Vaya Health Prevention and Population Health Management Plan

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VAYAHEALTH

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Introduction

Vaya Health (Vaya) takes a population-based approach to improving the overall health of the Medicaid members enrolled in our health plans. Population health management is the proactive application of strategies and interventions to a defined population of individuals across the continuum of healthcare delivery to maintain and/or improve the health of the individuals within the population while ensuring the right care, at the right setting, at the lowest cost, with the best member experience. Vaya uses aggregated data to identify, analyze and impact specific health conditions and health disparities, improve member outcomes, and reduce unnecessary costs.

Vaya engages as an active partner in Healthy NC 2030 planning and we collaborate with community-based organizations (CBOs) to address targeted public health concerns and initiatives such as the opioid crisis, infant mortality, mental health awareness, and nicotine use prevention/cessation. Vaya's Executive Vice President & Chief Operating Officer (COO), in collaboration with the Chief Medical Officer (CMO), is responsible for the strategic direction and coordination of Vaya's Prevention and Population Health Management (PPHM) programs. These include care coordination, care management, network development and management, access to services, System of Care, and utilization management (UM). Coordinating these programs ensures an integrated organizational approach for prevention, population health, and quality improvement. Vaya outreaches and collaborates with other payers, CBOs, and advocacy groups to achieve organizational population health goals and meet requirements of Vaya's contracts with the NC Department of Health and Human Services (NCDHHS or Department). Vaya's PPHM programs reflect needs identified in Community Health Assessments conducted by Local Health Departments (LHDs) in our region. Vaya makes PPHM programs available to all members, using multiple data sources and pathways to identify members who are most likely to benefit. These include the care management comprehensive assessment process, claims analysis, member self-referral, and referrals from providers, caregivers, care team members, and other representatives.

Scope

The physical health components of Vaya's PPHM programs are primarily designed for Medicaid members enrolled in the Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plan (Tailored Plan) that Vaya operates pursuant to a contract with NCDHHS. Vaya does not manage physical health, pharmacy, or long-term services and supports (LTSS) for Medicaid members enrolled in the NC Medicaid Direct Prepaid Inpatient Health Plan (PIHP) or for State-funded Services recipients. Some components of the PPHM programs (e.g., tobacco cessation, opioid misuse) are available to State-funded Services recipients and NC Medicaid Direct members. Vaya's PPHM programs will include a thorough review and discussion of Tailored Plan-level data and quality performance.

This document describes Vaya's strategy for managing the health of the population enrolled in our health benefit plans. It provides an overview of how the needs of the population are identified and stratified for

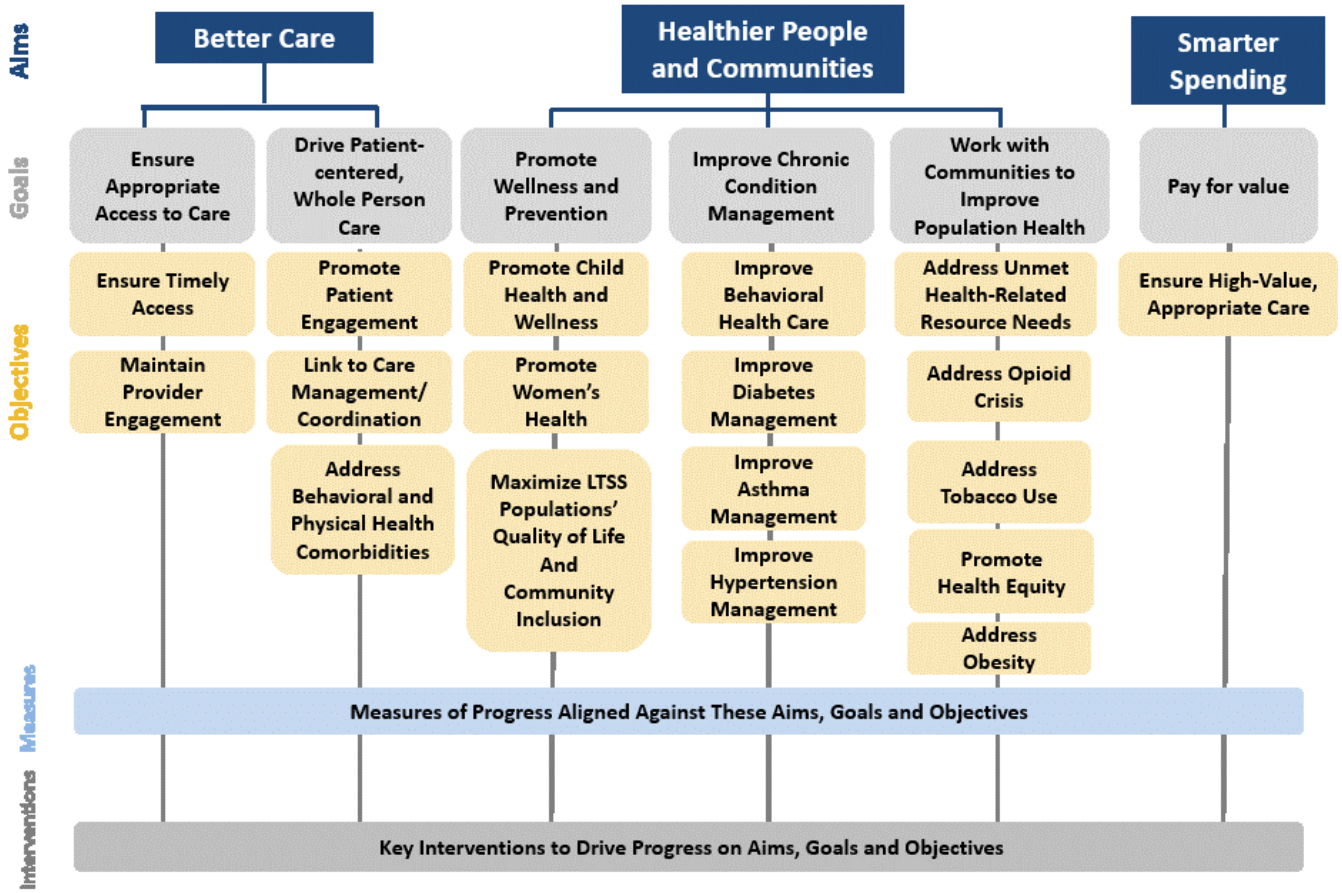
intervention, summarizes the PPHM programs we will employ to address the needs of the population across the entire health and illness continuum, and explains enabling strategies used by Vaya to promote the transition to value-based care in our contracted network.

Alignment with Department Priorities

Vaya's PPHM programs align with the Department's larger public health goals and Quality Strategy as detailed below in **Figure 1.1**. The Department will provide population-level measures to Vaya, such as measures related to infant and maternal mortality, to inform Vaya about regional trends and assist Vaya in performance improvement efforts. Department-identified priorities include the following:

- Diabetes
- Asthma
- Obesity
- Hypertension
- Tobacco cessation
- Infant mortality
- Low birth weight
- Early childhood health and development
- Additional PPHM programs that encourage improved health and wellness among members, such as interventions that will improve functional status and quality of life among members with behavioral health conditions, I/DD or traumatic brain injury (TBI).

Figure 1.1, NCDHHS Quality Strategy Aims, Goals, and Objectives Framework



Prevention and Population Health Management (PPHM) Program Structure & Staffing

The following departments and teams all play a role in ensuring Vaya achieves PPHM program goals. The CMO clinically oversees all PPHM programs and works closely with the COO to design and achieve the goals of Vaya's PPHM programs. Note that all references to "clinician" refer to any member of the healthcare team with a valid unrestricted license regardless of specialty.

Medical Division

Vaya's CMO leads the Medical Division and oversees all medical, pharmacy, and quality management operations. The CMO oversees and is responsible for all Vaya clinical activities and provides clinical supervision, consultation, and direction to clinical departments administratively supervised by the COO. In addition, the Deputy CMO (DCMO), and Vice President (VP) of Pharmacy Operations provide clinical consultation to clinical departments as it pertains to their respective specialty areas and as determined by the CMO.

- The Deputy CMO ensures an integrated approach to members' physical and behavioral health, including those with I/DD and TBI conditions, and supports the CMO in activities as assigned, including, but not limited to, the proper provision of covered services to members, selection and development of clinical practice standards, clinical policies and procedures, UM, pharmacy, population health, care management, and quality management.
- The VP of Pharmacy Operations oversees Vaya's Medicaid Pharmacy Program and Vaya's contract with a Pharmacy Benefit Manager (PBM) that performs delegated aspects of this program. Pharmacy Operations staff apply evidence-based medication use strategies that enhance member-specific and population health outcomes while optimizing health care resources, including:
    - Medication review for members who meet pharmacist review criteria and those identified by Registered Nurse (RN) Care Managers as at-risk for poor health outcomes related to medication issues;
    - Communication and collaboration with members, prescribers, and pharmacists;
    - Institution of practices and processes that detect unsafe medicines to ensure patient safety;
    - Evaluation of pharmacy resources (analytics, health information technology infrastructure, workflows); and
    - Assessment and evaluation of effectiveness of new treatment modalities for disease categories.

Care Management Department

This department provides plan-based Tailored Care Management (TCM), a complex care management model for eligible Tailored Plan and NC Medicaid Direct members, and complex care coordination, a face-to-face care coordination program for select NC Medicaid Direct populations.

- **Care Coordination (CC)** activities include identification, assessment, care planning, referral and linkage to routine and specialty services, care team coordination, and service and plan monitoring.
- **Care Management** is a set of activities delivered by care managers with or on behalf of a member to help members and their caregivers manage health conditions and co-occurring psychosocial factors. These activities focus on the acute needs of the individual as part of a population and in relationship to the overall healthcare system. Care Managers employ an integrated, whole-person approach to support high quality, cost-effective healthcare through promotion of correct diagnosis, team-based care planning, linkage to specialty care providers and organizations that address unmet health-related resource needs, reduction of behaviors that result in readmissions/ recidivism, monitoring for substandard care, and identifying opportunities to improve service quality.

