.810 --> 00:44:39.780
Krystal Hilton: Since the am H plus practices and Taylor plans do not deliver home with me based services conflict free case management rules are not applicable is applicable to some the cma entity our care management agents.

277
00:44:41.760 --> 00:44:55.380
Krystal Hilton: The department is is planning to connect further with cms to determine its approach for conflict free care management for individuals in the tribal option, and that is, including the extent to which firewalls can or cannot be used.

278
00:44:57.420 --> 00:44:58.320
Krystal Hilton: Next slide please.

279
00:44:59.850 --> 00:45:05.010
Krystal Hilton: The six months misconception is related to capacity building estimates.

280
00:45:07.920 --> 00:45:20.940
Krystal Hilton: H plus practices and cma will be held to the estimates of Members that will be served and staffing submitted in their initial capacity building assessments, this is also a misconception.

281
00:45:22.200 --> 00:45:40.290
Krystal Hilton: We recognize that a major plus practices and see amaze have limited data on the number of Members that there'll be serving as well as their staffing needs to serve the population, the department also understands that providers are still exploring health information technology investments.

282
00:45:42.390 --> 00:45:49.980
Krystal Hilton: Taylor can management providers have the opportunity to submit updated estimates as they obtain additional data.

283
00:45:50.730 --> 00:46:01.320
Krystal Hilton: Also, as these estimates are find the Taylor plans are able to update their distribution plans and submit to the department for reconsideration and further approval.

284
00:46:02.130 --> 00:46:17.730
Krystal Hilton: So, as the data informed as we gain this additional information on the staffing and the Member estimates the capacity building distribution plans can be refined.

285
00:46:19.290 --> 00:46:20.160
Krystal Hilton: Next slide please.

286
00:46:22.470 --> 00:46:29.580
Krystal Hilton: And our last misconception misconceptions sevens also related to capacity building, but it's related to capacity building, reimbursement.

287
00:46:30.540 --> 00:46:41.700
Krystal Hilton: And the thought is that a image plus practices and see amaze must been funds in order to reimburse to be reimbursed with capacity building dollars, this is a misconception.

288
00:46:42.390 --> 00:46:50.400
Krystal Hilton: That capacity building program is designed to allow providers to receive funding from future Taylor plans in advance of spending.

289
00:46:51.120 --> 00:46:55.830
Krystal Hilton: And this is to help ensure startup funding for important capacity building activities.

290
00:46:56.490 --> 00:47:10.500
Krystal Hilton: With the approval of the distribution plans be detailed plans to see their first capacity building payments on the department and they can then use those funds to provide startup funding to the tailor care management providers.

291
00:47:11.580 --> 00:47:22.050

Krystal Hilton: to access the funding providers must participate in capacity building assessments that are administered by the future Taylor plans and on an ongoing basis, work to meet.

292
00:47:22.500 --> 00:47:28.380
Krystal Hilton: The targets, demonstrating progress towards achieving capacity building milestones that have been identified.

293
00:47:29.100 --> 00:47:49.080
Krystal Hilton: The providers will receive their first distribution of capacity building funds only once they are certified as an AMA H plus practice or a cma just want to repeat that again in order for provider to begin receiving capacity building funds, they must be certified.

294
00:47:50.100 --> 00:47:53.790
Krystal Hilton: As a H plus practice or a cms.

295
00:47:55.080 --> 00:48:00.810
Krystal Hilton: we've included a link at the bottom of this page to provide more details on the capacity building Program.

296
00:48:01.830 --> 00:48:03.300
Krystal Hilton: And I hope this has been helpful.

297
00:48:04.590 --> 00:48:05.280
Krystal Hilton: Our next slide.

298
00:48:06.930 --> 00:48:12.060
Krystal Hilton: Okay, I believe I am turn it over to Brian to facilitate our question session.

299
00:48:15.450 --> 00:48:17.160
Bryant Torres: crystal yes, thank you.

300
00:48:18.270 --> 00:48:30.150
Bryant Torres: To you, and Kelly, and hope for the great presentation and we do have a few questions that have come in, so let me pull those up.

