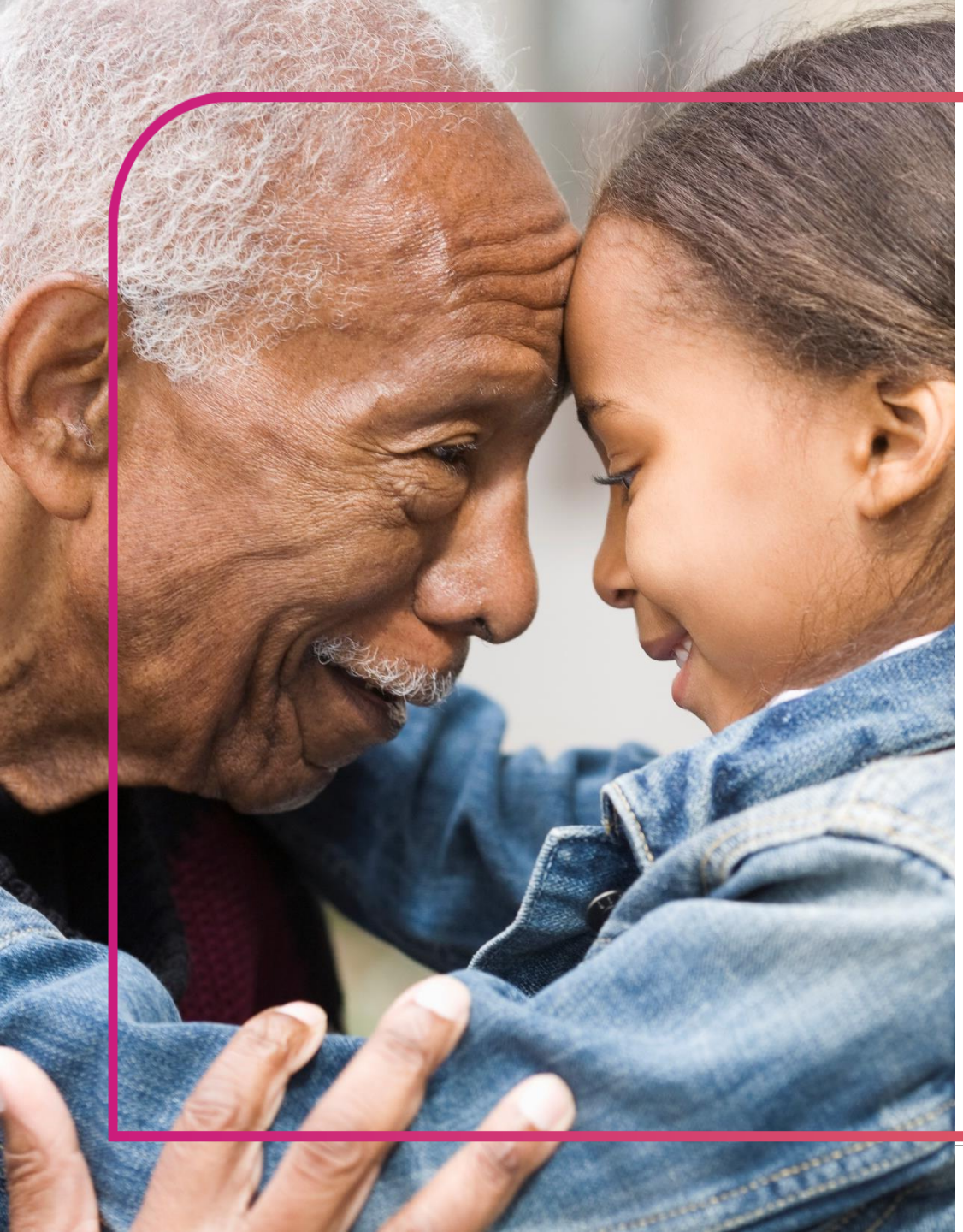


carolina complete health™

Provider Webinar:
Blood Pressure Self Monitoring Prevention Program

Hosted in partnership with:

carolina complete health network™

the YMCA
NORTH CAROLINA ALLIANCE OF YMCAS

Webinar goals:

- Review the AMH Quality Strategy related to Controlling High Blood Pressure (CBP)
- Provide an overview of the Blood Pressure Self Monitoring Program and referral pathway on the Blood Pressure Self Monitoring

Why we're in business

OUR PURPOSE

Transforming the health of the community, one person at a time

What we do

OUR MISSION

Better health outcomes at lower costs

What we represent

OUR PILLARS

Focus on the Individual

+

Whole Health

+

Active Local Involvement

What drives our activity

OUR BELIEFS

We believe healthier individuals create more vibrant families and communities.

We believe treating people with kindness, respect and dignity empowers healthy decisions.

We believe we have a responsibility to remove barriers and make it simple to get well, stay well, and be well

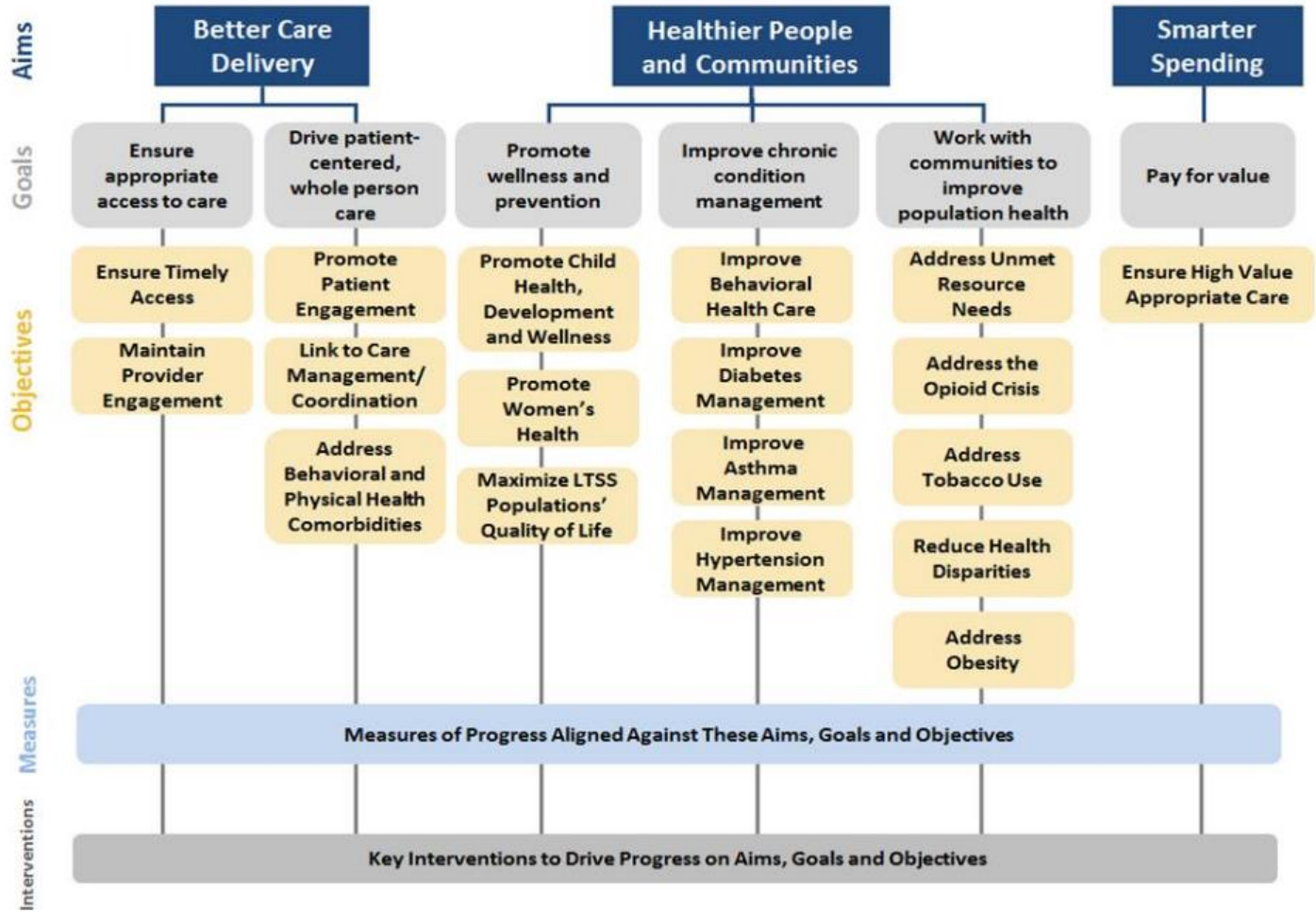
We believe in treating the whole person, not just the physical body.