- **Care Plan** is a single, unified plan that addresses the member's integrated care needs including physical health, behavioral health, and unmet health-related resource needs. The Care Plan includes input from all healthcare providers and other individuals/ organizations involved in the member's life. The Care Plan must address all applicable social, civil, or legal requirements and does not negate a member's right to privacy under federal and state law.

Vaya delivers Care Management to people who are at increased risk for poor health outcomes or whose services have been identified as more likely to incur high cost to the public system due to complexity and need for care coordination, as well as Special Healthcare Populations defined in the Tailored Plan contract. Care Management and Care Coordination outreach and engagement is offered to members via phone and face-to-face interactions. Care Management staff include licensed behavioral health clinicians, RNs, qualified professionals (QPs), and peer support specialists. Care Management teams are based in the communities they serve, co-located in local community organizations such as county Departments of Social Services (DSS) and LHDs, and embedded within local emergency departments (EDs), private community hospitals, and NC Division of State Operated Healthcare Facilities (DSOHF) locations to ensure cohesive transitional care to the community. Acute Transition Care Managers provide onsite transition planning from inpatient settings for Vaya members, ensuring that discharge planning and cross-system coordination occur from the first day of admission.

Coordination of Member Programs [PHM 1(A)(4)]

Care Management provides ongoing assessment of a member's needs, functional status, and appropriate levels of care and treatment settings; coordinates needed services including assisting with appointments and referrals; develops individualized member Care Plans with the member and their care team to maximize the potential for health management; and aids members with developing self-management plans and support in monitoring the plan. Individual. Vaya also provides pharmacy assistance with medication reconciliation to each member, as needed. Care managers will assess the need for referrals to Vaya's PPHM programs and community resources and make appropriate linkages when necessary.

Care Managers collaborate with internal Vaya-based programs such as the Acute Transition Team and the Transition and Housing Team to ensure members' transition of care is optimal. This integration of services can occur in community-based Care Team meetings, discharge planning meetings, and consultation with other departments. Vaya's Care Management platform is accessible to all Vaya Care Management, Care Coordination, Acute Transition Team, and Transition and Housing Team staff and allows each department to view the member's health record and programs in which members are enrolled.

Sharing Data and Information with Practitioners

To support care management activities, Vaya shares a variety of data with Advanced Medical Home Plus (AMH+), Care Management Agencies (CMAs) and Clinically Integrated Network (CINs) providers, including:

- Clinically relevant and available enrollment/eligibility data
- Member assignment files
- Acuity tiering and risk stratification information
- Quality measure performance information at the practice level
- Encounter data
- Prior authorization data
- Pharmacy lock-in data

- Admission/Transfer/Discharge (A/D/T) feeds

The clinical collaboration and data exchanges help members get more effective and high-quality care with a complete view of the member's health.

Clinical Strategies Department

Clinical Strategies ensures that Vaya implements integrated, whole-person care and supports implementation of Vaya's population health, care management, and care coordination strategies through collaboration with other departments and teams. Department activities include utilization review, workflow mapping, training, implementation support, process design, monitoring for process adherence, and outcome evaluation with a focus on improved technological efficiency and robust data collection.

- Vaya's Utilization Management Program Description includes detailed information about the staffing and functions of the UM Team. The UM team works closely with the Network & Services Management Committee (NSMC) to develop the organization's benefit plan(s) and conduct service utilization and trend analysis to guide organizational decision-making. UM is responsible for NCQA-accredited UM functions, including prospective, concurrent, and retrospective utilization review. The UM team evaluates the medical necessity of requests for services against Coverage Criteria defined in the UM Program and provides clinical support to other Vaya departments.
- Independent Assessment Team – The Independent Assessment Team Director oversees two assessment teams that provide direct evaluation of member functioning.
    - Supports Intensity Scale (SIS) Assessment Team members are certified through American Association on Intellectual and Developmental Disabilities (AAIDD) to provide standardized assessments to members enrolled in North Carolina's 1915(c) Medicaid Home and Community Based Services (HCBS) Waiver, known as the Innovations Waiver. SIS assessments are administered during the initial needs determination process for members seeking an Innovations Waiver slot, as part of an Innovations participant's initial assessment, during the re-evaluation process, or following a major life change.
    - Personal Care Services (PCS) Assessment Team – This team of RN assessors provide in-home functional assessments that help determine member eligibility for State Plan PCS.
- System of Care (SOC) Team - The North Carolina System of Care is the framework through which Vaya delivers public behavioral health services to children and youth. The objective of SOC is to provide evidence-based, trauma-informed/resiliency developed BH services to all children, youth, and their families. Vaya employs SOC Coordinators and Family Partners that conduct comprehensive SOC planning, implementation, coordination, and training related to NCDHHS-required core functions in each county in Vaya's region.
- Care Coordination (CC) Team– Vaya's CC Team provides telephonic care coordination functions that comply with the requirements in 42 C.F.R. § 438.208 for all Medicaid members in Vaya's health plans. This team also provides telephonic outreach to members who are eligible for TCM to engage them in this program.
- Transition of Care (TOC) Team – The TOC team consists of QP-level TOC Coordinators who provide coordination of services for members transitioning between Vaya's Medicaid plans and other Medicaid plans and delivery systems in North Carolina. TOC Coordinators ensure transitions for members who are at high-risk for poor health outcomes include live information-sharing meetings between clinical staff at sending and receiving plans so that these members experience adequate support from their new health

plan. The TOC team also ensures that transitions for all members occur in a timely fashion and that members' records, authorizations, and claims information is appropriately shared with the receiving plan.

Member and Recipient Services (MRS) Department

Vaya provides and maintains appropriate access to healthcare services. Using valid methodology, we collect and analyze data quarterly to measure our performance against telephone access standards for screening and triaging calls. We annually evaluate access to appointments and other member services access standards to identify and prioritize opportunities for improvement. The MRS Department is responsible for Vaya's call center functions and five service lines:

- Behavioral Health Crisis Line (BHCL) – The BHCL is a 24/7/365 toll-free phone line providing screening for people experiencing a behavioral health crisis. The BHCL is staffed with clinicians who link people to services that address members' crisis needs and appropriately divert from the ED. MRS clinicians perform screening and triage using uniform clinical decision support tools that measure acuity, have electronic access to members' crisis plans, and make referrals to Vaya network providers in accordance with access and appointment standards established by NCDHHS.
- Member and Recipient Service line (MRSL) – The MRSL functions from 7:00 a.m. – 6:00 p.m., Monday through Saturday, including holidays, and helps members access non-emergency services and resources. The MRSL is staffed with MRS representatives who meet QP requirements, conduct initial screening and member satisfaction surveys, warm-transfer calls to MRS clinicians when needed, answer general questions about Vaya health plans, provide information about mental health (MH), substance use disorder (SUD), I/DD, and TBI resources and services, document complaints and grievances, and follow up on appointments and provider availability. MRS representatives help members choose a TCM provider and primary care provider (PCP) and assist callers with the application and waitlist process for the 1915(c) Medicaid Home and Community Based Services (HCBS) Waiver, also known as the Innovations Waiver.
- Provider Support Service Line (PSSL) – The PSSL functions Monday through Saturday from 7:00 a.m. to 6:00 p.m., including holidays and is staffed with QPs. The PSSL responds to provider inquiries about claims, contracts, authorizations, benefits, and accessing communication bulletins, forms, and training opportunities.
- Nurse Line – The Nurse Line operates 24/7/365 to provide medical information and advice to members and to help members access care. The Nurse Line is staffed by RNs.
- Pharmacy Service Line – The Pharmacy Service Line is available to Vaya in-network pharmacies and prescribers Monday through Saturday from 7:00 a.m. - 6:00 p.m. and is available for warm transfer from other service lines based on caller risk factors. Prescribers' prior authorization services are available to meet 24-hour review requirements to ensure timely access to prescription medication.

Provider Network Operations (PNO) Department(s)

Vaya's Behavioral Health & I/DD and Physical Health & Value-Based Contracting (VBC) PNO Departments are responsible for provider network functions including the development, management, and maintenance of the contracted provider network, development and monitoring of value-based contracts, and design and delivery of provider communications and training. PNO is ultimately responsible for meeting the service needs of Vaya members by managing access, service availability, quality of care, cost-effective services, and provider fiscal and operational stability in accordance with federal and state laws, rules, and regulations, and NCDHHS Contract

requirements. PNO recruits, selects, and contracts with all participating providers to ensure quality services, fiscal sustainability, geographic accessibility, and member choice, where required. PNO is also responsible for contract scope of work development and negotiation and provides technical assistance to participating providers via phone, virtual meetings, and email. PNO develops and submits a Network Access Plan that measures network adequacy and informs the development of innovative programs that create and enhance access to care and improve service availability, quality, and efficiency, including capitated and outcome-based payment models. PNO ensures that the Vaya Provider Search Tool and Provider Directory are accurate and current and assists other departments to identify available providers that meet member needs. PNO works with community stakeholders to develop effective community partnerships and improve or develop services, oversees Supported Employment initiatives, and increases access to care for populations at high-risk for poor health outcomes.

Value-based Payment (VBP) Arrangements

Vaya offers VBP incentives to provider types including primary care practitioners, behavioral health providers, hospitals, and specialty providers. We structure our alternative payment methodology to encourage providers to meet HEDIS metrics, including EPSDT requirements. To further the assimilation of these payment models, we offer multiple provider contract arrangements. Vaya's approach to VBP includes implementing alternative payment methodologies (APMs) that encourage value by incentivizing efficient and appropriate care—the right care, in the right place, at the right time. We use APMs and corresponding performance measures to promote whole-person care by integrating program measures that address physical health (e.g., well-child visits and child immunizations) into the VBP. Further, we target the I/DD population through measures aimed at increasing integrated care and coordination of services across provider types.

