North Carolina Institute of Medicine
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Task Force on Accountable Care Communities

TASK FORCE ON ACCOUNTABLE CARE COMMUNITIES

MEETING SUMMARY

April 30, 2018

10:00 am – 3:00 pm

North Carolina Institute of Medicine

630 Davis Drive

Morrisville, NC 27560

Attendees:

- *Co-Chairs:* Miles Atkins, Reuben Blackwell, Ron Paulus
- *Steering Committee:* Jason Baisden, Chris Collins, Allison Owen, Melanie Phelps, Jeff Spade, Shelisa Howard-Martinez
- *Task Force Members*: Paula Swepson Avery, Rep. MaryAnn Black, Tristan Bruner, Heidi Carter, Debbie Collins, Kathy Colville, Will Broughton (for Al Delia), Robert Feikema, Peter Freeman, Kim Green, Mark Gwynne, Dee Jones, Lisa Macon Harrison, Nicolle Miller, Kevin Moore, Barbara Morales Burke, Sharon Nelson, Abbey Piner, Hannah Randall, Brendan Riley, Maggie Sauer, Kim Schwartz, Tish, Singletary, Anne Thomas, Sheree Vodicka, Mary Warren; *Via phone*: Shauna Guthrie, Abbey Piner

Introductions:

Task Force Co-Chair Miles Atkins opened the meeting and asked Task Force members to introduce themselves. Steering committee members, Task Force members, and guests introduced themselves, including their position and the organization they represent.

Review of Initial Thoughts on Recommendations and Next Steps for the Task Force
Brieanne Lyda-McDonald, Project Director, North Carolina Institute of Medicine

Ms. Lyda-McDonald reviewed upcoming topics for the next two meetings: financing accountable care communities and implementation issues and reminded Task Force members of the products that will be produced: a technical assistance manual and traditional Task Force report with policy recommendations. NCIOM is in the process of developing an initial outline of the TA manual, which will include examples, resources, and best practices for communities geared at different stakeholders.

The presentation reviewed initial recommendations developed by NCIOM staff and the Task Force Steering Committee based on presentations and discussions to date and discussion followed, comments or suggestions can be sent to blydamcd@nciom.org:

1. Recommendations regarding evaluation/replication of the North Carolina Department of Health and Human Services social determinant of health (SDOH) pilots.

2. Recommendation to Division of Medical Assistance (DMA)/Pre-paid Health Plans (PHPs) about community reinvestment dollars – what part of PHPs' 87% medical loss ratio (MLR) can be used for community reinvestment?

3. Recommendations around funder requirements/guidelines for grantee collaborations when funding work in community health/SDOH, funding technical assistance for collaboration.

4. Requirements for Community Health Assessments to include SDOH

5. Need Health in All Policies

6. Need higher-level leadership to bring "silos" addressing different social needs together, also address accountability across silos.

7. Need strong outside facilitator – Backbone agency with enough latitude, may include foundation support for development of backbone.

8. Need to consider how to align work being done at the local level with statewide SDOH framework that DHHS is developing.

9. With the new DHHS standardized SDOH screener, is there a need for recommendations around how to consolidate/reconcile/streamline use of other SDOH screeners that health facilities and social service orgs. use.

Lyda-McDonald presentation here.

Accountable Care Community Workforce Needs: Care Managers
Claudette Johnson, Vice President for Clinical Programs, Emtiro Health

Ms. Johnson's presentation began by covering the requirements for effective care management (understanding the population that will be managed; determining key factors affecting the population; considering staffing needs – multidisciplinary teams). Care management should be patient-centered and shared decision-making is key when developing care plans. Some of the challenges facing care managers in the state are recruitment and retention (funding and salary are not the same across clinical settings) and diverse sets of skills and competencies that are needed. The barriers that care managers face to their work include: uncertain scope of practice, dissimilar and complex cases (chronic diseases might have very different social needs). Care management must be able to ask the right questions to understand a patient's needs. Care managers may use telemonitoring via tablets, which is helpful for patients with transportation challenges.