We believe local partnerships enable meaningful, accessible healthcare.

Quality Strategy:
Controlling Blood Pressure (CBP)

North Carolina's Quality Strategy for Medicaid

Figure 3. Overview of the Quality Strategy Framework



[NC DHHS Quality Strategy]

Advanced Medical Home Quality Measures

Figure 3. AMH Quality Metrics for Calendar Year 2022

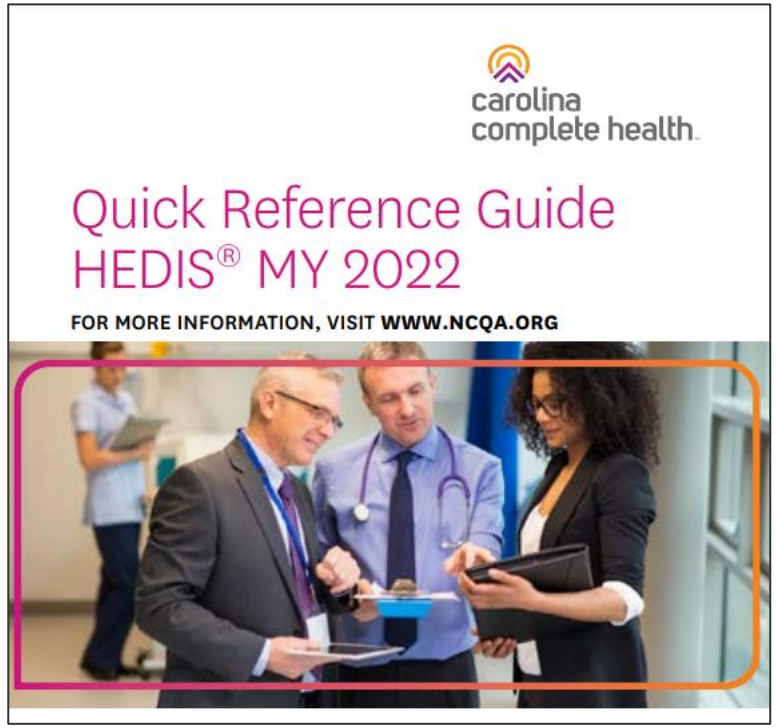
Calendar Year 2022 AMH Measure Set
• Child and Adolescent Well-Care Visit • Childhood Immunization Status (Combination 10) • Immunization for Adolescents (Combination 2) • Screening for Depression and Follow-up Plan • Well-Child Visits in the First 30 Months of Life[18] • Cervical Cancer Screening • Chlamydia Screening in Women • Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) ★ Controlling High Blood Pressure • Plan All-Cause Readmission – Observed to Expected Ratio

AMH Provider Manual

Controlling High Blood Pressure (CBP)

Description	Measure Guide
Percentage of members 18–85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90) during the measurement year	Higher rate is better

Calculation	Eligible Population
$\frac{\text{Members whose most recent BP is adequately controlled (<140/90) during the measurement year}}{\text{Members who have hypertension, per the eligible population}} \times 100$	Members 18–85 years of age who had at least 2 visits on different dates of service with a diagnosis of hypertension on or between Jan. 1 of the year prior and June 30 of the measurement year