Transition and Housing Department

The Transition and Housing Department oversees diversion, in-reach, and transition activities to identify and engage members who can live safely in the home and community of their choice with wraparound services and supports. This Department has three teams:

- Transition to Community Living (TCL) Team: This team supports adults aged 18 or older with severe and persistent mental illness (SPMI) or severe mental illness (SMI) who are eligible for the NCDHHS TCL program. The team links eligible participants with wraparound behavioral health, medical and other support services that help them live in a home of their own choosing rather than an Adult Care Home (ACH) or other institution. This team includes RNs and Occupational Therapists who work closely with TCL members to address their medical needs as part of the transition.
- Housing Supports Team – This team secures and manages housing resources, increases housing resources through partnerships with affordable housing providers, and collaborates with community partners to provide safe and stable living situations that support wellbeing and recovery and reduce crisis events. Vaya's housing programs include the Transitions to Community Living Voucher (TCLV), the Permanent Supportive Housing program, non-Medicaid Residential Services, the Housing Supports Grant, the Independence Project, and the Integrated Supportive Housing Program.
- IDD In-Reach and Transition Team– Using wraparound supports, the IDD In-Reach and Transition Team supports eligible members with an I/DD diagnosis transitioning from long-term institutional care to a home of their choosing. State Developmental Centers (SDCs) and Intermediate Care Facilities for Individuals with Intellectual Disability (ICF-IIDs) are often the institutions where eligible members reside when starting these transitions. The Money Follows the Person Pilot program and the Innovations

Waiver, provide services and supports to members who transition to the community.

Activities That Support PPHM Programs and Services [PHM 1(A)(3)]

Collaboration with regional healthcare partners, community-based organizations, network providers and other stakeholders in the communities we serve is vital to achieving improved population health. Building on our years of experience and efforts to create a healthier North Carolina, our PPHM programs aim to expand the impact on improving the health, wellness, and quality of life of the communities in which we live and work. As described above, Vaya's PNO Department offers training for all network providers on our PPHM programs. Vaya's Learning and Development Department creates and delivers a training series for care management and care coordination staff about Vaya's PPHM programs.

Addressing Unmet Social Needs

We identify the unmet social needs of the population in two primary ways: (1) group, population level identification and analysis of needs and patterns, and (2) individual level identification of needs. Population-levels strategies include completion of ongoing assessments of the population to determine any additional Unmet Needs and identify strategies to accommodate or address those needs. Vaya aggregates the results of various assessments and screenings as well as the population analyses to identify recurring trends, themes, and demonstrated areas of need for all members - or key subpopulations. These aggregated trends inform how we tailor and change member outreach, screening, and TCM delivery as well as how we support external TCM providers to do the same – including through partnership with medical and community-based providers. Additionally, we build on the efforts of various public health partners and cross -disciplinary coalitions to incorporate and leverage the value of secondary data, community health assessment and community health improvement data, "hot spot" geo mapping, and other population and community data gathering. Interventions, activities, and strategies that Vaya has historically implemented, is currently implementing, and implement in the future.

Reducing Healthcare Disparities and Promoting Health Equity [PHM 1(A)(6)]

Vaya is committed to centering equity in our policies, procedures, member engagement, and partnerships at local, regional, and state levels. Achieving equity supports the North Carolina Medicaid quality goals of better care, healthier people and communities, and smarter spending. Addressing health equity also aligns with our values of fairness, diversity, and inclusion.

Foundational to our overall strategy, we will identify disparities present in member health outcomes and service utilization data according to the associated factors of age, gender, race, ethnicity, primary language, geography, and, where possible, sexual orientation. We will also identify major subpopulations according to eligibility, disability, and service needs such as long-term services and supports (LTSS). These data will be used to guide further analysis to identify causes, barriers, and intervention selection and development. Key stakeholders, such as members, families/caregivers, providers, and community leaders, will be engaged throughout the process for Vaya to fully assess the unique demographics, risk factors, challenges, and strengths of the communities we serve.

Vaya will analyze and identify disparities, determine causes and barriers, and implement interventions utilizing a plan/do/study/ act methodology. We will also include assessments of inequities and disparities in our Performance Improvement Projects (PIPs) and develop interventions considering identified disparities.

Informing Members about Available PPHM Programs [PHM 1(A)(5)]

Information about our PPHM programs is posted on Vaya's website and in the Vaya Member Handbook, which the MRS Department mails to each member when they enroll in a Vaya health plan. The Handbook explains how to learn more about tobacco cessation services and interventions available through the Quit for Life® programs. The Handbook includes information for members at risk for developing diabetes that Vaya and our community partners offer online and local onsite classes to help them prevent high blood sugar, learn more about eating healthy, reducing stress, and increasing physical activity. The Vaya website also has a diabetes risk calculator for members to self-administer and provides steps in seeking assistance. The Handbook also provides detail about TCM and explains the role of the care manager, the types of organizations that may provide TCM, and methods for members to get more information on TCM (e.g., visiting Vaya's website or contacting Member and Recipient Services. The Peer Bridger Program information is provided to members once they meet program eligibility. This information is provided at the time that the service is offered.

When a member is determined to be eligible for identified PPHM programs (e.g., Peer Bridger, TCM, TCL, MFP, Housing Supports, etc.), Vaya provides specific information about how they became eligible to participate, how to use services, and how to opt in or out of the program. [PHM 1(B)].

Clinical Practice Guidelines and New Clinical Treatment Modalities and Technologies

Vaya uses clinical practice guidelines (CPGs) to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. Vaya's Clinical Advisory Committee whose membership includes practicing clinicians [QI (10)(A)(1)], reviews and recommends CPGs for approval by the CMO, as outlined in Policy 2397 Development and Review of Clinical Guidelines, Treatment Modalities, and Pharmacy Procedures. All UM enrollee education, coverage of services, and other decisions will be consistent with adopted CPGs, as applicable. Vaya will monitor, identify, review, make determinations and disseminate information regarding coverage under Vaya benefit plans of new clinical treatment modalities and/or technologies and new uses of existing technologies. This process will be conducted by or under the direction of the CMO.

Managing Chronic Conditions

Interventions that impact chronic conditions have the potential to yield the most results for overall population health. Vaya addresses diabetes, hypertension, and asthma in alignment with NCDHHS priorities. Vaya's chronic condition management programs mobilize the resources of the TCM network to achieve Vaya's goals. While our aim is for all eligible Vaya members to engage in TCM, members who are not eligible for, or choose not to participate in TCM still have access to the benefits of the programs. Vaya employs staff trained to deliver chronic condition management program interventions outside of the TCM program so that any member may participate.

Vaya has designed clinically sound interventions to achieve program goals but recognizes that provider based TCM organizations also may have developed successful programs designed to achieve the same outcomes. We do not mandate that provider based TCM entities use the exact interventions described herein. Instead, we expect TCM providers to achieve the same goals through any effective interventions they choose. Vaya offers support to providers who do not have these programs in place to enable them to build an effective program as part of the TCM benefit. Descriptions of each chronic condition management program are included later in this document.

Population Assessment

Integrating data from diverse sources, Vaya conducts an annual (or more frequent) assessment of the needs and characteristics of the overall member population and key subpopulations such as children and adolescents, members with disabilities, members with SPMI, members of racial or ethnic groups, and members with limited English proficiency. This assessment informs the ongoing enhancement of Vaya's PPHM functions and associated programs, initiatives, and resources [PHM 2(B) (2-6)].

Our assessment also identifies unmet health-related resource needs, also referred to as unmet health-related social needs, or social determinants of health (SDOH). The World Health Organization (WHO) defines SDOH as the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Research shows that up to 80% of a person's overall health is driven by SDOH. NCDHHS has identified four non-medical influences on health outcomes for intervention in Medicaid services: housing, transportation, access to food, and interpersonal violence/toxic stress.

Data Integration for Population Health [PHM 2(A)]

Vaya integrates multiple internal and external data sources in its electronic data warehouse (EDW), as provided through its claims, care management and other platforms, to support population identification and various PPHM functions. For those data sources not included in the EDW, data is accessed through tools and platforms available to multiple staff within the organization. Once accessed, Vaya's Performance Reporting Team (PRT) coordinates with teams and departments across the organization to consolidate and analyze data and information into relevant reports and/or presentations for use in PPHM functions. Vaya's internal and external data sources include:

- Medical, behavioral health, and pharmacy claims submitted by providers;
- Health appraisal results collected within Vaya's care management system;
- Health promotion programs, including programs intended to improve chronic condition management; and
- Other advanced data sources such as UM authorization data, TCL data, and data collected through member surveys.

Population Stratification

Vaya combines data from multiple sources to use in its population stratification and program eligibility process. The following data is used to identify specialty populations:

- Medical and behavioral claims/encounters
- Pharmacy claims
- Laboratory results
- Health appraisal results
- Acuity tiering
- Electronic health records
- Data from Vaya UM and/or CM specific programs
- Special population designators (e.g., LTSS, Foster Care, etc.)
- Member experience data.

Annually, Vaya uses its system to segment, and risk stratify the entire enrolled population into meaningful subsets for targeted interventions. Information about the process used is defined in the description of specific programs in the sections which follow. A description of subsets and the type of intervention offered to members is described in Appendix A.

Identifying SDOH Needs [PHM 2(B)(1) and Other Needs of Subpopulations [PHM 2(B)(7)]

In accordance with Policy 3102 Care Coordination and Care Transitions, Vaya care managers and care coordinators conduct SDOH screening for all members. Screening, at minimum, addresses the four priority areas identified by NCDHHS: housing, food, transportation, and interpersonal violence/toxic stress. County, zip code, and/or census data on resource gap "hot spots" are also available to potentially supplement the above screenings. These geographic information system data include publicly available geo mapping data sets through NCDHHS, and the analytics dashboard associated with the "social determinant" network application NCCARE360. The dashboard can identify locales where certain health-related resources (e.g., services and supports designed to address SDOH, including but not limited to public welfare benefits such as Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Women, Infants and Children (WIC) program, utility assistance, food banks, housing) may be insufficient to meet member needs.