Emtiro is collaborating with hospitals, social agencies, home health, behavioral health agencies, and primary care for care managers to look at all the files and data at each of the offices/clinics/agencies where the patient is served once a month. Care managers can help alleviate burdens of other staff who currently handle some administrative tasks (e.g. an RN making a phone calls for transportation, which can be done by the care manager).

Training for care managers is needed on an ongoing basis – both tailored and generalized to all staff. Training includes motivational interviewing. As far as credentialing and certification, Emtiro incentivizes staff by providing the certification course and encouraging them to take the exam within a year, if they pass they are reimbursed for the course and then get a bonus. IT needs and challenges for care managers currently include limited sharing of clinical data, limited sharing of behavioral health data, inefficiencies and documentation errors by working in multiple systems creates, lack of real-time data, and lack of actionable reports.

Questions/Discussion:

Question: What are the benefits and implications of certification?
Answer: The education provides a better understanding of Medicare, disability, resources in the community. We do the incentive with the bonus, I don't know if hospitals are requiring it, most places prefer it. Experience in critical thinking, develop the skill set of looking beyond the clinic walls is beneficial.

Question: Thinking about the care team side, what sort of work is done to prime providers to help integrate care teams into the work?
Answer: Care managers have to prove themselves, talk with providers to show them care plans they developed. We try to get providers to look at behavioral health side, integrating behavioral health – requires space in the office.

Question: I think there is a balance between a centralized care management team that is working out in the field and partnerships with hospitals. How do you make those relationships better?
Answer: This is easier in some settings than others; we try to have a presence in the practice; building relationships with the receptionists since they are often the gatekeepers.

Question: Do you make an effort for care managers to have a panel of clients with a single primary care provider (PCP) so they can get to know that provider's particular rhythm? How does the care manager communicate back to the PCP, what is your method of communication and documentation?
Answer: Yes, to the first question. Some practices allow us to document on their electronic health record (EHR), when we do a care plan a copy is given to the provider and one to the patient. Care managers should be working with the provider or triage nurse, relationships with receptionist come in handy again here.

Question: For credentialing, if care managers have certification, can you bill for a higher rate and if not how are you paying for those raises?

Answer: We get paid a PMPM so we do not bill. Because we have multidisciplinary teams, we can manage costs and budget for raises.

Question: Do you see academic institutions recognizing the need to train in team-based care or are they still much more acute care focused?
Answer: We do have internships with UNCG and A&T. But there is still a gap in training.

Question: We met with community college on certification for health coaches and community health workers and they are not sharing their curriculum yet, so that is something of concern for us.
Answer: Yes, there is very little training for community health workers in NC.

Johnson presentation here.

Accountable Care Community Workforce Needs: Community Health Workers
Tish Singletary, Program Consultant, Division of Public Health, Chronic Diseases and Injury Sections, North Carolina Department of Health and Human Services

Ms. Singletary explained the development and status of North Carolina's community health worker (CHW) initiative, which has been going on for several years. CHWs are "contextual experts on the continuum of health," helping patients navigate a complex health care system. Currently cannot bill for CHW services because there are no standards that exist nationally or at the state level.

The mission of the initiative is to establish a sustainable infrastructure that acknowledges the value of CHWs, supports their professional identity, and integrates their role in the healthcare team. The goals are to: 1) Identify core competencies for NC CHWs; 2) Recommend model training curriculum; 3) Develop model certification process; 4) Develop model program credentialing process; and 5) Devise strategies for reimbursement of services. CHWs in North Carolina work with many different populations, including formerly-incarcerated individuals and Latin(x) populations.

CHWs are different from other professionals and effective because of their shared life experience and cultural background with the population they serve. They do not provide clinical care, can provide some direct services if they are trained and supervised – some hold a clinical license. CHW core values are equality, justice, and empathy.

