Keeping Kids Well Project: Common Questions

General Project Highlights

- NC Medicaid, CCNC and NCAHEC are partnering together to address this important public and child health initiative..
- The aim is to improve the number of pediatric patients in compliance with the AAPs recommended well-child visits and vaccinations to at least pre-COVID 19 levels. Additionally, improve utilization disparities in African-American and Latinx populations.
- CCNC and NCAHEC Practice Support will provide 1:1 coaching support to practices with 500+ overdue care alerts listed on the CCNC dashboard (Care Impact dashboard information is based on Medicaid claims data).
- This involves 300 independent pediatric and family medicine practices, FQHCs and RHCs and some health system practices.
- Practice support comprises collaboration with the practice in reviewing and introducing clinical workflow best practices. Standardized workflows, scripts, tools and collateral will be shared.
- There will also be a mass communications strategy to nearly 2,000 primary care practices and patients/beneficiaries.
- The project will begin in early August and go through September. The initiative may go longer depending upon need.
- More information and training will be provided to CCNC and AHEC coaches in July 2020.
- Information was provided during the AHEC/CCNC/DHHS webinar June 2020 highlighting the problem and at a very high level, the AHEC/CCNC work that is coming to help address the issue.

Frequently Asked Questions

What kind of practice/patient data is required to participate in this initiative? Pre/ Post Data? Where can we find this data?

- Data will be collected from Care Impact - Value Based Population Health Dashboard available through CCNC/ and for CCPN (Community Care Physician Network) Practices and your own practices' EHR.

What is the age range of our pediatric patients we will focus on in this initiative?

- Including ages 0- 18 years old with prioritization to children 0-2 years of age since they are highest risk.

How much time will our practice need to invest in participating in this initiative?

- It depends upon how long it will take to see improvement in utilization. For some practices, there may be some "do it now" solutions. For others, there will be workflow redesigns that will be accomplished in a more methodical way.

What kind of support can we as a practice enrolled in this initiative expect from CCNC/ AHEC?

- As a participant in the Keeping Kids Well initiative, practices will have access to an on-site or remote practice support coach to help with data collection, workflows, and/or training.
- You will also be given a tool box that includes best practices, tip sheets, and patient education materials in English and Spanish.
- We are interested in helping your practices redesign workflows to improve the underutilization of well-child visits and immunizations during the pandemic.

What kind of resources can we share with our patients/ families to better educate them on the importance of the HPV vaccine(s)? There is so much confusion and concern around the HPV vaccine.

- See the Pediatric Immunization FAQs for Patients and Families for detailed information.

Do I need designated vaccine champion for my practice or clinic?

- As part of the Keeping Kids Well initiative, we ask each practice to identify a champion for this project. This person can be clinical or non-clinical but must have access to vaccine information and be able to lead the practice in transformation.

Are tip sheets available for patients/families?

- Yes, CCNC/AHEC have developed several tip sheets that are both provider and patient facing to aid in this work.

Will I receive assistance, if needed, with developing workflow around ensuring the clinic is documenting correctly, use of VIS sheets, assisting with storage, and confirmation of billing?

- Yes, as an assigned practice support coach you will assist practices in identifying best practices, workflows, and/or project evaluation.

What should the response be for providers who point out discrepancies in their attribution list as this is a common complaint we hear?

- CCNC receives enrollment data from NCTracks. Members have the choice of choosing their CAII provider but if they do not indicate a choice thru their county DSS office the member will be auto assigned to a CA II practice. Auto assignment utilizes provider information and parameters the practice has listed in NCTracks. For members assigned to a practice the practice will receive the PMPM management fees.

What if the practice doesn't have access to the CCNC dashboard and/or understand how to utilize it? Will AHEC coaches be trained on this?

- CCNC can provide key support on the Care Impact Value Based Population Health Dashboard to the specific practices that are CCPN members. CCNC coaches can work with AHEC coaches to train the practices on the Care Impact Value Based Population Health Dashboard. If a practice is not a member of CCPN (Community Care Physician Network), then the AHEC coach/ CCNC coach can work with the practice on pulling reports from their EHR.

Is there a specific BAA for this project or do we use our standard BAA? (AHEC specific question)

- AHEC staff will use our standard BAA.

Will the list of practices that have access to the VBPD also show which practices are CCPN and can have access and which ones are not CCPN and cannot have access?

- At this time only CCPN practices can get access to VBPD. The list of CCPN practices will show the ones that are already on boarded to VBPD.
- Also, the CCNC PRRs are working now to try to get the CCPN practices in this effort that aren't on boarded to start the process to get a jump start for the project.

Is NC Medicaid pushing letters out to parents about recommended vaccinations and the importance as well as information regarding the Well Child visit?

- We haven't heard plans for a mass mailing by Medicaid/ NC DPH. There are communication plans using social media to promote.

Is the Care Coordination intervention available to all practices or just ones that already have a relationship with CCNC?

- All practices on the master list are CCNC CAII practices so care management/care coordination are a component already- so yes.

What does PRR stand for?

- Provider Relations Representative

Is there data on disparities in WCC for providers in the available resources?

- Dr. Cykert also provided a script on having conversations about disparities as well. That is in the toolkit as well.

Is there aggregate data… more so than patient level data?

- Yes- we can see percentages in the dashboard.

Some practices are getting WCC/vaccination gaps data from other resources such as Health System Partners that they use to close the gaps. Is it Ok to incorporate that process in our work?

- Yes, absolutely.

If more than one air table form is done in a submission period, the new won't write over the original, correct?

- They will not be written over

This air table form filled out every time we have some sort of engagement with a practice, not just the initial contact and conversation?

- Correct!

Do we make an entry every time we make an attempt to contact? For example, if we make a phone call and an email, should we make two separate entries?

- Yes

How will healthy systems be handled, since we may be dealing with one contact? Is there a group documentation option?

- You will document as a group. For groups pick the primary location and will count for the group.

If a practice requests our help but aren't part of the 300 practices, do we document this?

- Based on replies during the webinar, the core team will discuss and will get back to team leads/directors, PRRs, and coaches.

Are these care gaps based on claims data from NC Medicaid or based on EHR documentation?

- Based on Medicaid claims data received from the state.