HEDIS Quick Reference Guide

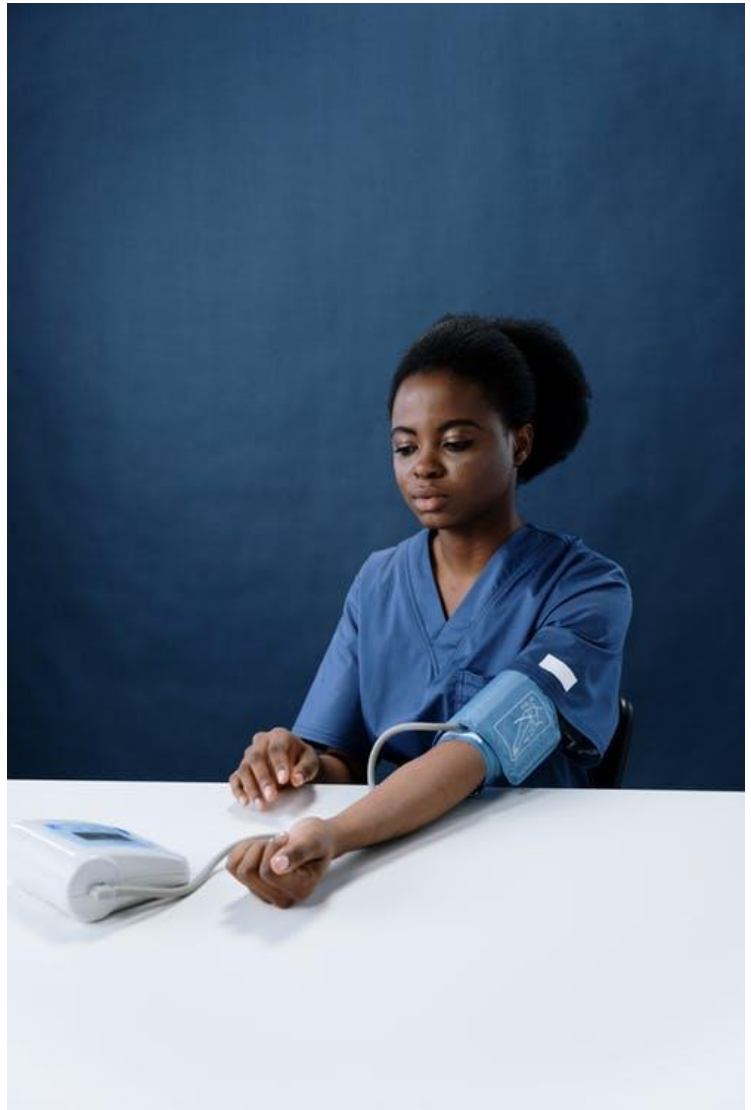
CBP Best Practices

If the BP reading is high at the beginning of the visit, retake it at the end of the visit and record the lowest systolic and diastolic reading

Schedule follow-up appointments and/or BP checks if BP is not controlled

Include CPT coding as appropriate when submitting claims

Schedule virtual or telephone visits for members who are nervous about coming into the office



What are CPT II Codes?

- ❑ CPT II Codes are supplemental data tracking codes that can be used for performance management

- ❑ These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures

Why Should We Use CPT II Codes?