DPH created an inventory of CHWs in the state by sending and request to nearly 300 organizations for information and 117 responded to participate in the inventory. DPH held an initial stakeholder meeting and received a directive from the group asking: What can we do to research workforce development and training; What could we recommend in using CHWs going forward? DPH developed a set of recommendations to address training, certification, and sustainability. DPH wanted to recommend starting a standardized training and looked at what other states are doing. They also had some technical assistance to help with understanding the financing and credentialing for CHWs because there are no national standards, although there is consensus around the core competencies for CHWs. The stakeholder initiative came up with nine competencies (communication skills interpersonal skills, service

coordination skills, capacity building skills, advocacy skills, education and facilitation skills, outreach skills, knowledge base, and personal skills and development), four roles (cultural liaisons, health navigators, health and wellness promoters, and advocates), and an idea for standardized training.

Next, DPH conducted a survey in July 2017 with the 117 organizations from the inventory, which asked them to forward the survey out to community health workers. They received 168 responses representing 42 counties. Findings showed that the majority of respondents have college degrees, are black, aged 24-34 & 54-64, are mostly working for community organizations, religious organizations, and community health centers. The majority of CHW respondents have been working in that role for 1-4 years and over half are paid full time. Respondents' roles and responsibilities include working with the uninsured, disabled, seniors, rural residents and providing resource connections to health care, food assistance, transportation, and insurance.

In thinking about the training to be developed, DPH looked at training offered through Brody School of Medicine and also training available in other states. Some community colleges offer standardized core competency training (Edgecombe and Durham).

The overall workforce development recommendations include: 1) there should be some kind of certification and a board may be helpful for oversight of what kind of trainings are offered for CHWs, 2) CHWs need to be paid a living wage (32% of respondents were volunteering), 3) CHWs need to be provided with the necessary tools – including EHR access or documentation, 4) there should be protocols for care teams to recognize CHW contributions.

Questions/Discussion:

Question: What is average salary for people being paid, are CNAs doing this work?
Answer: $20/hr is what they are normally paid. Some certified nurse assistants (CNAs) are doing this work. Asheville/Buncombe Institute for Parity Achievement. What is the difference between CNA and CHW – a lot of intersection, CHW is for the most part someone from that community and is probably not a licensed clinician. As we create the structure, we need to be sensitive that this is a volunteer role often so don't want to mandate too much.

Questions: A high percentage of CHWs had bachelor's degree, do you know what field? That also creates considerations of student debt with living wage.
Answer: We held listening sessions in communities, a lot of them are working with nonprofits and have a public health background, many are identifying as health educators.

Question: For the CHWs who are employed, is the wage anything that can be modified to encourage retention and I always wonder about, because CHWs do make a big difference and are not always recognized as a part of the care team, is there an opportunity to get feedback from the rest of the team about the value of CHWs? Are you increasing their feeling of the value they bring so that along with the wage is a mechanism for retention?

Answer: CHWs part of the stakeholder workgroup – pay was very important, but the recognition that they are contributing to outcomes was what resonated most with them. If they can get the respect they need they are more likely to stay.

Singletary presentation here.

Panel: IT Infrastructure Needs to Support Accountable Care Communities – Stakeholder Perspectives
Lanie Honeycutt, Product manager, Son Information Systems, Inc.

Ms. Honeycutt explained MATCH, the McDowell Access to Care and Health, which is funded by the Kate B. Reynolds Charitable Foundation. She explained that technology is only as good as people know how to use it, and it's only as good as the infrastructure it's built upon/what it is built around. The lead network agency for MATCH is a community-based organization, trusted by the community and other organizations (McDowell Health Coalition). Network Partner Agencies receive funding from the grant (Community Care of Western NC and McDowell Hospital). Network Participating Agencies include behavioral health, YMCA, PCPs, faith communities, school systems, EMS, Career Center, Food Pantries, Division of Social Services, and the Health Department. Clients signed a consent for to participate in the network with the understanding that their information was going to be shared.
For the IT design, they wanted system that would enable separate work since not all participants need to see all the data. There are separate "sites" so every single agency is its own site within the system. The system allows users to manage resources and referrals and capture needs in a secure web-based system.

