Transcript for Division of Health Benefits: Health Care Professionals Webinar Series
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Hugh Tilson

It's 530. Let's go ahead and get started. Good evening, everyone and thank you for participating in this evening's COVID-19 webinar for Medicaid providers. This webinar is part of a series of informational sessions put on by NC Medicaid, CCNC and NC AHEC. Next slide. As you can see, we've got a full agenda and a ton of great timely information tonight, including an update on Medicaid policies and a discussion about a recently launched initiative called Keeping Kids Well, you hear about the underlying data and trends, some lessons from the field, an overview of the project and its interventions. We will then respond to your questions and provide a list of resources. My name is Hugh Tilson. I'll be moderating tonight's webinar with Tom Wroth. Before I turn it over to Shannon, I'd like to thank everybody for making time in your busy schedules to participate this evening. We hope the information provided tonight will help you in your important work and make navigating these trying times a little easier. Next slide.

After you hear from our presenters, we'll turn to your questions we've learned in past webinars, that presenters will often address your questions during their presentations. We should have time to get to your questions, I encourage you to wait till the presenters are through their presentations before submitting a question. Please know that we'll incorporate any questions that we don't get to and send them to Medicaid so that we can figure out how to get information back to you. If you're participating in the webinar, you can submit a question using the q&a feature in the black bar at the bottom of the screen. So that q&a function on the black bar if you're on the phone, you're muted, so you can't do that. The only way you can submit a question is by emailing us at questionsCOVID19webinar@gmail.com. We'll record this webinar will make that recording and a transcript available as soon as possible. And we're getting the slides mounted now and should have those available to you quickly. So you can follow along. We'll try to get that out to as quick as we can. Now, let me turn it over Shannon.

Dr. Shannon Dowler

Great to see everybody virtually again, one day, we actually have video at the same time, so I can actually see all of your faces. But thanks for joining us tonight after a long day of work. I wanted to give you a ton of updates in a short timeframe, and then turn it over to the rest of the team to talk about an exciting initiative to close some care gaps. So we'll go on Nevin to the first slide. So, those of you that

know Dave Richard, know he's my boss and behind every great boss, there is a great team. So the Medicaid team has done a phenomenal job. I think this year in responding they always do a phenomenal job but they have really hit it out of the ballpark in trying to be responsive and get things done. And so some of what I'm going to share with you tonight as some of the data on how the field has used, the things that they've turned on a lot of the codes that we've implemented and some that we're making permanent, some that we're still investigating and studying, I think it'll be interesting for you to see where that stands. Next slide.

This is a summary we did have accomplishments of trying to kind of look at some of the work that the team has done in a numeric way. And this will be in the deck if you're interested in accessing it. But when we look at our provider webinars, we've hosted 90 webinars 38,416 attendees put together would fill the Dean Dome and Duke stadiums together. We've, we've we've done, handled 67,829 calls through the phone line, which is the same number of people that could fill the Carolina Panthers stadium. So we put together a list of kind of making it a little more fun, all the work that the team's been doing during the pandemic. Next slide. We predicted and we are now seeing that Medicaid enrollment is going up. You know, ideally, in a perfect world, this would go up and up and up because we'd be expanding Medicaid. But we're definitely seeing the impact of the pandemic on people's financial status and ability to be insured in other ways change and so we are seeing more Medicaid enrollment, and we expect to see that rise over the next several months and, and maybe even exponentially with the Medicaid expansion. Next one.

One of the things we've talked about and finally have in place is a program through the federal government that allows us to provide Medicaid for testing uninsured patients for COVID-19. This is only testing so don't get too excited. It literally just pays for the testing. But it's another way that we can help get resources to our patients and decrease barriers to coming in. It's federal funded, so it doesn't cost any state dollars. It won't pay for the treatment of COVID but the testing. Testing collection providers have to be enrolled in Medicaid to get reimbursed for it, which makes sense. But starting September 1, and it'll go through the end of the public health emergency, we will be putting a process in place where people can do a very quick abbreviated application with self attestation of their uninsured status, residency, citizenship and Immigration status. You have to meet those requirements, the state will verify those and it allows up to three months of retro eligibility to cover the cost of testing. So there should be a bulletin coming out very soon on that but I wanted to give you a heads up because I know a lot of you out there have been really involved in testing and this will come as good news.

Dr. Shannon Dowler

Ok so, Next Slide. So originally, I thought I was going to have to present this myself. But Greg Griggs, from the North Carolina Academy of Family Physicians started tearing up our email this week because providers are reaching out to him, physicians around the state saying these work notes are killing us everybody wants to know to go to the gym. And so, Betsy Tilson you can't hear her talk without like seeing her hand gestures. And so I found a picture of her using hand gestures, but not in a mask but then I found a picture of her in our mask or I put them together and there she is in a mask using hand gestures, and she's on the call unexpected. So Betsey will you take the next two slides?