- ❑ Decreases the need for record abstraction and chart review, thereby minimizing the administrative burden on physicians and their staff

- ❑ Helps close gaps in care more accurately and quickly – this drives HEDIS measures and quality improvement initiatives

- ❑ Best practice – all payers moving to this (if not already)

Controlling High Blood Pressure (CBP)

DESCRIPTION	CODES*
Essential Hypertension	**ICD-10:** I10
Systolic Greater Than/Equal to 140	**CPT-CAT-II:** 3077F
Systolic Less Than 140	**CPT-CAT-II:** 3074F, 3075F
Diastolic Greater Than/Equal to 90	**CPT-CAT-II:** 3080F
Diastolic 80-89	**CPT-CAT-II:** 3079F
Diastolic Less Than 80	**CPT-CAT-II:** 3078F
Telephone Visits	**CPT:** 98966-98968, 99441-99443
Palliative Care	**HCPCS:** G9054, M1017 **ICD-10:** Z51.5

*Codes subject to change

Source: HEDIS quick reference guide (HQRG)(Measurement Year 2022) (PDF)

Additional Quality Resources

Closing Care Gaps Guide (PDF)

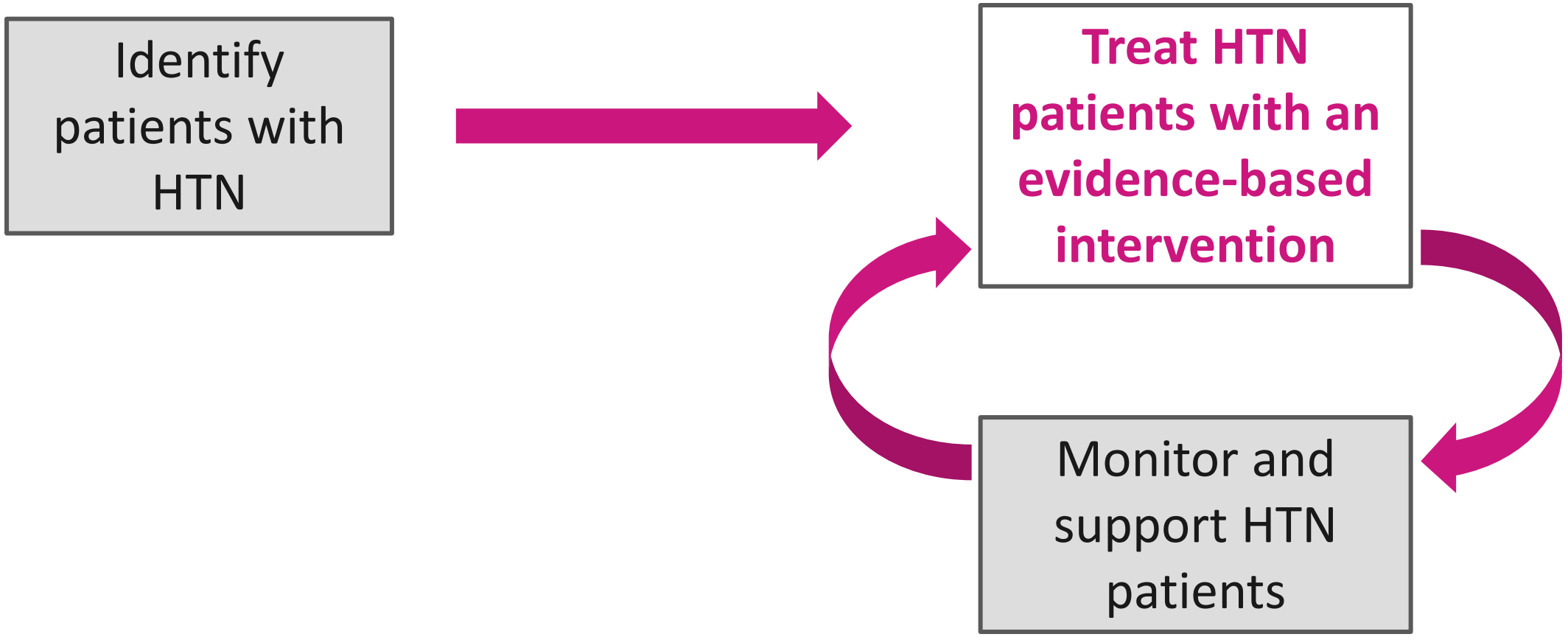
HEDIS quick reference guide (HQRG)(Measurement Year 2022) (PDF)