The initial goals for the system was that all network agencies participate in a shared data system creating a closed-loop referral system. That shared system would then act as an information hub. They also wanted to track client-determined goals to measure patient activation and stratify patients so some receive more intensive follow-up, referrals, etc. In reality, after over four years, most agencies have reverted back to traditional referral methods – many agencies already have an IT system and referral methods that are tied to funding/grants. There is varying comfort with technology and computers at the agency level. The communication and events kept network agencies engaged and active.

Lessons learned for the work are that IT is a tool, relationships are the glue and success comes down to the trust built. There must be a balance between capturing data and preserving client interactions. Also, incentives are key, suggesting that it may be helpful to build incentives into the system and direct resources to need that is identified or give a reward for closing the loop on referrals. Finally, there are always security and technology risks.

Katie Bartholomew, Manager, Clinical Operations, Mission Health Partners

Ms. Bartholomew described the care footprint of Mission Health Partners (MHP. In rural counties, community resources vary greatly, and transportation is challenging, however Appalachian culture is resilient, independent, and community-based. These factors combine to make community outreach challenging. MHP nurses are assigned a group of practices. MHP wanted to identify and track SDOH and they found tools that could track SDOH and tools for medical the piece but not necessarily both at the

same time. They originally tried out the Pathways HUB model and had to build a medical case management piece, however this didn't really work with existing reporting requirements. MHP ultimately went with a traditional medical case management tool vendor and then built the Pathways HUB into it for SDOH.
The model allows for information about care transitions, provider referral, and whether an individual is high-risk for admission, which triggers the comprehensive initial assessment. The assessment identifies social needs and then a patient is referred through relevant pathways (financial, transportation, medical home, med access, housing, food, legal support). The tool is not an official HER, so different partners can go in to report. Partners can pass back some de-identified information around patient utilization. MHP uses predictive analysis to visualize patient risk for unplanned admission using claims data and big data.

Christie Burris, Executive Director, NC Health Information Exchange Authority, North Carolina Department of Information Technology

Ms. Burris gave an overview of the creation of the department of Information Technology and their development of NCHealthConnex. They have set up a secure network for the health information exchange (HIE) with SAS as the technical vendor. NCHealthConnex will serve as an electronic network for providers to share health-related information across a statewide platform. The platform will allow provider to enter information into an EHR (they are working with over 100 EHR vendors across the state). As such, they are trying to meet providers where they are – meeting data requirements, not everyone can report the same amount of data. A basic patient ID is required for patients to be tracked from provider to provider.

The vision is to create connected health care communities. There is a need to align claims data with clinical data. They are also working with DHHS to consolidate data requirements in the state. The law mandates that if you are receiving state funds you are required to connect and send clinical and demographic data on your patients through NCHealthConnex. The timeline set for Medicaid providers is June 1, 2018, however some providers will not make the deadline. There has been significant progress – in Spring 2018: 1101 facilities, 2805 providers were added.

In the first year of development, the providers that were included in the system were hospital health systems, FQHCs, and public health departments. Then, in 2017, specialists and primary care were added and in 2018, behavioral health and other specialists (vision dental home health) were added.

A Data Quality Program is working with the provider community to ensure value. They are working to ensure the data they are receiving is complete. They are also examing whether incomplete data may not be the fault of providers, but rather an issue with the vendor.

A Diabetes Registry will be ready on June 1, 2018 for DPH to utilize for public health purposes and will subsequently go to Phase 2 to allow community partners to see patient-level info.