Dr. Betsey Tilson

I will and I apologize to the audience for the Frankenstein photo of which I don't think I was supposed to see but thank you for that. Yeah, I'll take the next two I'm happy to be able to be with you tonight I thought I was going to have a conflict but it got rescheduled so happy to be with you on for the next two slides that are not Medicaid specific but um, but more overall. So, the first thing is that, for those of you who are following all of our executive orders. We have kept gyms closed. There's a lot of reasons for that. In the short is that gyms in general are a pretty high risk setting for viral transmission there's some good data that shows outbreaks. It's an indoor setting there's lots of respiratory effort, ie then more chance of respiratory droplets spread there's lots of surfaces and fomites. And so we have kept them closed. And we have seen in other states that open gyms they really saw big surges and that was one of the things that they reversed they closed their gyms. So we have. That's why we have kept our, our gym and workout facilities closed.

However, as part of and there was some legal proceedings as part of that and as part of the legal proceeding there was an exception that if somebody really needed an indoor exercise facility as part of a true medical treatment plan. So for example, it was that if someone is in rehab or in PT and typically for rehab or PT, you can use the equipment at a rehab or PT but if that specific PT or rehab center didn't have the equipment, then this could be an exception that somebody would you could use an indoor equipment as part of a very formalized medical treatment plan. The expectation was that this would be an exception that this was limits and those would be a small number of people because we don't want a bunch of people in gyms and that it would be subject to mass gathering limits in the gym, no more than, than 10 people, who was meant to be a very limited true medical exception for people who really needed that indoor equipment for medical treatment. This has been interpreted differently across the state and not not the intent of it. So, if people come to you and say I need to note, just, you understanding the intent behind it is that we don't want a lot of people in a gym because that is a high risk setting and I understand that exercise is really important for people with chronic disease, but they're also the ones at higher risk for COVID. So it is meant to be a very limited limited medical exemption for people who really need the indoor machines, and we have though allowed for outdoor fitness. Awesome. That's great outdoor fitness is fine but really wanted to limiting the number of people in an indoor gym. So just want to make sure you had that guidance and the intent behind that guidance to help you respond to those requests.

Next slide. The other thing that happened yesterday was we have been getting working with our local health departments working with our schools working with our providers, I know you're going to talk about today about trying to get some of the immunization rates up. We saw a lot of different things coming together, that made us pretty nervous about children being able to meet the immunization requirements and the last thing that we want. When so many of our children have been out of school is further, having them be kicked out of school or or not being able to participate in school and really we're worried about that. There's a couple things that came together, one in the spring, as you all know there are some new immunization requirements, especially for adolescents fo r their Meningococcal vaccine

typically in the spring, there's a lot of big push out for education on those, those new vaccine requirements that obviously was somewhat impeded by COVID, as we know there was decreased folks coming in for well child visits I know immunization rates are down. Third our local health departments who often do a lot of this work and immunization clinics obviously they have been completely responding to covid. They also often do mass vaccination clinics around this time, and bring a bunch of kids in to vaccinate obviously they cannot bring a bunch of kids to vaccinate to do that because of the social distancing so that's been an impediment and also the first month of school typically the schools, really it's kind of all hands on deck to get kids that documentation, up to date and the first month of school our schools are going to be struggling so much with just trying to operationalize all these new COVID health and safety protocols.

So all that together, we were worried about people being able to meet those, those deadlines and then again we didn't want even a yet another barrier for kids to be not connected in with learning for all of that, we decided to do the same thing that we did during Florence and do a 30 day extension of both the immunizations and the health assessment requirements, not a waiver, but just a 30 day extension. And typically, kids have to get those assess those requirements in 30 days after their start date their first day of school. And so sometimes it's a moving target. So instead of saying, 30 days after your first day we just said instead of most kids go to school August 25th. And so they would be due September 25, but to kind of give that month grace period we said the clock doesn't start until October 1. So basically I have to get everything in by November 1. So, just wanted to be sure you're aware that backup pushed out yesterday and wanted to be sure you, you have that and the rationale behind that. And that's it for me.

Dr. Shannon Dowler

Thank you for jumping on the call. We appreciate it.

Hugh Tilson

Could we ask a quick question we got a question about enforcement. How will enforcement not having acquired immunizations or school health assessment. After the extended deadline, especially if children are enrolled in online school.

Dr. Betsey Tilson

Yeah, so it applies, so attendance will be both online and in person so even if a child is doing remote learning, and they're not meeting those, then they would need to be discontinued from even online online learning for so it would be the same for both in person and online. Yeah.

Dr. Shannon Dowler

All right. So, I'll switch back to some a couple of Medicaid items that I think are important for this group to hear. Last week, you probably saw our special bulletin that went out around, extending clinical policies temporary policies and rates that have been changed during the pandemic. So, the, we've been waiting on the federal guidance on the public health emergency. They did end up extending the public health emergency. And so for that reason we're going to hold on to the higher rates that we've been giving providers that providers have been earning we haven't been giving them. Those higher rates, until the end of September. And so they were originally supposed to sunset much sooner. We've kind of June was the original time they're supposed to sunset we've slowly like continued them as possible. The first cut of checks should be coming out from that 5% bump. That's been in processing with our vendor we're pushing really hard to get that money out to practices because we know how, how much you need it right now. But we are going to continue to the end of September, it is possible that we will be able to continue on past that. But we've got to sort of get through the budget process and see if we're gonna be able to pull that off.