Vaya regularly identifies and addresses disparities among various historically marginalized groups and subpopulations at risk for health disparities. We stratify available health access and outcome data according to factors including race, ethnicity, age, sex, sexual orientation/gender identity (where/when available data permit), disability status including members needing LTSS, primary language (and limited English proficiency), and geography. Indirect data sources are the primary source for this stratification. As data availability permits, we will also stratify data on member experience and satisfaction. To supplement these surveys, claims, and other data, we elicit feedback from stakeholder groups (members and families, providers, community members) about perceived subpopulation needs and experienced disparities.

Vaya focuses special attention on characteristics and needs for members transitioning from DSOHF facilities or transitioning/ being diverted from placement in ACHs. This focus aligns with our overall commitment to deinstitutionalization of members with MH, SU, I/DD, and/or TBI conditions. We also stratify data on health access and health outcomes for these groups. We identify members with SPMI through claims, service authorization requests, participation in programs where a SPMI diagnosis is requisite, and/or other means.

Analyses for the SPMI subpopulation may include review of service utilization patterns such as use of crisis and ED services, transitions of care, follow up after discharge, regular engagement in ambulatory and outpatient care; and, for members using antipsychotic medication, evidence of screening for diabetes and metabolic disorders. Additional data sources about the availability and adequacy of services can help identify potential gaps and needs for specific subpopulations – for example, the availability of certain services in rural counties for members with SPMI.

Vaya assesses the needs of the child and adolescent population (ages 2-19) by identifying members in this age range and then stratifying using the priority population categories listed below to pinpoint subgroups that have special care needs and develop interventions to address these. Vaya conducts additional as-needed segmentation analyses of these subgroups, and this information may also be included in the annual population

assessment, as warranted. As part of this process, Vaya will annually perform segmentation activities. Our segmentation activities will include a process to assess for racial bias. Priority population categories include members with significant chronic disease burden such as members with multiple chronic conditions like hypertension, diabetes, heart disease, etc. and priority subpopulations (segments) [PHM 2(D)(1)]:

- Members with LTSS needs and services;
- Members with diabetes;
- Infants referred to the neonatal intensive care unit (NICU);
- Members eligible for HOP
- Foster Care members;
- Members who are WIC eligible but not enrolled;
- Members enrolled in SNAP;
- Transitioning members;
- Members with special health care needs;
- Members who have a rising risk for poor health outcomes;
- Members enrolled in the care management for high-risk pregnancy (CMHRP)program; or
- Members enrolled in the NC Integrated Care for Kids Pilot (InCK).

Finalizing the Assessment

A cross-disciplinary group of subject matter experts will meet to review the initial results of the population health assessment(s) and recommend additional analyses, if needed, to cross-validate trends across data sources; identify additional commonalities and characteristics of key groups – that is, determine if some diverse groups have a common unmet need or experience; and/or identify and prioritize specific opportunities for improvement and program development or enhancement. The group completes a comprehensive review of our measurement system and identifies measures that predict future health care and social needs based on past utilization, with the goal of identifying alternative methods to substitute or supplement the data. [PHM 2(D)(2)]

The cross-disciplinary group employs the following four-step process to screen for racial bias in our algorithms as recommended by the Center for Applied AI at Chicago Booth in the *Algorithmic Bias Playbook*:

- Inventory: List all the algorithms being used for the population health assessment.
- Screen: Screen each algorithm for bias, relative to its ideal target.
- Retrain: Improve or suspend the use of biased algorithms.
- Prevent**:** Set up structures to prevent future bias.

Activities & Community Resources [PHM 2(C)]

Vaya annually analyzes and reviews the population assessment to identify and focus programs and interventions that meet specific population needs. This review also identifies the community resource gaps that members experience which Vaya can address by integrating additional resources into our program offerings. This review occurs in Vaya's Performance Data Workgroup where recommendations for updated activities and resources are made. Vaya's PHD prepares a summary and recommendations using this analysis and shares this with Vaya's Executive Leadership Team (ELT) for review and incorporation into Vaya's Strategic Plan. The PHD uses the results of the assessment along with feedback from ELT to identify needed programs, activities, and community resources for integration into program offerings. Additionally, the PHD identifies, and then modifies, or updates at least one program, activity or resource that specifically addresses health care disparities for at least one identified population. The PHD uses the identification of community resource gaps to incorporate additional resources into our existing tools that connect members to these supports or to inform our community relations efforts to increase the availability of these specific resources in the communities we serve.

After conducting a data analysis, we determine if changes are required to PPHM programs or resources. In addition, there is an evaluation of the extent to which PPHM programs facilitate access and connection to community resources that address member needs outside the scope of the health benefit plan. Modification to program design and resources are made based on these findings.

PPHM Programs

Promoting Wellness and Prevention

Vaya mobilizes the network of Tailored Care Managers, both plan- and provider-based, to promote wellness and prevention by educating members about and referring them to Vaya's prevention and population health programs and/or other programs addressing exercise, nutrition, stress management, substance use reduction/cessation, harm reduction, relapse prevention, suicide prevention, tobacco cessation and self-help recovery, and other wellness services based on the member's needs and preferences. Vaya participates in community-wide prevention and early intervention strategies, coalitions, and other initiatives to discourage inappropriate access, misuse, and abuse of legal and illegal substances (alcohol, tobacco, e-cigarettes, and other drugs) by members and to improve the emotional health and well-being of members.

For those members receiving PPHM program support, Vaya will notify their PCP and Care Management Agency (CMA) (if applicable) by letter, email, fax, or Provider Portal of their member's involvement, unless the member notified Vaya not to inform their PCP and CMA (if applicable).

Self-Management Tools

Vaya is committed to helping members stay healthy and reduce their risk of new or worsening health conditions. To this end, Vaya provides tools, derived from available evidence, which offer information and support in multiple wellness and health promotion areas. For example, resources may help members determine risk factors, provide guidance on health issues, recommend ways to improve health, or support reducing risk or maintaining low risk. Usually, they are interactive resources that allow members to enter specific personal information and provide immediate, individual results based on the information. Vaya maintains resources for no less than four (4) of the following topic areas at any given time:

- Healthy weight (BMI) maintenance
- Smoking and tobacco use cessation
- Encouraging physical activity
- Healthy eating
- Managing stress
- Avoiding at-risk drinking
- Identifying psychiatric symptoms through self-assessment
- Recovery and resiliency
- Treatment monitoring

The tools may include traditional self-management resources (e.g., interactive quizzes, personalized worksheets, logs, diaries, tracking tools), toolkits, videos and webinar recordings, links to internet resources, and/or links to downloadable applications (e.g., for smart phones and other mobile devices). [QI 8(A)]. Self-Management tools are available through multiple media including digital formats like our public-facing website, email, and web links, print/hard copy, and by telephone via the MRSL. [QI 8(D)].

No less frequently than every 36 months, Vaya evaluates these tools for usefulness using internal staff not involved in the development of the self-management tools. Usability testing ensures that the language is easy to understand, and that special accessibility needs (i.e., vision, hearing, reading ability, etc.) are also addressed. Vaya is committed to a diverse workforce including the hiring of people with lived experience (i.e., people who

have experience with MH, SUD, I/DD, and/or TBI conditions). Often, these employees work directly with members, acting as family or peer supports. Vaya conducts usability testing with these employees and members of Vaya's Consumer and Family Advisory Committee (CFAC).

Vaya's wellness and health promotion resources are based on reasonable scientific evidence and/or best practices. Vaya's Clinical Advisory Committee (CAC), which includes internal staff as well as network providers/ practitioners, reviews available information and makes necessary updates to resources every two years or more often if needed (e.g., when significant new evidence or recommendations are released). This review occurs between and in advance of biennial reviews. In this way, Vaya organizes, presents, discusses, and finalizes recommendations for changes.

Diabetes

Diabetes Prevention

According to statistics released by the National Institutes of Health, in 2021 about 97.6 million Americans ages 18 years or older have prediabetes, and 38.4 million individuals have diabetes. Among those with diabetes, approximately 95% have type 2 diabetes — a condition that can be prevented or delayed with lifestyle changes. People with diabetes and prediabetes are at higher risk for developing other serious health problems, including heart disease and stroke. Vaya's goal is to decrease the percentage of Medicaid members who develop diabetes by screening members and linking them to effective lifestyle change programs that have the best chance to promote normal blood sugar levels. Vaya members include historically marginalized populations that have increased risk for diabetes, such as people diagnosed with SMI, I/DD, and SUD.

Interventions

- **Risk Identification:** Vaya uses assessments, claims data analysis, pharmacy data analysis, member self-referral, care manager/care coordinator referral and provider referral to identify members at risk for developing diabetes. Vaya pharmacists identify members who receive Vaya TCM, meet criteria for pharmacy review, and are at high risk for diabetes due to psychotropics during chart review and initiate appropriate levels of prescriber contact.
- **Diabetes Prevention Programs**: There are more than 75 CDC-recognized Diabetes Prevention Program (DPP) providers in North Carolina that offer online or onsite classes. Diabetes Prevention Programs are offered in varied community locations in the region, LHDs, YMCAs, community centers, faith-based organizations, hospitals, and worksites. Vaya will harness the power of this existing network of providers who deliver DPPs. The programs are evidence-based, positive lifestyle change programs for members at risk of developing diabetes. These programs encourage eating healthier, reducing stress, and increasing physical activity. The positive health outcomes of DPPs have the potential to persist for years and positively affect the lives of a substantial percentage of Vaya Medicaid-enrolled members.
- **Outreach and Screenings:** Vaya staff outreach to members who are at-risk of developing diabetes and offer linkage to screenings and to DPP programs. Additional screenings for the larger population may occur through direct member contact, linkage on our website to an online diabetes risk assessment tool, and in the course of interactions with the provider network. Providers also conduct screenings, or ensure members have been screened, for abnormal blood glucose levels in people taking an antipsychotic medication, are overweight or have obesity. These screenings occur, at a minimum, on a yearly basis in people who continue to have normal blood glucose. Monitoring should be continued if their blood glucose is elevated.