Adult measures pocket guide (MY2022) (PDF)

Pay for Performance Provider Education (PDF)

CCH Value Added Services:
Blood Pressure Self Monitoring Program

Physicians and providers can lead the way in heart health



Health Equity Approach

A shared vision between Carolina Complete Health and the Y

- Health Equity by definition
  - Everyone having the opportunity to attain their full health potential

Inequities affect the health and wellness of millions

- High Blood Pressure Disparities
  - African Americans 42%
  - Whites 28%
  - Hispanics 26%
  - Asians 25%

Value-Added Services

At Carolina Complete Health, we understand that health is more than what happens at a doctor's office.

Social Determinants of Health (transportation, education, housing) can account for up to 80% of the factors that influence overall health and longevity.

That's why Carolina Complete Health developed Value-Added Services to support the children, expectant parents, and families covered by Medicaid.

For more information, visit our website!

YMCA Blood Pressure Self Monitoring Program

CCH is partnered with the YMCA to provide BPSM at no cost to qualifying CCH members.

The Y in North Carolina works to increase partnerships in community integrated health networks to:

- Improve the health and well-being of our residents in North Carolina
- Improve our state's health ranking

the YMCA

NORTH CAROLINA ALLIANCE OF YMCAS

YMCA Blood Pressure Self-Monitoring Program

- A four-month program works with participants to build skills and capacities that help them:

Manage high blood pressure	Identify and control triggers that raise blood pressure	Adopt healthier eating habits

- Twice a month, participants attend the program and receive personal coaching, as well as attend monthly nutrition meetings (all virtual)
- **Eligibility Requirements:** The program is available to Carolina Complete Health members age 18 years or older who have been diagnosed with high blood pressure. Participants cannot have had a recent cardiac event, have atrial fibrillation or other arrhythmias, or be at risk for lymphedema.
- **Requires physician referral form**
- **More information:** https://www.carolinacompletehealth.com/members/medicaid/resources/vas/ymca-benefit.html

Additional benefits of BPSM

Members receive:

- Blood pressure cuff
- Blood pressure log
- Meetings with heart health ambassador twice each month
- Nutritional guidance including a DASH diet cookbook

Lifestyle interventions for BPSM

Nutrition

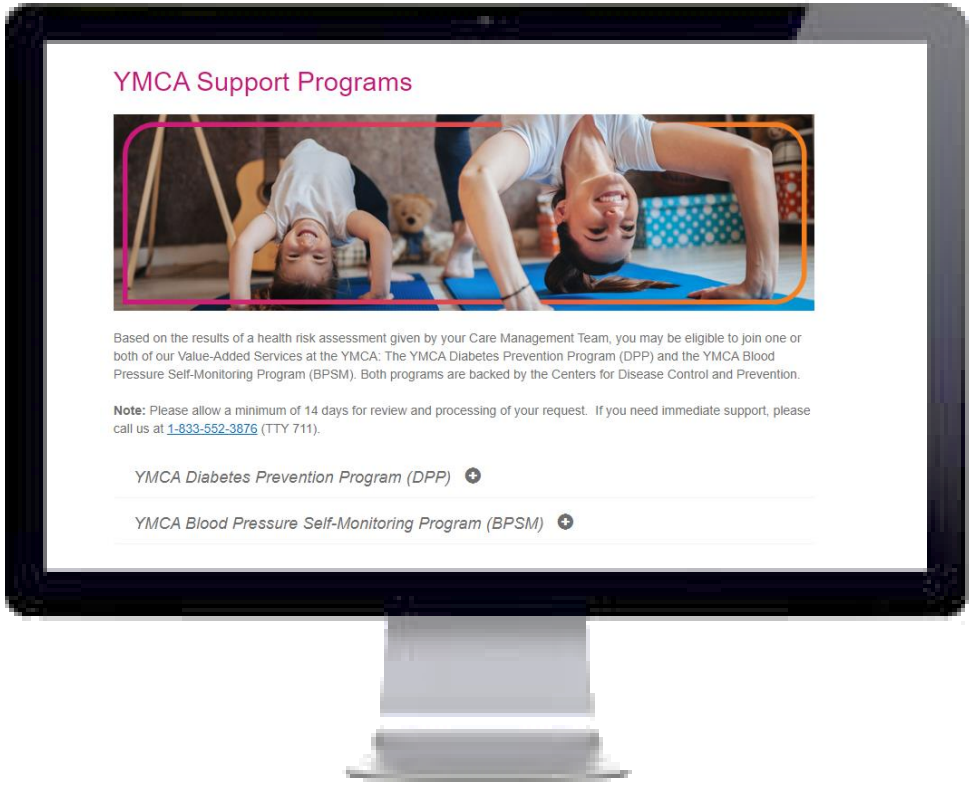
- Studies show that the DASH diet can lower blood pressure in as little as two weeks by limiting sodium to less than 2,300 mg per day.
- DASH can also lower low-density lipoprotein cholesterol levels.