The clinical provisions, the temporary modifications that we made in response to the public health emergency. We have now said we're going to keep on till the end of December. So we've been talking about permanent changes to policy those will still be permanent changes to policy starting in January, but we wanted to take the opportunity while we were still in a public health emergency to have our temporary policies in place so things that have been covered. Since March, or slightly beyond that will continue to be covered through the end of the year, wanted you to know about that. Next slide. There was a question about what rates exactly are you talking about, and we have changed so many rates in across the board. I mean, just dozens and dozens of rates. And so an example would be that per member per month rate that you get for medical home that's going to continue. The one thing. The only thing that doesn't, it's not necessarily is around the LM/ MCO rates. That's up to those MCO's to pass their rate determinations on, they have received rate increases from the state but it's their determination on how to pass it on to providers, so we can't control that piece of it, but all the other rate changes plan on staying in.

Next slide. So this is the part that I think is really interesting. So our team in our informatics world have built some super cool dashboards. We asked them to as soon as we started turning on these tele health modalities, so that we could study it and see how it's being used. And so these are some dashboards you are the first people to see them, looking at some of the less traditional modalities and telehealth and telephonic services to see how they got taken up during the pandemic. So I'm going to go through them really fast but I just think they're kind of interesting. So this is looking at our specialized therapy category. So, speech therapy PT, OT those sorts of things and you can see the highest utilizer, by far, is speech, speech evaluation and therapy followed by a PT and OT but pretty far down the pack. Very little utilization with outpatient respiratory therapy which makes sense to me. Very little utilization by audiology also makes sense to me. Not much utilization of nutrition and dietary evaluation counseling that one doesn't make as much sense to me. But I think the the others, kind of play along with what I would have expected. Next slide.

So this looks at that virtual telephonic utilization, and you see here that there's really only one modality one specialized therapy PT and OT did some early on telephonic work but thne pretty much that's dropped off, as people have been going back into the office. Next slide. Behavioral Health has been incredibly engaged partner in doing telehealth and telephonic care. And this shows you that big yellow line is the psychiatric diagnostic evaluation and psychotherapy combined, followed by the enhanced behavioral services as the top two. Autism spectrum disorder, growing uptake over time. Same with developmental screening and testing, but relatively low utilization. Next slide. When we go to telephonic what you're going to see is a flip flop of that. And you see that the enhanced behavioral health services were used more telephonic and psychotherapy and evaluation, were a little bit below that, and then very little in the next two categories. Next slide. So this looks at all the claims across the state by county, and who used different modalities, from a county view. And so this is everything total claim so find your find yourself find your county that you're in. And the next slide looks at the telehealth claims, and how much telehealth was used in these different parts of the state. And then you go to the telephonic claims, which is the next slide and you can see how the thought shift around a little bit. So this is an interesting look you can see in some of the more rural counties that have big dots you had early adopters, you know folks that were really leading into this technology early.

Next slide. When we look at utilization of the specialized therapies around the state this is the PT, OT and looking at which percentage are telehealth versus virtual telephonic claims and where those claims happen. You see a lot more in the western part of the state which is interesting because they don't play as large in some of the other utilization. Next slide. When you look at speech therapy, again you see that really hit more of your urban centers which makes a lot of sense but we're in the east, in the eastern part of the state. And again, you see telehealth being the majority of all of their claims. Next slide. audiology very low uptake and actually only use in a couple places in the state. Next slide. This is where I'm super disappointed I thought we were doing something really cool by this turning on self measured blood pressure, and where we would bill for doing blood pressure management, but it turns out, nobody wanted to do that. So, we were on, we struck out on that one.

Next slide. This one is, I think should be higher. I think maybe it was just everybody had different focuses at the time I'm sorry my home phone's ringing we still have a landline in the mountains. This is smoking and tobacco cessation. No telephonic claims, but a handful of telehealth claims. This is something I would like to see go up in utilization go on this over time because I think it's a great way to connect with patients without making them come into the office for these services. Next slide. This one's another strikeout for me, it turns out I don't know y'all at all. This is that interprofessional consult code the MD, MD consult where we were saying that if if someone does a consultation, they can get paid for that consult work, because we knew a lot of that was happening. And it turns out it's, I guess it's probably my guess is putting on my provider hat. It was probably too much work to bill for that but the logistics of arranging it finding out the patient all that it's easier to the phone call and not bill for it, that's my guess. But that has not been picked up.

Next slide. So we're back into the looking at the psychiatry the diagnostic evaluation codes. This includes the psychotherapy and you can see the telehealth and telephonic claims huge uptake around the state, and around the state. You can also I think when you look at these little dots and where you see very low utilization is not necessarily around the ability to have access to, to bandwidth because you'll see telehealth being utilized in one county for one type of service but not at all for another type of service so it's more around the provider behavior sometimes. Next slide. This is another one I've got really excited about and you guys didn't, I mean there was a little more use of this this is that portal communication that that when you're doing portal communications with patients, that's work, it should be counted and have an RVU assigned to it and it should show up somewhere. And so we made reimbursement happen for that. And early on, it was used but it looks like that just really petered out, and so I'm not sure why that's something I want to understand more. Next slide. So when we look at the top 10 utilize flexibilities we've kind of been through them number one overall of everything speech therapy. Then we get into the psychotherapy and psychiatric evaluation and then the basic e&m codes, kind of what you would expect. Next slide. The next slide is the bottom 10 flexibility so the ones that people are like, not using at all. And, and sadly my blood pressure monitoring, falls in there. You guys are not nearly as excited as me. T

Next Slide, want to touch really quickly on managed care launch. So, July 1 we're going live, and it is happening. We are the teams already starting to dig in and work on it. I think the way everything happened last year. It's just the way it happened. But what we're doing is making lemonade out of lemons, and we're taking the things we learned that reflux points and things that were most stressful the feedback we got, and we're trying to really polish and shine on the program, so that we fixed some of those things before we go live so it's a great opportunity.