301
00:48:34.170 --> 00:48:46.620
Bryant Torres: So there is one related to disparities and apartments role in measuring disparities, the question was what about disparities experience by the LGBT Q community.

302

00:48:47.580 --> 00:49:03.360
Kelly Crosbie: that's a that's a really great question and Crystal and hope feel free to join me i'm i'm you know I the example I used was, but it was a race example right, I talked about Caucasian white and black and African American children but it's how demonstrated.

303
00:49:04.560 --> 00:49:13.470
Kelly Crosbie: We we at the state, but also we ask all of our plans to use the demographic data we send them to stratify measures by race, ethnicity.

304
00:49:14.310 --> 00:49:23.250
Kelly Crosbie: gender identity and let's put an asterisk by that i'll come back to the moment by county in some cases by additional age fans the measures themselves are usually beholden to age.

305
00:49:25.500 --> 00:49:37.710
Kelly Crosbie: We actually asked them to we have a proxy for Members with lt SS we stratify measures by children and kept he kept da so we do a lot and we we separate measures we look at the whole we look at members and Center plans happens.

306
00:49:38.490 --> 00:49:43.920
Kelly Crosbie: Because it's too easy to hide a disparity unless you look at the data.

307
00:49:45.120 --> 00:49:48.570
Kelly Crosbie: in so many ways, and so absolutely.

308
00:49:49.980 --> 00:49:55.890
Kelly Crosbie: i'm part of the heart of what is takes time to kind of cultivate the.

309
00:49:57.000 --> 00:50:05.340
Kelly Crosbie: disparity specific keywords interventions that hope mentioned is a really good understanding by each plan of their measure.

310
00:50:06.450 --> 00:50:10.530
Kelly Crosbie: And what their data is telling them sorted out by the Members that are assigned to them so.

311
00:50:10.980 --> 00:50:19.770
Kelly Crosbie: that's really what we want to spend the first couple of years, doing with the plans having them see their measures and stratify them but disabilities or in a variety of ways right.

312
00:50:20.250 --> 00:50:28.620
Kelly Crosbie: They could absolutely be disparities experienced by the LGBT sorry cutie cutie a group.

313
00:50:29.520 --> 00:50:48.270
Kelly Crosbie: It could be race, it could be ethnicity, it could be county we see lots of county base disparities, and so our expectation is in the in the definition is is quite broad it's where we see disparities, we will have targets for you to close those and we want you to work on.

314
00:50:49.350 --> 00:50:52.500
Kelly Crosbie: Specific QA interventions to not perpetuate.

315
00:50:53.160 --> 00:50:58.260
Kelly Crosbie: These disparities, I think it's important, and the reason I put an asterisk there by gender identity is because.

316
00:50:58.500 --> 00:51:04.050
Kelly Crosbie: One of the things that we know we know this about all of our demographic data and we're talking about now and i'll state you're talking about.

317
00:51:04.380 --> 00:51:08.130
Kelly Crosbie: Making sure we do a much better job at collecting data from Members.

318
00:51:08.460 --> 00:51:16.740
Kelly Crosbie: That they have all the options, they need when they fill out a form for medicaid so we're getting all that it's self reported data not someone else checking a box for them so.

319
00:51:17.190 --> 00:51:27.240
Kelly Crosbie: Absolutely, the expectation, with all the data we give you be able to support it, gender identity is one of those but we're also really exploring the underlying data and making sure it's being collected.

320
00:51:27.630 --> 00:51:36.660
Kelly Crosbie: or adequate choices for Members and Members are able to identify self identify when they make those choices when they sign up for medicaid that's where we get the data when people sign up for medicaid that's where we get it.

321

00:51:38.940 --> 00:51:39.690
Kelly Crosbie: Back to you, Brian.

322
00:51:41.820 --> 00:51:44.250
Bryant Torres: Thanks Kelly super helpful.

323
00:51:45.540 --> 00:51:48.900
Bryant Torres: hey there's another, this is a comment.

324
00:51:49.950 --> 00:52:03.420
Bryant Torres: So, unlike the pathway of a Co development image plus EMAS will not be paid for reporting reporting in the first year so Kelly, if you want to provide clarification there.