Physical Activity

- 30 minutes of PA a day (equivalent to brisk walking) 6-7 days per week (180 minutes each week) may result in better management or a reduction in one's blood pressure

Referring Carolina Complete Health Members to BPSM

- CCH Referral Form



Physician Referral Form

carolina complete health | the Y

☐ **I am referring my patient to the following YMCA program(s).**

☐ **YMCA Diabetes Prevention Program (for those with pre-diabetes)**

One-year program to help adults reduce their risk of converting to full diabetes by learning about physical activity and nutrition leading to weight loss and risk reduction. **Who is eligible? For Active adult members age 18 years or older, Adult members at risk for diabetes, Adult members with a BMI equal to or greater than 25, Adult members with an A1C between 5.7% - 6.4%.**

☐ **Blood Pressure Self-Monitoring Program (BPSM)**

Adults: 4-month program. Participants measure their blood pressure twice a month, attend two personalized consultations per month and attend monthly nutrition seminars. **Who is eligible? 18 years or older and have been diagnosed with high blood pressure. Participants cannot have experienced a recent cardiac event, have atrial fibrillation or other arrhythmias or be at risk for lymphedema.**

MEDICAL PROVIDER INFORMATION

Medical Provider Name: _____

Practice Name: _____

Office Phone: _____ Office Fax: _____

Medical Provider Certification
This patient is:
☐ Not cleared to exercise at this time ☐ Cleared to exercise with no restrictions
☐ Cleared to exercise with the following restrictions. Please list restrictions below:

_____
_____
_____
_____

☐ I have obtained participant authorization to release information to the YMCA and to include the patient's most recent medical records.

Medical Provider Signature _____ **Date** _____

Member Incentives

$75 Healthy Rewards

- All members receive a My Health Pays Rewards Visa Card within two weeks of enrollment.
- **Members can earn up to $75 in rewards loaded on the card when they complete specific healthy activities such as a care needs screening or a wellness visit.**
- Members can also receive an additional $75 reward for their first, second, or booster vaccination received between 11/15/21 – 12/31/22.

Healthy Activities Eligible For Rewards

- **$20 - Care Needs Screening.**
  Must be completed within the first 90 days of becoming a member
- **$20 - Child Well Care Visit.**
  Ages 2-20 years old. Once per year.
- **$25 - Infant Well Care Visit.**
  Must complete all six visits with assigned PCP. 2, 4, 6, 9, 12, and 15-month infant well care visits.
- **$20 - Adult Well Care Visit.**
  Ages 21-65. Cannot earn the same year as Care Needs Screening reward.
- **$10 - Flu Vaccine.**
  Ages 18 and up. Once per flu season: September-April.
- **$20 - Comprehensive Diabetes Care**
  Ages 18 and up. Must complete all of the following once per year:
  HbA1c test
  Kidney screening
  Retinopathy screening (dilated eye exam)

Questions?