- **Education and Engagement:** Vaya continues to educate providers about historically marginalized populations who are at increased risk of diabetes. Member engagement and education plays a significant role in the diabetes prevention campaign. Vaya uses evidence-based educational materials via Healthwise, a health education platform, to coach members on the role of low activity levels on metabolic diseases, the impact of a family history of diabetes, the role of obesity, and the impact of smoking on blood sugar levels.

Through these interventions, we expect a reduction in the percentage of the population at-risk for developing diabetes and the percentage of the population with pre-diabetes who later receive a diagnosis of diabetes, especially in those who choose to engage with the National DPP. Over time, we expect members to experience a higher quality of life and lower rates of chronic kidney disease, eye disease, heart attacks, and strokes stemming from diabetes.

Diabetes – Chronic Condition Management

Interventions

Vaya's Diabetes Management Program interventions include educating members about diabetes, teaching members how to self-manage this disease, emphasizing the importance of regular care, and providing support tools and screenings to reduce diabetes-related complications, morbidities, and death. To ensure members' diabetes is well managed, Vaya links members to a PCP. Vaya monitors members who are overdue for follow-up appointments. To do this, Vaya monitors for a hemoglobin A1c (HgbA1c), or lipid panel done within the past 13 months, an overdue urine microalbumin test or an overdue dilated retinal exam.

Vaya links members or their guardians to education about how to use home blood glucose monitoring equipment so that they can regularly monitor blood glucose levels, record these levels, and report them to their provider. This information enables providers to monitor effectiveness of prescribed therapies and attendance scheduled clinic and laboratory appointments which include laboratory-tested blood glucose levels. When Vaya's pharmacy staff identify members who have diabetes during regular medication review, they initiate appropriate levels of prescriber contact to address any medication concerns.

Supporting the Care That Providers Deliver

Vaya is committed to a team-based approach to diabetes management. Collaboration between clinical staff, Tailored Care Managers and members improves health and quality of life for members. We encourage members to follow preventive service recommendations made by their providers (e.g., to get a foot exam, flu and pneumonia vaccines, a dental exam, or a retinal eye exam) and clinical guidelines (e.g., checking HgbA1c, blood pressure, and cholesterol levels) which need to be ordered/completed during member encounters.

Asthma, hypertension, nicotine dependance, cardiovascular disease, hyperlipidemia and depression are significant and common co-occurring conditions with type 2 diabetes. These co-occurring diagnoses increase the challenges to effective diabetes management. Vaya care managers identify and address barriers to care which may include transportation, lack of education about diabetes, or behavioral health symptoms. We link members to self-management support to increase their likelihood of remaining healthy while living with type 2 diabetes.

Practice and Provider Supports

Vaya requires providers to monitor all members diagnosed with diabetes and communicate to the member or

their caregiver about the need for further/timely monitoring of the following items:

- hemoglobin A1c
- lipid panel
- medical attention for diabetic nephropathy (urine micro albumin, etc.)
- diabetic retinal exam and
- prescriptions necessary for diabetes, lipid lowering agents, hypertension, and blood glucose monitoring.

We educate providers about the importance of referring members to or providing Diabetes Self-Management Education and Support services (DSMES) via their internal diabetes educators or the network of diabetes educators. For providers who do not offer these DSMES, but are interested in doing so, Vaya links them to the DSMES toolkit. Through these interventions Vaya promotes improved health outcomes and reduced serious long-term complications. Providing between-visit education and support reinforces the provider's message and facilitates communication between diabetes care team members. These interventions lead to improved outcomes such as decreasing percentage of the population who have a HgbA1c that is greater than nine (9).

Asthma

Asthma- Chronic Condition Management

The CDC estimates that more than 25 million people (7.8% of the population) in the United State have a diagnosis of asthma. In North Carolina, 8.3% of adults and 11.5% of children under the age of 18 are living with asthma. Asthma disproportionately affects low-income populations. Members of certain racial and ethnic groups are at greater risk of suffering and dying from asthma.

Vaya's Asthma Management Program helps members gain control of asthma symptoms and lead healthier lives. We aim to prevent chronic symptoms that interfere with daily living and thereby support members to participate in all activities of daily living at work, school, and recreation. Ultimately, our goal is to decrease asthma-related ED visits and inpatient care for this population.

Interventions

Vaya offers Asthma Self-Management and Education (AS-ME) for members whose asthma is not well-controlled through medical management alone. Key educational messages of AS-ME include basic facts about asthma, roles of medications, how to use asthma medications correctly, what to do when asthma symptoms worsen, and how to reduce exposures to asthma triggers (e.g., environmental allergens and irritants).

Vaya also helps members work with their providers to develop an asthma action plan to support their ability to effectively self-monitor. Use of these plans increases the chances that members can both prevent and control asthma attacks. Creating an asthma action plan and following it, even when there are no asthma symptoms, is important for long term asthma control. Learning personal triggers and avoiding those triggers, when possible, will prevent members' asthma from getting worse. When Vaya's pharmacy staff identify opportunities to increase inhaler adherence, RNs provide direct member/ caregiver education to maximize access and effectiveness of this medical intervention.

Vaya promotes strategies that help people access and continue to use asthma medications and devices. We cover spacers as a medical device without a copay for children under 21 up to the annual limit to encourage

spacer use and improved inhaler administration. We encourage 90-day refills on asthma maintenance medications and monitor for rescue inhaler overuse. Tobacco use and secondhand exposure is a trigger for asthma attacks. Interventions to reduce smoking and secondhand smoke exposure can improve asthma control and reduce health care costs. Vaya employs an array of interventions designed to assist members to stop smoking, including access to Quit for Life. These are described in the Vaya Tobacco Cessation Plan.

Home Visits

If a member's asthma is not under control with medication and education, Vaya's trained asthma assessors may provide home visits. The primary purpose of a home visit is to identify and mitigate the effects of exposure to environmental triggers in the home. Home visits help people with asthma learn how to manage asthma and reduce triggers in their own home. This service is focused on people at higher risk of asthma attacks (for example, people with prior hospitalizations or ED visits for asthma). Home visits reveal barriers to member engagement, adherence, or asthma control not previously recognized or fully appreciable in the outpatient, ED, or hospital setting (e.g., housing conditions, social stressors, work, and family obligations that affect individuals' or families' abilities to manage asthma).[1][2]

Practice and Provider Supports

National Asthma Guidelines provide evidence-based recommendations for asthma medical management. Unfortunately, prescriber adherence to these recommendations is not high, which increases the chances of inadequate asthma control.[3] Vaya aims to increase the use of effective interventions by linking providers to asthma-focused training tools. Vaya also encourages the use of decision support tools that promote guidelines-based medical management. Examples include current asthma guideline summaries and treatment algorithms. We encourage providers to use electronic health record (EHR) system reminders to increase the likelihood of adherence to evidence-based recommendations. Shared decision making has been shown to improve the adherence to recommended asthma treatments, allowing for discussions of goals, preferences, and patient concerns. Using this readily available technique has been shown to decrease rescue medication use, improve lung functioning and result in fewer asthma-related medical visits. We include education on shared decision making in provider education and trainings specifically as it relates to asthma action plans.[4]

Vaya expects to decrease asthma-related ED visits and hospitalizations through comprehensive assessment, action-planning with members, promotion of tobacco cessation and provider supports that reinforce evidence-based asthma treatment.

Obesity

Obesity has a significant impact on overall health. There is a large body of evidence linking obesity to diseases such as diabetes, cardiovascular disease, poor cancer outcomes, orthopedic morbidities, and death. There are four primary modalities used to obtain weight loss for individuals living with obesity: dietary changes, increased physical activity, pharmacotherapy, and surgery. Each of these modalities plays a role in obesity management

[1] Implementing an Asthma Home Visit Program: 10 Steps to Help Health Plans Get Started, 402-K-05-006, August 2005 (epa.gov)
[2] Strategies for Addressing Asthma in Homes (cdc.gov)
[3] https://www.cdc.gov/asthma/exhale/achievement.htm
[4] https://www.nhlbi.nih.gov/health-topics/guidelines-for-diagnosis-management-of-asthma pg. 100

and require lifestyle modification for better health and quality of life. Individual factors (e.g., comorbidities, genetics, activity, gut microbia, etc.) interact in important ways with diet so one single modality does not work for all individuals.

Vaya provides support to members to facilitate obesity management in multiple ways, each tailored to the member specific need. These supports include linkage to the appropriate provider, dietary counseling, lifestyle management support, and coverage of prior approved indicated bariatric surgery.

Hypertension

Hypertension – Chronic Condition Management

In 2021, hypertension was a primary or contributing cause of death for 691,095 people in the United States. Controlling high blood pressure is a key step in preventing heart attacks, strokes, and kidney disease. Almost half of all adults have hypertension, but only one in four have their blood pressure under control. Some of the factors that contribute to high blood pressure are not alterable (e.g., family history, age, and race), while others (e.g., tobacco use, weight, diet, and activity level) are alterable.[5]

Interventions

Medication Therapy Management (MTM) programs are an important part of hypertension management and have been shown to significantly increase blood pressure control. Vaya leverages retrospective pharmacy utilization review programs to help members use their antihypertensive medication as prescribed.