325
00:52:03.840 --> 00:52:12.450
Kelly Crosbie: Yes, and hey Dr Kelly, I was really excited to see your question, so that people don't know Dr Kelly he's he's brilliant and marvelous but uh but no, no um so.

326
00:52:13.650 --> 00:52:22.230
Kelly Crosbie: The the measures that we've or trying very hard to pick for Taylor career management agencies is with the knowledge that we think we have a convention, it can help a lot right.

327
00:52:22.650 --> 00:52:31.920
Kelly Crosbie: But we also want to acknowledge it's a really complex and challenging program so we want measures that we think can be easily calculated by the state or by the plan meaning.

328
00:52:32.280 --> 00:52:37.800
Kelly Crosbie: There measures where we have the data already in our system right so just i'm sorry i'm a nerd for a minute.

329
00:52:38.250 --> 00:52:46.410
Kelly Crosbie: When you look at well visits you just look at claims you look at the claims for any child in a specific age range, who was eligible for a well visit.

330
00:52:46.800 --> 00:52:50.430
Kelly Crosbie: it's very scripted has a lot of codes that's why some of the analysts look at that right.

331
00:52:50.790 --> 00:52:59.400

Kelly Crosbie: Very scripted it says this universe of children who had a build intervention during this time period and were eligible for a well visit who got one.

332
00:52:59.880 --> 00:53:06.330
Kelly Crosbie: So you pull up all the kids you should have been eligible, and then you pull up the universe of claims for the kids who actually did get a visit and then get your rate.

333
00:53:06.810 --> 00:53:14.250
Kelly Crosbie: No data from providers, we just require a primary care physician to build a claim if they sought out for a while, is that so.

334
00:53:14.520 --> 00:53:28.560
Kelly Crosbie: The point is, is to not burden Taylor career management providers with a lot of data collection in the first year right, so we want to give someone, a measure that we are able to calculate and then to show you here's the rate for all the kids that you see what Taylor career management.

335
00:53:29.910 --> 00:53:37.950
Kelly Crosbie: And so it's not that we don't want to give an incentive to like pay for reporting or pay for performance it's that in that first year, I think.

336
00:53:38.910 --> 00:53:43.320
Kelly Crosbie: Taylor can management agencies will be getting used to the assigned membership they're getting.

337
00:53:43.920 --> 00:53:51.540
Kelly Crosbie: they'll be being used to getting a quality score on something like well child well visit, for example, and we don't want them have to report data to us so.

338
00:53:52.020 --> 00:53:58.140
Kelly Crosbie: we're actually trying to in a good way not burden Taylor career management providers with additional data reporting in the first year.

339
00:54:02.070 --> 00:54:05.670
Bryant Torres: Thanks Kelly, a few more quality related questions.

340
00:54:06.810 --> 00:54:09.750
Bryant Torres: um one being.

341
00:54:12.090 --> 00:54:18.210
Bryant Torres: Well, take care management agencies be required to send data to the state for other quality measures.

342
00:54:19.650 --> 00:54:24.540
Kelly Crosbie: It hope crystal feel free to jump in anytime again know that we don't want that right.

343
00:54:24.990 --> 00:54:32.940
Kelly Crosbie: Again, a lot of times the measures are reflecting not something that happened at Taylor career Management Agency it's reflecting something happened somewhere else right.

344
00:54:33.270 --> 00:54:40.440
Kelly Crosbie: So well care visit probably isn't going to happen at the tender care manager nation, so you know my if it's an advanced medical home plus if its primary care office.

345
00:54:40.890 --> 00:54:53.430
Kelly Crosbie: But if it's to the career Management Agency you didn't provide the primary care we don't want you to be sending us data we have it, we have it want to share it with you that's why we send you all kinds of claims information, so you have it too um.

346
00:54:54.540 --> 00:54:56.370
Kelly Crosbie: There is something and it's very.

347
00:54:57.390 --> 00:55:06.480
Kelly Crosbie: remember how we talked about like in order for us to get authority to even pay for the service right, we have to get federal authority from cms we talked about that.

348
00:55:06.840 --> 00:55:13.290
Kelly Crosbie: We have to get a health home spa so Taylor plans are health homes and that allows us to pay for care management that's just the federal 30.