If I was going to tell you three things that I really want you to hear and know based on this. Go live is July 1, we're doing the whole state at once, and it's gonna happen. Thing number one. Thing number two, if you want to get in that provider directory, and you want to get in that provider directory. You really need to get through your contracting by January, so that by the time the directory is out there and patients can make their choices with enrollment, you're in there and it shows what plans you're with. The plans can do direct consumer advertising, so they can tell about their amazing value added services and help people decide what plan they want to been in. We want your patients to find you. And so we. Ideally, you'll have the plan they want you'll be part of. But just know that timing. It takes a long time to get all this paperwork and process done. So getting contracts signed by January, we'll make it so that you're in the provider directory and ready to go. The last thing I would say is, our provider team is really worked hard to improve turnaround time for provider record updates and really make that streamlined Christina Bunch on our team is leading that work and has done a phenomenal job. It's now a great time for your practice to update your records and nctracks. Just check on it, make sure everything's right and update it, that it's not a really busy time for us right now and as we get closer to managed care launch the crazier it'll get. So I would say take advantage of that now. Next Slide. All right. With that, I'm going to turn it over to my colleague, and co conspirator in the department. Kelly Crosbie.

Kelly Crosbie

Hi everyone this is Kelly Crosbie, and we are here I'm here with a team of folks with Chris Weathington from a hack and Jennifer Cockram from CCNC, and to physician leaders that I just had the pleasure of meeting by phone, and prior to the meeting to talk about the keeping kids well campaign, we introduced it about a month ago, and hopefully most of you have heard about it, information has gone out about it. CCNC and AHEC have developed a wonderful website. But today we wanted to dig a little deeper and tell you more about the data and feedback that we're getting from from y'all and from the field, and some of the activities that we're engaged in. I want to give a special thanks always to CCNC and AHEC for working with our teams around everything from creating data that's important for us to use for us to track things. And for our practices and care managers to target and work with practices, and of course just for all the wonderful coaching and support that goes CCNC and AHEC to do with the practices. And the biggest thing of course is to do all the providers on the phone. And on the webinar today.

So, let me go to the next slide, just to tell you about our problem statement. I prefer to call it an opportunity statement but it is a bit of an issue. So, we shared Sunday the last time that COVID-19 has led to measurable decreases in pediatric preventative care across all of our population so total populations, no matter how you stratify the data. We look at it by gender, and we look at it by age. A lot of these are age banded measures we look at it by race by ethnicity, by county, big practice and little practice. We're seeing decreases in pediatric preventative care. We're going to talk about three particular rates today, that we'll show you in data. We shared last time that there are disparities in our rates across populations. And those are fairly persistent across the last four or five years we shared some of that data last month. In general, I'm going to speak in generality, but it just tees you up for what you're going to see. Generally speaking, African American children tend to have lower rates across all of our child measures so less immunization plus well visits. In general, our Hispanic groups tend to have higher rates than the state average on a lot of our child measures. Those are generalities, but I kind of just wanted to remind folks of the trends that we see. You won't see a lot of difference here you'll see a lot of those persistent trends.

So here's some here's some points that we want to share before we get into the data. And this is information that we've gleaned our partners have gleaned from providers and families and the community. So parents are not certain if vaccines are required with virtual education. Parents are afraid that they or their children will contract COVID-19 or experience barriers if they're trying to visit their pediatrician or family physician. We all I think acknowledge that under utilization of well visits are missed opportunities to identify other things. Physical, developmental, behavioral concerns, many of which could be managed or treated. And of course missed vaccines can lead to other community outbreaks which certainly no one wants right now. So let me get into the data until you just quickly about the data if you could go to the next slide we're just going to look at three, three measures. We're going to look at well visits for zero to two, we're going to look at, well visits three to six and we're going to look at immunizations. That particular immunization rate we're going to look at as Combo 10, that's the big one, it's all the immunization for kids by the age of two so those are the three metrics, we're

going to look at. You're gonna see all the rates stratified by race, ethnicity, and gender, tried to keep it pretty simple. And we're always going to look at percentage of the population.

So let me tell you this first slide. So this is our proportion of the population with overdue well child visits. This is our birth to well visits, it is a stratified by race and a higher value is not good. Okay, so we start all of these rates in January, and in January, just to orient you to how these slides work. Look at the purple line on all of these will be a purple line the purple line is our African American children. They already started out at about 14% of the population with an overdue well visit. And as you can see that line goes upwards. Yellow is always going to be the Caucasian or white line. So that is very close, it's very close to the African American line that represents African American children that starts out around 13% but we see again the line goes up and that means we have more overdue well visits for kids birth to two. So always the blue line is going to be our Native American and Alaskan Native group, and green is going to be our Asian and Pacific Islander group, you'll see the same theme across all the slides. We started out with a certain percentage of people with overdue care, and the lines go in the wrong direction. The other thing I do want to point out of this is a week by week look which is kind of a different way to look at measurements measurements usually an annual rate. So the lines are a little erratic. But look at this weekly line that goes over six months. It is a trend, and it is trending in the wrong direction, unfortunately. So, if you go to the next slide.