Vaya encourages collaboration between prescribers and dispensing pharmacies for improved blood pressure control. Vaya educates providers about methods to improve hypertension control. These include pharmacy interventions such as a 90-day supply of medications, combination medications and blister packs. Vaya supports members so that they understand the importance of adhering to prescribed therapy, self-measured blood pressure monitoring, a 90-day supply of antihypertensive medication and quarterly PCP check-ins.

Team Based Approach

Team-based care increases the proportion of people with controlled blood pressure and reduced systolic and diastolic blood pressure, especially when pharmacists and nurses are part of the team. Vaya's pharmacist identifies members who have hypertension during chart review and directs Vaya RN staff to initiate member education and prescriber contact if appropriate.

Vaya monitors members diagnosed with hypertension who are receiving plan based TCM and are not prescribed blood pressure lowering medications. We use this information in our team-based approach to identify barriers to care, provide education about lifestyle modifications and set goals that support improved health outcomes. For members receiving plan based TCM, or members who choose to enroll in the hypertension management program, Vaya uses targeted interventions including observing the member describe a routine that includes checking and logging blood pressure per physician recommendation over the last 30 days and sharing that log with the physician. When staff make home visits, they review members' medications and inquire about how closely the member follows their prescribers' recommendations for taking their medication.

[5] Facts About Hypertension | cdc.gov

Plan-based Tailored Care Managers are trained to understand the impact of stress, socioeconomic status, anxiety, depression, and behaviors on coronary heart disease risk. TCM staff understand the importance of addressing the member's psychological factors in parallel with treatment for hypertension. Vaya's member engagement approach is tailored and person-centered, taking into consideration a member's hypertensive management with diabetes, ethnicity/race, and other health conditions (like chronic kidney conditions) due to their increased risk of poor outcomes.

Practice and Provider Supports

Vaya educates providers about and encourages providers to use *Million Hearts Hypertension Control Change Package Second Edition* which includes key foundations, equipping care teams, population health management, and individual supports for hypertension control. These interventions include change concepts such as providing blood pressure checks without appointment or co-payment, flowcharts for tracking and managing hypertension in a population, the systematic use of evidence-based hypertension treatment protocols, and the use of direct care staff to facilitate member self-management.

Through these interventions, we expect to increase the percentage of members living with hypertension whose blood pressure is controlled. Controlling blood pressure has been shown to prevent or to arrest cardiovascular damage; reduce the incidence of stroke, ischemic heart disease, heart failure, and end stage renal disease.

Tobacco Cessation

For more information on Tobacco Cessation, see Vaya Health Tobacco Cessation Plan.

Infant Mortality

Vaya uses TCM, care coordination, disease management, and health education interventions such as those described in our chronic disease management programs to improve the health of mothers and their newborns. To track progress in improving birth outcomes, we will use the Prenatal (PND) and Postpartum Care measure and the PND and postpartum (PDS) depression screening and follow up.

Low Birth Weight

According to the CDC website, infants who are born with a low birthweight (weighing less than 2,500 grams) are at increased risk of infant mortality and a host of short- and long-term complications. The most common causes of low birthweight are premature birth (birth prior to 37 weeks gestation) and restricted fetal growth, meaning babies don't grow to a normal weight. Because there is no easy solution to low birthweight, research focuses on identifying interventions with the greatest potential to impact outcomes. Presently, individual-level interventions show the greatest promise. Racial disparities and maternal education levels play important roles and must be recognized.

Vaya's focus mirrors that of prevailing public health initiatives including:

- Improving the overall health of women, especially chronic conditions such as diabetes, asthma, and high blood pressure.
- Helping women improve fertility and family planning.
- Through education, encouraging women to engage in healthier behaviors, such as taking folic acid and

regular physical activity.
- Reducing the use of tobacco products, alcohol, and drug misuse among pregnant women.

Early Childhood Growth and Development

Vaya's program priorities align with the vision of the NC Early Childhood Action Plan, which states that all children will get a healthy start and develop to their full potential in safe and nurturing families, schools and communities. We work collaboratively with the Department to develop joint plans for reporting, education, and care management interventions for children who screen positive for hereditary and congenital disorders:

- On a member level, we use a comprehensive outreach and education strategy for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well-visits and screenings that includes text message campaigns for screening and immunization reminders. We outreach members when we identify a gap in recommended screenings and vaccination visits, link members to toddler and infant programs in the community and help schedule transportation or appointments. Vaya links children and their families to recommended preventive health services at an early age, including access to oral health care. Additionally, Vaya attempts to administer the Care Needs Screening to all members to identify and address unmet health-related resource needs (e.g., food insecurity, housing insecurity, exposure to interpersonal violence/toxic stress/domestic violence, and transportation needs).
- At the provider level, we offer training about the Vaccines for Children (VFC) program and the North Carolina Immunization Registry (NCIR). We also train providers about EPSDT review requirements for UM and notify providers of members who may have missed appointments.
- On a system level, we promote screenings and prevention with school districts and community centers, and support health education events and forums to promote early childhood intervention.

Pregnancy Intendedness

Unintended pregnancies are associated with delayed initiation of care during pregnancy and higher rates of maternal, neonatal, and infant mortality. Vaya includes assessment of pregnancy intendedness in our comprehensive care management assessment. Vaya's Provider Manual encourages PCPs to talk with members and families about reproductive health, contraception options, and family planning.

Newborn Screening

Newborn Metabolic Screening Services detect selected metabolic and genetic conditions at birth. All infants born in North Carolina are screened at birth for the following conditions:

- Spinal Muscular Atrophy;
- Congenital hypothyroidism (CH);
- X-Linked Adrenoleukodystrophy (X-ALD);
- Galactosemia;
- Mucopolysaccharidosis I (MPS I);
- Congenital adrenal hyperplasia (CAH);
- Pompe;
- Hemoglobinopathy disease (e.g., sickle cell);
- Critical Congenital Heart Defects (CCHD);
- Biotinidase deficiency,
- Cystic fibrosis;
- Severe Combined Immunodeficiency (SCID); and

- Certain metabolic disorders detectable by "Tandem Mass Spectrometry" (TMS), including phenylketonuria (PKU).

Vaya coordinates with NCDHHS on the Management of Inborn Errors of Metabolism (IEM) Program and coverage of metabolic formula. Vaya will establish a joint plan with NCDHHS to implement reporting, education, and care management activities regarding children who screen positive for hereditary and congenital disorders, including sickle cell anemia, during Tailored Plan Contract Year 1 or another timeframe defined by NCDHHS.

Newborn Hearing Screening

Vaya promotes awareness of NC's Early Hearing Detection and Intervention (EHDI) Program. This program aids and education to hospitals, medical providers, and others. By connecting families to available resources, it supports families and helps them get the care their baby needs. Consistent with NC Gen. Stat. § 130A-125 and 10A NCAC Subchapter 43F, Vaya complies with state law and regulatory requirements governing the Newborn Hearing Screening Program, including reporting to the EHDI Program. Vaya will engage in joint planning with the Department to implement the requirements of hearing screening by one month of age, diagnostic evaluation by three months of age, and intervention by six months of age during Tailored Plan Contract Year 1 or another timeframe defined by NCDHHS.

Women, Infants, and Children Program (WIC)

Vaya identifies members potentially eligible for WIC, makes referrals, and provides comprehensive application assistance to help members access the WIC program. Members potentially eligible for the WIC program include pregnant women, women up to six months postpartum, breastfeeding women up to one year postpartum, and infants/children under age five. Linkage to WIC programs occurs through the Vaya website, which connects directly to the WIC Special Supplemental Nutrition Programs allowing members and Tailored Care Managers to easily locate the WIC program in the desired county. Vaya has relationships with WIC entities and collaborates with the NCDHHS Division of Child and Family Well-Being, Community Nutrition Services Section, Office of the State WIC Director to coordinate these activities and share data as needed to accomplish joint program goals.

Vaccines for Children (VFC) Program and NC Immunization Registry

Vaya recognizes the critical role that vaccination plays in individual- and population-level health outcomes. North Carolina's average vaccine exemption rate in the 2022-23 school year was 2.28%. However, several counties in the Vaya region have higher than average exemption rates. In the 2022-23 school year, Buncombe County had 5.39% of kindergartners receiving religious exemptions. Other counties in the region with high vaccination exemption rates include Haywood (4.65%) and Cherokee (6.25%). Our vaccination initiative targets the infant and child member population. The CDC-recommended schedule of pediatric immunizations guides our strategy. Our objectives are to 1) increase the rates of childhood vaccination for the member we serve across all counties; 2) increase immunizations for adolescent members to meet the Department's quality metric and 3) increase well-child visits (which include vaccinations) within the first 30 months of life.

Vaya identifies the baseline percentage of Medicaid members who have delayed vaccinations. We access the NCIR information to support tracking at a member, provider, and population level.

- Member level: Vaya sends vaccine education and reminders to members enrolled with Vaya. Our public-facing website includes information on the importance and benefits of vaccinations. Through partnership with providers and local health departments, we identify reasons for vaccine hesitancy,

whether they are barriers to receiving the vaccine or beliefs that have a protected exemption under North Carolina law. We obtain member input from CFAC and the Innovations Stakeholders Committee. Based on information gathered from members, we use communication strategies, venues, and language that incorporate cultural humility and compassion to address vaccine hesitancy. We also review immunization status during care transitions and include immunization screenings and education throughout enrollment processes, wellness programs, and disease management programs.