Clinical notifications of real-time data are currently being piloted, which involves a provider sending DIT a patient cohort, where it is scanned in their system for anything that has happened at other providers, and then the information is sent back to providers, who can use it for referrals or interventions. DIT is

updating the HIE to allow for real-time reporting. DIT will work with DHHS as they undergo Medicaid transformation to develop a roadmap to help identify overlapping areas between the two agencies. Other opportunities in the future include integrating with HIEs outside of the state, such as Georgia and the Veterans Administration, as well as states that North Carolinians commonly move from.

Questions/Discussion:
Question: Getting quickly to ROI is pretty critical, and where we are delivering value back to pre-paid health plans (PHPs) is important, so how do you get to this point of where you are delivering a service that is paid for and saving money?
Answer (Bartholomew): We try to be intentional, our model is telephonic so it improves efficiency, and we have seen a decrease in readmission rates, and really recognizing which team member is necessary – when we are evaluating a patient's needs we do that with a nurse and then pass it on to the appropriate team member.

Question: As Medicaid gets transformed and focuses on SDOH how are you integrating SDOH into HIE?
Answer (Burris): HIE is for all providers – having the HIE act has helped participation to grow, it's not just state-funded patient records. There's a future for SDOH info to be presented back through HIE. There's a PREPARE tool that has been developed that takes that social needs assessment and puts it into fields so that it can be mapped back to the EHR. This makes it easier for providers to stay in their work flow. Because it is a clinical portal with protected health information, we'll have to be careful with that.

Question: $11 million in savings for your program, what were the overall costs? The bigger point is that it's difficult to measure the cost/benefit ratio. How many clients did your team work with to get to $11 million in savings?
Answer (Bartholomew): Our population in 2014 – same footprint but 50k people. Typically, we serve about 11% of the population we reach out to personally. About 4 interventions per patient.

Question: Have you thought about working with EMS so that they can have access to health data?
Answer (Burris): We do have a meeting with EMS around specific use case. We do want EMS to have access to data they can use when they arrive at an emergency

Question: If you were advising a community that was developing an ACC-type model, what is your advice on where to start with IT?
Answer (Honeycutt): We identified the model before we developed an IT system. We identified a vendor that was willing to work with us, so it is important to find a system that is not set in stone and can change with the work.

Question: I worry we are creating a chaotic data environment, my instinct is that we should support HIE and make sure it is integrated with care management info and becomes a care management software platform, but we want to be able to take this and be helpful in supporting IT needs for ACC.
Answer (Burris): We can't customize, we have to standardize. Thus, data needs to be easily transferred among EHR systems. With the adaptation of FIRE and other technology we can supply platforms for practices to use that are aligned with the data.

Answer (Honeycutt): A lot of the work we did in care coordination/CHW is captured in narrative, but that needs to be codified and standardized so that it can be integrated with HIE
Answer (Burris): The government data analytics center is underway with a project to build a service catalog (pilot with VA and juvenile justice).

Question: Provider-agnostic data for specific populations, you are talking right now about provider audiences being the principle audience for aggregated data, is there a place for data at the county level for use by others?
Christie: DPH is interested in that.

Question: Presentation from a health plan in Oregon and they are tying payment to it so that when community agencies meet a need, they get payment that makes this more sustainable. Thinking more about incentives.
Answer (Bartholomew): just started with ABIPA (Asheville Buncombe Institute of Parity Achievement) to talk about a payment model to close the loop. But they would get a certain payment for the assessments and each pathway that they close. We are in the "figuring it out" stage.

Honeycutt presentation here.

Burris presentation here.

Discussion of Task Force Recommendations: Workforce and IT
Facilitators: Maggie Bailey, Brieanne Lyda-McDonald, Berkeley Yorkery, Adam Zolotor

Two small groups discussed potential recommendations related to workforce and two small groups discussed potential recommendations related to IT infrastructure.

Next Steps
Brieanne Lyda-McDonald, Project Director, NCIOM

Ms. Lyda-McDonald gave a brief presentation on the upcoming meeting dates and topics we will cover.

Lyda-McDonald presentation here.