This is just the same look by ethnicity. So as I mentioned before, typically in North Carolina and this is a trend we've been persistently for the past four or five years, children in our Hispanic or Latinox populations tend to have better rates. So we're already starting in January with children of Hispanic origin, there are, they start out at about a 12% of the missing overdue well visit. But, non Hispanic rates are higher to begin with but still both are going in the wrong direction. So we're missing more overdue care for the birth to two. And then the last slide if you could go to the last slide that's broken down by gender. We just use two genders in these slides. And we've got male and female, we see a persistent pattern of males having more over due care across all of these slides.

So, next slide should be percentage of population with overdue well child visits by three to six by race. In this it's a little reversed. So our Caucasian line is a little higher, that is that is that is similar to what we see in the three to six populations in general trending over the past four to five years. And you see this is a little higher than our birth to two. So we actually our rates in general for the three to six population are lower than our rates of well visit for birth to population, but this you see the same trends, we're still going more we're overdue care progressively week over week. If you look at the next slide, it will be by ethnicity, see the same trends, both Hispanic and non Hispanic are going up, so there's more overdue care. But again, our Hispanic population is actually doing a little better than non Hispanic population. And this one we actually think it's probably statistically significant there's probably big enough gap there, and some of the other ones lined the gaps aren't as big. And then the last slide will be by gender. And so again, you'll see males are a little bit higher in overdue preventative care.

And then the last slide, I'm going to show you are immunizations. These ones are really wacky immunizations are you see a lot of variation these ones week over week. And we're not sure if we're seeing an uptick there. In June, and you see a really big spike in June and a really big spike at the beginning of July. But in general, at least we saw going down into April and May a persistent dip. And this one we see the common the trends that we're typically used to so the Caucasian or wait rate was higher. So there are higher rates of immunization in this group. There was definitely a significant difference our African American population was certainly lowest across immunizations, and both you see the trend down fairly significantly through April, we hope that's starting to pick up in May, June and July, and that we'll continue to watch this of course. So this one this is the reverse right. So this is a line going down is bad in well visits the line going up at more overdue care. And this one a line going down means less immunizations.

The next slide should be ethnicity. This is the one that it's very small numbers but it's it's, this is the one where we actually, for the first time we see our two rates diverging and they're diverging in the wrong direction. So typically, our rates for Hispanic children immunization rates have been historically better over the past four to five years, but they have actually plummeted to meet the line for non Hispanic immunizations, again, maybe that's like in July is something to look forward to, but this is the actual true kind of, we really had that meeting of two different lines that you don't want to see it was a meeting of the wrong direction. And then the final slide should be immunizations, by gender. There's a little difference between the male and female lines here but again, these immunization lines are the most eratic. So that's the data I wanted to share with you and I think I'm gonna turn it over to Tom who's going to talk with some physician leaders. And then, Chris and Jennifer are actually going to talk more about the, the, keeping kids well campaign, some of the work in the community. And some of the interventions.

Dr. Tom Wroth

Great, thanks so much Kelly and I really want to thank Kelly you and Dr Dowler and folks on your team for your leadership and bringing together all the folks to kind of move those lines in a different direction. This has been really exciting engaging work for both AHECand CCNC. So I want to thank Dr. Yun Boylston from Burlington pediatrics who of course is a pediatrician, for coming back to the webinar and Dr. Tom Koinis is from Duke Primary Care in Oxford is a family medicine physician, and as CCNC and AHEC often do we're going first to some of our physician experts in that are working on the front lines and gaining insights from them on what they're doing in their, their practices in this particular with this particular problem that we have to solve. So thank you both and we're just gonna have an informal discussion and just maybe start with you, Dr Boylston, maybe, tell us a little bit about what Burlington pediatrics is doing to bring their children in for well child checks and immunization.

Dr. Yun Boylston

Thank you so much and thank you for the invitation to join this webinar and just can't thank CCNC and DHHS and AHEC enough for your support, especially independent practices like ours. So I'd love to get started, we approach the challenge of declining well child visits as well as vaccines and they certainly go

together and we've approached this in several ways. One, I think one initiative that we're particularly, particularly proud of that maybe other practices, I'd love to put a bug in other people's ears, is we've reached out directly to the Alamance Burlington school system in a very intentional way and made some really fruitful connections with Amy Whidderich who is their lead nurse as well as members of the administration, who've been really supportive and, and the initiative has involved a couple of different measures. One is a request to feature the medical home prominently in the informational messaging, the phone messages and reminders that all students get within the district, as well as the emails, just reminding them that the overwhelming majority of children in Alamance County received their vaccines through their primary care provider. And that's been really helpful.

We've also participated in sharing information across platforms so it turns out, the nurses actually created their own informational videos, the school nurses, and so we helped amplify amplify the audience for that by sharing that on our Facebook page, which has close to 3000 followers so getting a little bit more traction and, and they did a really thoughtful job of putting that together so we were happy to share that. The other parts that, that just kind of naturally came out as an extension of that collaboration with the school system. One is participating in several inservices for the school nurses. Initially it started off as Hey, we'd love to be able to, you know, share information with you about covid about best practices about the upcoming flu season, and that really extended to hey would you like our psychologists, to do an in service on behavioral health and that was incredibly well received. So a lot of different ways that we're working together with them.