- Provider level: Pursuant to Section 317(j) of the Public Health Service Act, 42 U.S.C. § 247b(j), via the annual Vaya Learning Summit, Provider Advisory Council (PAC) meetings, Provider Touchpoint webinars, provider communication bulletins (PCBs), Provider Central website, and provider trainings, Vaya delivers general vaccine education, including VFC program linkage, use of the NCIR and You Call the Shots training. We partner with network providers to reduce false or misleading information about vaccine effectiveness and help provide vaccine science resources they can distribute. We refer providers to the NC Department of Public Health Immunization Branch for enrollment requests and additional information.
- Population level: Vaya's Deputy Chief Medical Officer (Deputy CMO) participates in Buncombe County's Immunization Coalition to work alongside LHDs to overcome vaccination barriers within the system. Vaya develops community health fairs or seasonal campaigns in the summer, before school resumes, to raise awareness and provide education about vaccinations. We also incentivize vaccination adherence through the Value-Added Services program, "Vaya Total Care Perks." Moreover, we understand the importance of modeling good behavior within the organization. We are committed to educating employees about the benefits of vaccines, providing health care benefits that cover recommended immunizations, and offering onsite vaccination clinics.

Baseline data ultimately informs the specific goals to increase the rates of childhood vaccination in members, increase immunizations for adolescent members and increase well-child visits (which include vaccinations) within the first 30 months of life. Initially, we intend to increase overall childhood vaccination rates by 0.5%, increase adolescent immunization rates by 0.25%, and increase well-child visits within the first 30 months of life by 5% to meet the Department's quality metric. These goals may need to change once we establish baseline rates.

Other Prevention and Population Health Management Programs

Vaya actively participates in and supports the Department's public health initiatives and coordinates with all existing public health and human services programs, including reporting, education, and care management activities.

Ensuring Innovations Waiver Participants Have Access to Primary Care

In July 2017, the Department adopted new criteria for measuring the performance of the LME/MCOs by introducing four key benchmark measures. These "Super Measures" were implemented to improve member care, reduce medical and behavioral health care costs across North Carolina, and align with national best practices. One of the Super Measures required Vaya and other LME/MCOs to ensure that at least 90% of Innovations Waiver participants visit their primary care doctor annually. Vaya engaged in deliberate planning and execution of clinical and network management strategies to optimize our performance in line with expectations. More than 96% of Vaya's I/DD population participating in the NC Innovations Waiver received their yearly primary care visits in FY 2022 and 2023.

Effective January 1, 2025, Vaya will re-integrate the Department's Annual Primary Care Visits Super Measure as a value-based measure in our provider contracts. Vaya contracts with five agency-based providers designated as Community Comprehensive Centers (CCCs) that maintain service sites serving MHSU and IDD disability groups within each county in Vaya's region. Similar to the Certified Community Behavioral Health Center (CCBHC) model, CCCs are designed to offer the optimal mix of services to Vaya members, improve ease of access to clinically appropriate care, improve member outcomes, and help ensure continuity of care at a single agency.

Member Education and Program Referrals

Vaya population health programs include procedures for referral and education to increase access to resources that support members health goals. We work collaboratively to implement targeted health initiatives and ensure that Advanced Medical Homes (AMHs), CMAs, and Vaya-based Tailored Care Managers promote wellness and prevention initiatives to members. Vaya partners with Healthwise, which provides current educational information about health topics that Vaya shares with members. We also refer members to existing resources in the community, including YMCA programs that promote exercise, the Western North Carolina Aids Project and the North Carolina AIDS Action Network, which provides clean injection supplies. Focus areas for member education and program referrals include the following: exercise, nutrition, stress management tobacco cessation, harm reduction and relapse prevention and suicide prevention.

Ensuring Appropriate Human Immunodeficiency Virus (HIV) and Hepatitis C Screenings

For more information on how Vaya will ensure Hepatitis C and HIV screenings occur for members in accordance with U.S. Centers for Disease Control and Prevention (CDC) guidelines, see Vaya Health Hepatitis C and HIV Annual Screening Plan attached to the Quality Assurance and Performance Improvement plan (QAPI).

Human Immunodeficiency Virus (HIV)

An estimated 1.2 million people in the United States have the human immunodeficiency virus (HIV), and approximately 13% are unaware of their status. An estimated 40% of new HIV infections are transmitted by people undiagnosed and unaware they have HIV.

Diagnosing HIV quickly and linking people to treatment immediately are crucial to achieving further reduction in new HIV infections. Vaya's PCPs are the front line for detecting and preventing the spread of HIV. In alignment with the CDC, Vaya ensures PCPs:

- Conduct routine HIV screening at least once for all their patients
- Conduct more frequent screenings for patients at greater risk for HIV
- Link all patients who test positive for HIV to medical treatment, care, and prevention services.

Hepatitis C Virus (HCV)

Vaya is committed to support the Department's goal of decreasing new HCV infections by at least 60%. Given advances in HCV antiviral therapy, elimination of this infection in the Vaya region is a realistic target, and we are committed to raising awareness, promoting partnerships, and mobilizing resources to help achieve this goal. Routine HCV screenings and education at BH visits improves chronic hepatitis C management interventions. At a member level, we provide disease-specific HCV education regarding risk factors and long-term consequences of HCV infection. We also encourage the use of medications that can now offer a cure. On a provider level, we will offer value-based provider incentives that support HCV screening and linkage to care. On a system level, we

promote HCV awareness, coupled with screening. We require providers to screen for HCV or include harm reduction and treatment as prevention. Vaya's network PCPs are required to be familiar with the CDC's Hepatitis C Guidelines and follow them. Vaya will coordinate with local Ryan White HIV case management programs and providers.

Promoting Women's Health

North Carolina's female population is steadily growing, and women are projected to outnumber men through 2030. North Carolina Women's Health Report Card uses many different data sources to provide an accurate picture of women's health and Vaya uses this information to focus our efforts in the most impactable areas. The topics of women's health most needing attention include preventive health, prenatal health, chronic disease, obesity, mental health, substance use disorder, cancer, infectious disease, poverty, and access to healthcare.

Using claims data, we will track and monitor the following NCQA measures as they pertain to women's health:

1) Cervical Cancer Screening (CBE# 0032), measuring the percentage of members 21-64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:
    a. Members 21-64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last three years.
    b. Members 30-64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing performed within the last five years.
    c. Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last five years.
2) Chlamydia Screening in Women (CBE# 0033), measuring the percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
3) Prenatal and Postpartum Care (CBE# 1517), measuring the percentage of deliveries of live births on October 8 of the year prior to the measurement year or between that date and October 7 of the measurement year. For these members, the measure assesses the following facets of prenatal and postpartum care:
    a. Timeliness of Prenatal Care: the percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.
    b. Postpartum Care: the percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery.

Maximizing Quality of Life for the Long-Term Services and Supports (LTSS) Population

Vaya works to maximize quality of life and prizes community inclusion for people who receive LTSS. We have history of successfully supporting members in this population. We will continue the efforts below:

1) Deinstitutionalization
2) Transitions to Community Living (TCL)/ diversion from institutional settings: We have developed a highly structured diversion program that is specifically designed to identify, engage, and divert adult members

and recipients living with SMI to a home or community-based setting rather than residing in an Adult Care Home (ACH) or institutional setting.

3) Supported Living Remote Monitoring Initiative: Technological advances provide increased opportunities for people with disabilities to live at home. These tools include sensors that alert or remind members to complete daily life tasks and remote patient monitoring applications that increase autonomy. Technology empowers members with disabilities to live a self-determined life. Vaya currently contracts with SimplyHome, a technology vendor that specializes in smart home technology. SimplyHome offers revolutionary ways for providers to safely conduct remote patient monitoring for individuals with I/DD and products that support member safety such as locked pill boxes or door and window alert systems. This vendor provides supplies for NC Innovations Waiver services like Assistive Technology offered.

When Vaya identifies people at risk for needing LTSS, we connect them to the needed resources and supportive services to enable them to live in their community.

Behavioral Health Care

We aim to continue our proven history of meeting or exceeding Department standards for quality and performance measures and routinely demonstrate our excellence by developing unique solutions and strategies for complying with these measures. We strive to consistently meet standards all four "Super Measures" established by the Department, as well as continuing to be the statewide leader on penetration measures for both Medicaid and state-funded services. As a Tailored Plan, Provider Network Operations Department works with Vaya's Quality Department and providers' quality staff to develop quality improvement projects. We track use of multiple anti-psychotics in adolescents and children, metabolic testing for children and adolescents on antipsychotics and antidepressant medication management.

Opioid Misuse and Prevention Program

Vaya implements initiatives to increase access to medication-assisted treatment, including initiatives to increase the number of providers offering this treatment. For more information on the Vaya Opioid Misuse programs, see Vaya Health Opioid Misuse Prevention and Treatment Program.

Addressing Behavioral Health and I/DD Stigma

Vaya seeks to reduce the impact of stigma for people with behavioral health and/or I/DD diagnoses. We know stigma is a barrier to inclusion and acceptance. People who experience this type of discrimination are less likely to seek help and more likely to experience low self-esteem. One of the best ways to decrease stigma is to increase awareness and understanding through local, contact-based education. While Vaya has delivered community education for many years, we believe that we can increase the effectiveness of this intervention to more directly target and measure effectiveness at reducing stigma. Our goal is twofold: to reach more community members and stakeholders in education efforts and to ensure that addressing stigma is a component of these educational interventions.