349
00:55:13.740 --> 00:55:25.860
Kelly Crosbie: But in order to have this authority cms makes this report a lot of measures for people in health phones and they can they're complex measures they're like people's body mass index and people's blood pressure lab values for people.

350
00:55:27.000 --> 00:55:34.050

Kelly Crosbie: Those are things that will calculate at this date and sentence, the Ms so again that's really hard data to get we can get that from claims.

351
00:55:34.710 --> 00:55:40.380
Kelly Crosbie: We have to get that from clinical records so we're actually spending a lot of time working with the health information exchange.

352
00:55:40.740 --> 00:55:53.670
Kelly Crosbie: Who gets clinical data from provider records, so we can report that to cms so again, the goal is not to have Taylor career management agencies filling on spreadsheets with blood pressure rates for your Members or body mass index for your Members.

353
00:55:54.510 --> 00:56:01.980
Kelly Crosbie: Just helpful measure success, but again we'll we'll we'll get that data and we'll report this thing for the Federal Government.

354
00:56:04.380 --> 00:56:10.620
Bryant Torres: Thanks Kelly, and this is related and people have commented that they've heard about the health home measures.

355
00:56:10.860 --> 00:56:14.160
Bryant Torres: We clarify and maybe bring those two points together.

356
00:56:14.340 --> 00:56:23.040
Kelly Crosbie: yeah those are them right the Federal Government says to us if you have a health home right if we, we are giving you this wonderful federal money.

357
00:56:23.250 --> 00:56:27.570
Kelly Crosbie: For a health home you've got to show us that Members are getting healthier right.

358
00:56:27.840 --> 00:56:34.290
Kelly Crosbie: So that's why they asked us to send them quality measures at the state so for anybody in a cell phone we've got to send them measures like.

359
00:56:34.560 --> 00:56:40.470
Kelly Crosbie: body mass index and diabetes control, and so, if you look in a tailor care management certification.

360

00:56:41.100 --> 00:56:53.010
Kelly Crosbie: trainings we've done every time we share this health measures, but I think what we're trying to impress upon you today is, we will calculate those at the state, we will calculate them will share them with Taylor plans, who are the health.

361
00:56:54.150 --> 00:57:01.920
Kelly Crosbie: But there was a burden to collecting that data so we're not asking killer care managers to collect that data, so it is an obligation but it's the state obligation.

362
00:57:02.340 --> 00:57:05.940
Kelly Crosbie: to report that to cms so those Hello measures when you look at them.

363
00:57:06.630 --> 00:57:18.960
Kelly Crosbie: That is not going to be a responsibility for the tailored care managers to send us the data to calculate those health and measures, we will calculate them and we will share that information with cms but also with with your.

364
00:57:19.980 --> 00:57:20.280
dream.

365
00:57:21.510 --> 00:57:30.480
Bryant Torres: Thanks so when new the time and I know we have at least one or two more slides So if we want to put those back up and.

366
00:57:31.500 --> 00:57:34.980
Bryant Torres: Kelly and Crystal and hope i'll turn it to you to wrap us up.

367
00:57:39.750 --> 00:57:40.950
Kelly Crosbie: So you've taken us over me.

368
00:57:46.230 --> 00:57:47.250
Krystal Hilton: I will do so.

369
00:57:48.630 --> 00:57:59.550
Krystal Hilton: We really, really appreciate the time that you spent with us as Kelly said before you have access to the webinar on our telecare management training web page.

370
00:58:00.030 --> 00:58:08.070

Krystal Hilton: The transcripts and the actual presentations and sales are available, we will be publishing a Frequently Asked Questions documents as a result.

371
00:58:08.400 --> 00:58:20.310
Krystal Hilton: Of the information that is shared, so please if you did not get to your question, or if you have additional questions to submit, please note that you are able to submit those to the tailor care management.

372
00:58:21.480 --> 00:58:34.200
Krystal Hilton: email address, and we will publish it frequently asked questions of those in Tibet information at a later date, thank you all so much for joining us, as always, we appreciate being able to continue these conversations Thank you all have a great day.

373
00:58:36.870 --> 00:58:38.940
Mario Schiavi: Thank you for joining you may now disconnect.