The other parts that I think I would love to go back to miss Crosbie's on slides in terms of just at the aggregate trends, I think we would definitely those resonate with us, certainly, and I think it's really important for practices to kind of drill down and examine their own trends and analytics. So for example for us looking at our monthly trends. Our vaccine rates are certainly increasing since April, but you know one focus on primary target for us is the DTaP vaccine, which is typically given for 10 and 11 year olds. The other vaccines such as like the pneumococcal or the mumps measles rubella varicella all those are kind of in the net positive over last year, which which we are interpreting to mean that there is some catch up in, in terms of the kids who are getting that but for whatever reason the TDaP seems to be a lot lower, I think, over the past three months we're still down an average of about 30%. In July, we're still down about 10% and so that's clearly a target age group that we would like to focus on. And then lastly, and I'll turn it over to Dr. Koinis, but I think the multi channel communication with families is really important. So in addition to the auto texts and calls. We've been doing a lot of in person calls, which admittedly are very time intensive for our staff. And so we're quite excited about the keeping kids well campaign. We've had an initial meeting with Suzanne Lineberry our Greensboro AHEC representative to see how they can help us you know, reach out to families but also to be able to conserve some of our manpower. Thank you.

Jennifer Cockerham

That's great. Just a quick follow up question. Tell us a little bit about how you're pulling the data is that from NCIR from your electronic medical record how do you do that.

Dr. Yun Boylston

That's a great question. Um, so we're using. So our platform is office practicum. And so a lot of this data is based on. Really, some of the simply in the like provider or schedule metrics so we're able to pull data that way, in terms of the the well visits. And then compare comparing those to last year. And then within and then with the vaccines are staff you pull NCIR records as well. So we have different modalities for getting this information.

Jennifer Cockerham

Tom tell us a little bit about Duke primary care at Oxford and what you do.

Dr. Thomas Koinis

Well, we're a family practice, you know doing both, you know, children and adults, so we're actually dealing with vaccines at all ages. And we've also experienced both the decrease in people coming in as well as the concern of parents as well as adults of taking you know their vaccines at this time but we've been getting to see that people have been coming in a little more frequently. We've, fortunately, with Duke Primary Care, we've been running some Respiratory Care Centers so we've actually been able to keep a lot of our sick patients out of our office and send them to these Respiratory Care Centers in the triangle area. And that's allowed us to really focus more on our healthier patients, you know, coming in so our waiting rooms have been less occupied because we've been doing more telehealth and video visits. So, the crowding that we have had in the past is not quite as much and we've been able to get people in and out quicker. As far as looking at. We've been using a lot of the NCIR to look at our kids and what's been needed. In one case like looking at. who are we still missing the for getting the Meningococcal ACWY, you know, for their, you know, for the visit to, you know, they're a second visit for school. And so we've been looking at that. We found it maybe a little more helpful to pull off of NCIR to find that list. The letter that gets pulled out from NCIR doesn't list our name quite as prominently so we do and we have been manually going and sending letters or or through our myChart messages to our portal, you know to patients manually so we're actually using both our EHR and NCIR. You know together to, you know, to achieve. To achieve that. So we're working on getting our follow up on that and we'll be, we'll be continuing to use that on you know, for our younger, you know, kids with the zero to two platform and then again you know for our folks going into kindergarten.

Dr. Tom Wroth

Great, thanks Tom. So interesting both are using both EMR and NCIR as tools and in different ways I want to talk a little bit to you both about, about the barriers that are out there so we've, Kelly talked about some of the barriers that we've uncovered around, do parents know or feel like there's a need for

these assessments and immunizations when they're doing Virtual Education. What have you all found in in, on the front lines as far as the barriers to to families coming in and getting their preventive care.

Dr. Thomas Koinis

I think one of the things is really just the parents concern about, you know, coming in and being exposed, you know, to COVID, and the other is giving you know their you know their kids vaccines that would challenge them immunologically at a time when they might be having to worry about COVID also so there's a lot of reassurance that that has to go on to, you know, let them know that you know getting these vaccines at this time is is still going to be a safe thing to do, and doing the things that we're doing in the office with our screening at the front, the masking you know the hand hygiene. And I think everybody you know sees what we're doing. I think I'm pretty comfortable with the efforts that we're making to you know to keep things as safe as possible. We also have a kind of a backdoor to our to our office that's more of an employee door but it has access to a couple rooms. So, people that are at higher risk we've actually been able to actually bring in through the back door so they're actually not even having to transverse through the, you know, the waiting room and down the halls and they can kind of get in and out of the office, you know, very quickly, either for just vaccines or other testing or even, you know, getting set up for a well child visit that way and that that's been helpful to patients, and parents have been appreciative of efforts that we're making you know to accommodate them. Yeah.