In addition to Vaya's engagement in public awareness campaigns, including federally and state-supported campaigns designed to reduce the stigma associated with behavioral health, I/DD and TBI needs, Vaya offers education and training opportunities to help members, families, and stakeholders support wellness and build healthier communities. These interactive workshops for members and their families are designed to inform, increase awareness, and decrease the stigma associated with MH, SUD, I/DD, and TBI conditions. We believe

members, their families, and community members should feel comfortable having conversations about these conditions. Creating a safe environment empowers people to access the care and resources that they need to begin recovery. The Vaya website includes a calendar of events that includes upcoming trainings in our region. Examples of training include:

Community Education Classes

- Darkness to Light: Stewards of Children teaches adults, especially those who work with children, how to prevent, recognize, and react responsibly to child sexual abuse. It is the only nationally distributed, evidence-based program proven to increase knowledge, improve attitudes, and change child protective behaviors.
- The Vaya Geriatric and Adult Mental Health Specialty Team within the Learning and Development Department offers education for professionals, family caregivers, and the community. The team also provides support to agencies and family caregivers of people ages 60 and older who are experiencing behavioral health issues, dementia, or other emotional or behavioral challenges.
- Mental Health First Aid (MHFA) for adults and youth trains participants to help people experiencing a behavioral health crisis or developing a mental health or substance use problem using a five-step action plan. Participants also learn about local behavioral health resources. Youth MHFA is particularly useful for adults who work with young people, such as educators, coaches, or youth pastors.
- Person-Centered Thinking teaches parents, caregivers, and professionals the fundamentals of person-centeredness, including practical skill sets, activities, and real-world applications. Participants learn to use these lessons in their families and communities, in their work with clients and within their own organizations.
- Wellness Recovery Action Plan (WRAP) teaches participants, including people in recovery from mental health or substance use disorders, to enhance their overall wellness and learn skills and strategies to help them reach their full potential. WRAP is open to anyone who wants to decrease troubling feelings or behaviors and achieve life goals.
- Crisis Intervention Team (CIT) training provides an overview of mental health conditions and ways for first responders, including law enforcement and emergency medical teams, to better understand and respond to behaviors of community members who may have behavioral health disorders, as well as interventions and the nature of mental illness, unmet health-related resource needs and cultural influences.

Highlighting Suicide Prevention and Awareness

In addition to these trainings, Vaya has made a concerted effort to address suicide prevention and raise awareness in communities. The Vaya Provider and Community Education Team regularly offers Question, Persuade and Refer (QPR) training, which teaches community members to recognize warning signs of suicide, offer hope, and encourage people to reach out to natural supports and professional treatment. Participants of QPR training learn to talk to someone who may be experiencing suicidal thoughts and refer them to help.

Of the more than 47,000 suicides nationwide in 2017, over 8,500 involved adults ages 65 and older, according to the CDC. Men ages 65 years and older face the highest risk of suicide, while adults ages 85 and older are the second most likely age group to die from suicide. In recognition of National Suicide Prevention Awareness Month in September 2020, Vaya's Geriatric and Adult Mental Health Specialty Team presented "Suicide Indicators, Response and Prevention," a free class that teaches anyone, especially family caregivers, long-term

care staff, and other community agencies serving seniors how to help prevent suicide among this population.

Methodology

Vaya will continue to offer these valuable trainings to the communities we serve. Additionally, we are employing strategies to increase attendance at these trainings by including event reminders in Monthly Key Issues reports offered in county meetings throughout the Vaya region. These Key Issues reports highlight Vaya initiatives occurring throughout the region. All Vaya staff who attend community meetings use these reports to deliver consistent, up-to-date information in their required report-outs. We expect that including these in direct reports to our community partners will disseminate information in an interactive way that improves upon Vaya's online resources. Additionally, Vaya staff offering these trainings will include an assessment of how effectively the training addressed stigma as part of the training evaluation.

Intended Outcome

Vaya will increase the number of people accessing community-based trainings that address stigma. As we do not yet know the percentage of individuals who will have accessed trainings in the year prior to the launch of the Tailored Plan, we will set our goal based on this information at the beginning of FY2022-23. We will also assess training evaluation responses that measure effectiveness at reducing stigma at the outset of this fiscal year to set goals for the first year of Tailored Plan operations. In broad terms, our goal is to increase attendance at community-based trainings that address stigma and for 100% of attendees to report gaining a greater understanding of the impact of stigma related to behavioral health and/or I/DD following attendance at a Vaya training.

Appendix A: Prevention and Population Health Management Program Descriptions and Strategic Plan

Below, we describe in greater detail selected programs and strategic targets that align with each of the following four focus areas:

- Keeping members healthy
- Managing members with emerging risk
- Patient safety or outcomes across settings.
- Managing multiple chronic illnesses

Descriptions [PHM 1(A)(1)(2)]

Reducing Tobacco Use

- Eligible population: Vaya's Tailored Plan and Medicaid Direct Plan members
- Target populations: Members who report active tobacco use or who have a tobacco use diagnosis and have a behavioral health diagnosis or are pregnant.
- Focus area: Keeping members healthy.
- Goal(s):
  - 7% reduction in use of cigarettes among adults with SMI
  - 2% reduction in use of tobacco products, including e-cigarettes, among youth with Severe Emotional Disturbance (SED)
  - 7% reduction in tobacco use (goal supported by research indicating long-term substance use disorder (SUD) abstinence increases with concurrent smoking cessation)
  - 5% reduction in tobacco use (reduces co-morbid conditions, such as common cardiovascular disease and neoplasms in the I/DD population, which can both be worsened by smoking)
  - 5% decrease in tobacco use (decreases stress and irritability related to smoking, which can exacerbate TBI symptoms; encourage member partnerships with providers on smoking cessation counseling and treatment)
- Methods and data sources used to identify the eligible population:
  - Data gathered from Vaya's Care Needs Screening offered to all plan members.
  - Data gathered from Health Risk Assessments performed by care managers.
  - Members may self-refer to the program using a link on Vaya's website.
  - Quit4Life conducts an eligibility screening.

Tobacco Cessation Services – Quit For Life® Programs

- Tobacco Cessation Behavioral Health Program
  - For members who use tobacco and have a behavioral health diagnosis.
  - Program includes a team of dedicated coaches with extensive training about mental illness and tobacco use treatment. Quit4Life coaches adjust interventions and tailor treatment to meet participant needs. This 12-week program includes nicotine replacement therapy in the form of nicotine patches, with nicotine gum or lozenges available as supplements to reduce cravings. Members can access the program using a link on the Vaya website.
- Tobacco Cessation Pregnancy Program

- For female members planning or experiencing a pregnancy and new mothers who use tobacco products (including vaping).
- Program includes screening and access to an expert "quit coach" trained to provide specific interventions for pregnant women. Members are also referred to the program "You Quit Two Quit," a guide to help new mothers stay tobacco-free. Members can access the program using a link on the Vaya website.

Diabetes Prevention

- Eligible population: Vaya's Tailored Plan members
- Target populations: Members identified as at-risk for developing diabetes.
- Focus area: Managing members with emerging risk.
- Goal(s): Decrease the percentage of individuals diagnosed with prediabetes who go on to receive a diagnosis of diabetes by 0.50%.
- Services: Referral to screenings and Diabetes Prevention Programs (DPPs).
- Methods and data sources used to identify the eligible population: Health Risk Assessments, claims data analysis, pharmacy data analysis, member self-referral, care manager referral and provider referral.

Peer Bridger Program

- Eligible population: Vaya's Tailored Plan and Medicaid Direct plan members.
- Target populations: Members participating in the following services: Inpatient psychiatric care, Facility Based Crisis (FBC), and substance use rehabilitation at Alcohol Drug Abuse Treatment Centers (ADATCs).
- Focus area: Outcomes across settings
- Goal(s): More than 40% of members attend an outpatient appointment within 7 days of discharge from inpatient, FBC, and/or ADATC setting.
- Program services: Vaya contracts with outpatient behavioral health network providers to ensure that members attend timely discharge appointments. These providers contact members, ensure that they have an appointment and follow up with the member to ensure attendance.
- Methods and data sources used to identify the eligible population: Monthly report of discharges using Medicaid paid claims data from the previous 90 days. We track every discharge from Community Inpatient, Facility Based Crisis and ADATCs, then look for qualifying services within 7 days of the discharge.

Tailored Care Management

- Eligible population: Vaya's Tailored Plan members
- Target population: All Tailored Plan members with some exclusions defined in the NCDHHS Contract
- Focus area: Managing multiple chronic illnesses
- Goal(s): Reduction in crisis events. The total number of behavioral health crisis events will decrease by 15% compared to the number of crisis events the member experienced prior to care management enrollment.
- Services: Vaya's TCM Program promotes the wellbeing of members with chronic illnesses by empowering them to actively participate and take responsibility for their own health through the provision of education, coaching/counseling, and access to quality healthcare so that they are better able to self-manage their disease and enjoy an improved quality of life. The methods of interventions

used by the care manager are in-person and telephonic assessment, care plan development, educational coaching and educational mailings including email communication. Care managers link members to services and resources that address social determinants of health, medical, and behavioral health needs. In providing whole person care to the member, the number of crisis events should reduce over time as the member develops self-management skills with their disease.

- Methods and data sources used to identify the eligible population: Vaya has developed an algorithm that identifies eligible members and enrolls them in TCM. Members may elect to choose which care manager provides their service and can change care managers if they choose. Members should be enrolled in TCM a minimum of 60 days. Behavioral health crisis events are identified through inpatient and emergency department paid claims data. Crisis events are recorded three months prior to member enrollment, during member enrollment, and 3 months post discharge.

Analysis of Interventions and Programs

Annually, Vaya reviews all programs against the established objectives and goals. The analysis for interventions and programs identifies barriers to meeting goals and areas for improvement as well as adjustments to the programs to improve performance and any new initiatives that may be necessary to meet goals. Vaya's Clinical Strategies Department completes this analysis annually and presents the findings to the Quality Improvement Committee for review and feedback.

Related Documents: (All Hyperlinked) **Forms:** **Referenced Policies:** Tobacco Cessation Plan; Opioid Misuse Prevention and Treatment Program; **Other:** Healthy NC 2030, Quality Strategy, , Western North Carolina Aids Project, North Carolina AIDS Action Network, Hepatitis C Guidelines, , NC Early Childhood Action Plan, Vaccines for Children, NC's Early Hearing Detection and Intervention , You Call the Shots, North Carolina Women's Health Report Card, DSMES toolkit, *Million Hearts Hypertension Control Change Package Second Edition*, Question, Persuade and Refer

Accreditation Standards: **NCQA:** PHM 1(A), PHM 1(B), PHM 2(B), PHM 2(C), PHM 2(D) **URAC:** Subcategories of URAC not selected.
Supersedes: Not Set