Dr. Yun Boylston

Yeah, I would agree that. I think so many of our families are just so appreciative that we're available for them. I think in general, most families feel comfortable in our office we put a lot of information out there and we even have videos that we've made to walk families through the safety measures that we're taking, and it's quite visible even from the get go from a call into check in from the parking lot and then take them stepwise through the visit. I think for us a big challenge or a consequence of that is, you know, previously the provider was the rate limiting step for a visit. And now that's no longer the case. And so we have to block additional time, you know the cleaning measures the check in process all that. There's a lot of thought and it's got to go right because you can't have somebody who's unexpectedly in the building for 30 minutes longer than, than you thought they would be because before it was you know you've got behind a little bit but but now it really kind of compromises how everybody else's is fitting in and coming into the building. The other challenges are, you know, I don't know if this is arbitrary but just the thought of just how do you truly delineate the sick and well visits and we're still trying to do a really, we're trying our best to do that. You know, we still have to find times when we do well visits and we only see sick visits in the afternoon, but we also do telehealth visits, all morning, it can enter the building. And then we also have designated sick and well hallways. And so there's a lot of staffing and workflow procedures that are required for successful execution is really important.

Dr. Thomas Koinis

I would written, you know, those are great things and I think for certainly pediatric practices being able to do sick and well sessions and break it into halls, is very helpful I think in family medicine, it gets more difficult because we have such a breadth of ages and medical issues that you know that we're dealing with. We have found, we've talked about trying to do sick times and not and it just hasn't really been able to work that out, although we're wondering whether we're going to be pushed to do that more when we get to the flu season combined with COVID season which is one of the more scarier things to think about.

Jennifer Cockerham

The next challenge is challenge is cold, flu and covid season, all at once and so that's a good point. So with high risk patients or children or family members Dr Boylston have you had any situations where you have a child who was at high risk for covid complications or the parent was and how did you navigate that.

Dr. Yun Boylston

Oh yes, I think that's really a challenge. I'm sure all pediatric practice have really experienced by now. I think a great outcome of the telehealth implementation is that a lot of things, even though we might know that they'll ultimately end up as an office visit these we can touch base in real time and see exactly what the situation is. A great example would be our asthmatics. You know, sometimes it's hard to gauge, either in phone triage, or just in appointment set up exactly how you know how sick is this kid what kind of interventions do I need to introduce here and so some of that can be really helpful and sometimes you just catch them on, and, and I think with chronic care especially I think telehealth has had a really useful, useful role, and even with other applications I think another challenge is the newborns who are losing weight or at risk for jaundice I think we've found that to be incredibly difficult because we don't want to bring the infant in unnecessarily, for, you know, weight checks and, but at the same time you really want to promote breastfeeding and, and certainly not, or just, you know, just trying to make sure that the family doesn't get discouraged. And so we've done telehealth lactation consultations with our staff and we have an experienced lactation specialist at the office so I think that's one way that we've successfully bridged that.

Jennifer Cockerham

Thank you both so much. This is wonderful brief conversation and really so helpful to hear about what you're doing. So I'd like to Nevin if we can go to the next slide and ask the AHEC and CCNC team to tell us what you're going to be doing in this space.

Chris Weathington

Thank you, Tom. This is Chris Weathington with the Director of Practice Support NC AHEC. We're very excited about the opportunity for CCNC and AHEC and DHHS to work on this important public health

concern. Our focus is going to be accelerating this rebound of pediatric wellcare among Medicaid, Medicaid beneficiaries that are younger than 19 years of age, to the pre COVID-19 level, and also DHHS through, North Carolina Medicaid has convened a group of advisory group members including the pediatric society, Academy of Family Medicine, North Carolina Community Health Care Association, the Office of Rural Health and several other stakeholders to give us guidance, as we work through this project. In addition, AHEC and CCNC what we've done over the past several weeks has developed a strategic and a coordinated approach to improving wellchild and immunization rates through the provider and patient intervention so our collective work is really going to contribute towards getting these kids ready for school and for a life time of optimal health. Next slide.

So, just to give you a kind of an overview of what we're going to be doing the project started last Monday on August 3 and it's really going to be running through September and probably October, and we are firmly committed to working through this campaign until we feel like we're really bending the curve. So DHB is engaging with patients who are Medicaid beneficiaries in the public with information available in English and Spanish. The we've got a wonderful CCNC care management program that reaches out to families with tailored messaging to the Latin x and African American families in particular. We have local health departments that will be deploying care managers with active outreach to children in care management who are missing those immunizations and well visits. And as far as practice support is concerned, what we're going to be focusing on are practices with more than 500 care alerts for pediatric patients. And, with a focus on 300 independent health system practice locations across North Carolina, that's pediatrics, family medicine, health departments, FQHCs and Rural Health sites, and these care alerts are based on Medicaid claims data, and are overdue well child checks in particular. So what we're going to be doing is working with these practices hands on virtually for the time being, but hands on working with them on best practices or interventions standardizing their workflows, helping them redesign their clinical workflow, educational tip sheets and toolkits and we talked about telehealth and we certainly can work with the practice around that and also pulling the data out of their EHR. So I'm going to turn this over to Jennifer Cockerham over at CCNC.

Jennifer Cockerham

Thanks Chris and mindful of the time and know that there's probably questions so I'm just gonna really call your attention to this slide there are many interventions. You've heard great ones today by Dr. Boylston as well as Dr. Koinis and some of these they've mentioned. I really do want to encourage you to check out our website. This is a snapshot of suggested interventions, it's about a three page document on there that really drills down. So using your EHR to generate a list of children who are behind really is the first step in trying to understand well who is it really needs to come in. There are many other bullets under that and other tips to guide you along that one broad intervention. And that's the case for the remaining eight ones on this on this slide here, but as you've already heard using internet and social media has been effective. How do you really utilize your staff and, you know, keep it in mind what part of the problem is is parents have been afraid to bring their kids in, or they have other constraints, family members at home with chronic illnesses, they have work constraints, possibly transportation constraints, cultural, ethnic barriers that impede understanding or ability to bring their

kids in, so how are you really understanding what potential barriers could be there, and then strategizing for how to break through those.

Partnering with your local school system has already been said and a great testimony of how that was successful. Maybe running immunization promotion month, August is National immunization month, possibly doing a well child check or vaccine Saturday, of course utilizing social distancing and just really helping your patients and families understand that leaps that you're taking and the steps to make sure the environment is safe, all of this is about the best well being of the child. Are you able to incorporate well child checks into acute care visits if they're coming in for acute care issues. And then just other workflow issues, maybe they're getting their vaccines someone else somewhere else. How can you get that information in so you understand that that care gap has already closed. Next slide please. This is a snapshot of our well, of our CCNC, AHEC co-branded website. Again, I encourage you to take a look, there are a wealth of resources here it's not overwhelming. I think that our teams both AHEC and CCNC have done a really good job to try to glean off the cream of the crop things and take things that might have been cumbersome and develop them into a more useful tip sheet. Two things on here that I'll mention other than the interventions that I already spoke to, there's a tool for screening for social determinants of health that I think you'll find very helpful as well as some scripting and tools that will help with how to maybe identify racial and ethnic barriers in your practice and then how to outreach to those special populations. I think the next slide, next two slides I really won't speak to you can go back and find these, there are other resources that are not on our website but there are many many stakeholders involved in this effort, you could go ahead, across the state as Chris has said, we are trying to align our efforts and not duplicate but really complement one another. You can just keep going. Thank you. You may go to the next slide.

This is how you can get in touch with us, as has already been said CCNC and AHEC are working together with our practice support teams there's no wrong door, you can email us call us. Go on those websites that go to the website that was mentioned, and we're very happy to help you and point you to resources, and also help you strategize virtually, we're not going to come in right now, but help you with really implementing interventions that are necessary. That's all I have, I think at this time it goes back to Hugh or Tom for questions. Thank you.

Hugh Tilson

Thank you, Jennifer those and Chris and everybody Kelly and Yun and Tom great presentation. Shannon I know you wanted to respond to some of the questions that have popped up on the QA, who about Medicaid transformation so maybe we'll just turn it back over to you.

Dr. Shannon Dowler

Yeah, I just I saw a few of the questions that I didn't answer I tried to answer people's questions as we went if I could. But there were quite a few around transformation topics and more I'm not ready to

answer any of those questions yet. To be honest I'm afraid I would tell you the wrong thing. We are just digging in and our teams are getting repositioned and aligned again to dig into that work so I think what we're going to be doing moving forward in the future is like we've had these COVID Medicaid updates. I want to have a once a month managed care update that I'm going to continue doing. We will still do a once a month, sorry my dog shaking in the backgroun. We will still do it once a month partnership presentation with policy updates and working with CCNC on clinical topics. But once a month we are going to provide some managed care update, so that we can try to get your questions in real time. So, so look for answers soon we'll start putting stuff out there.

Hugh Tilson

Great. Wanted to make sure everybody sees the link to the slides. So please go to the CCNC AHEC website to get those. Tom I don't know if you have any of these questions that jumped out at you as..

Dr. Shannon Dowler

There's a question about flu vaccine. I think this is a really important question and topic. I think we got this from Chris last week saying we, we don't get our vaccine for children flu vaccines on time sometimes and we don't want to turn people away and so we actually have spent the last two weeks digging in to understand that there's a way that Medicaid can pay for that flu vaccine as VFC hasn't said, an adequate supplies for practice yet. And it looks like it's a federally regulated issue and that we're not going to be able to, and instead though I think what we're going to do is put together a clear guidance on the borrowing cause CDC allows the borrowing of vaccine from private stock, we were, we tried very hard to look for a way for us just to pay for it. So we haven't given up we're going to continue to push the question and the issue with CMS. Meanwhile we are going to have we're going to try to put more guidance out because we don't want you to have to turn anybody away for flu vaccine. If your supply is delayed

Dr. Tom Wroth

Hugh it's 6:29 I think we got to most of the questions.

Hugh Tilson

Yeah, it looks like it's so thanks everybody for making the time tonight Tom, thank you for your great moderation of this panel and Shannon, why don't I turn it back over to you and Kelly for any final comments before we sign off.

Dr. Shannon Dowler

Yeah, so I think what we're going to be looking at is a set pattern of meetings probably will be like the first and the third Thursday of the month. Moving forward, where we're going to have a fixed schedule of one's gonna be managed care and one's going to be more clinically focused, we'll get that schedule out to you as soon as we get it sorted out. But I think these webinars have been, they've been great for us as a team to have a way to reach out to providers around the state. And I've heard feedback that they've been good for folks. So we would love to have that be a regular part of your calendars and something you can count on and maybe delegate someone from your practice to pick up each one to be more efficient and that sort of thing. So thanks so much for joining us as always we really appreciate your time and the amazing work all of you do taking care of North Carolina. Thanks a bunch and have a great night.