

Clinical Quality Webinar Series  
November 19, 2020  
5:30-6:30pm

Presenters:

Shannon Dowler, MD, FAAFP, CPE CMO, NC Medicaid  
Velma Taormina, MD, MSE Senior Policy Consultant- Women's Health, DHB  
Richard Kirsch, MD, President NCOGS, OB/GYN  
Kathryn (Kate) Menard, MD, MPH, Professor, OB/GYN, UNC School of Medicine  
Tom Wroth MD, MPH, President and CEO Community Care of North Carolina  
Carrie Brown, MD, MPH, Chief Medical Officer for Behavioral Health & IDD

Hugh Tilson:

Good evening everybody, it's 5:30, let's go ahead and get start. This webinar is part of a series of informational sessions called Fireside Chats put on by Medicaid and CCNC. And supported by NCAHEC to support providers with clinical and quality issues during the transition to Medicaid managed care. Fireside chats will be put on the first and third Thursday of the month generally. I'm Hugh Tilson and I will be moderating our webinar tonight. As you can see we have a great cast of characters also known as presenters on women's health. In addition to getting updates we will ask for your thoughts and opinions through polling and then we will turn to your questions. Before I turn it over to Dr. Dowler, we will run through some logistics. If you need technical assistance with anything, you can email us at [technicalassistanceCOVID19@gmail.com](mailto:technicalassistanceCOVID19@gmail.com). The slides were available tonight on the AHEC and CCNC websites. You can see links to those in the Q&A. You may have to copy those into your browser. Sometimes the hotlinks don't work, but you can get them in either location. When it is time for the questions, know that everybody other than our presenters are muted. You can make comments either by using the Q&A feature or if you are dialing in, send an email to [questionCOVIDwebinar@gmail.com](mailto:questionCOVIDwebinar@gmail.com). Presenters will often address your questions during the presentation. I encourage you to wait until the end of the presentation to submit your question. We'll add the recording and transcription on the CCNC and AHEC websites.

Shannon Dowler:

Thanks everyone for joining us-- we have a super full schedule and want to leave time for questions at the end.

Tom Wroth:

Good evening and thank you everyone. Here is our first pole. Poll number one, you can pick three. The support my practice can use the most right now is.

Shannon:

Let us know. What are the top 3 things you feel your practice could use support with? How are we doing with that one?

Tom:

The winner. 48% help with quality metrics-- understanding and reporting. That's good to know. The AMH care readiness management, so we have our AHEC partners and others in that space. That is fantastic. Number three is contracting with PHP's. And then team-based care. And then utilizing telehealth.

Shannon:

I would say our AMH webinar series starts on the second Thursday of every month in December. Which is great timing. That is going to be totally focused on AMH readiness stuff so that is good timing.

Tom:

Great. So let's go to our first piece. So this is myself. I would like to introduce Dr. Richard Kirsch. He is the president of the North Carolina OB society. Great to have him here. We are going to talk for a couple minutes about the national view. And what we are saying out in the literature and internet around concerns about the impact of COVID on women's health. And I think one thing Richard, we have seen is we know that the impact of COVID on front-line workers is really important. And women make up a lot, 60% of the front-line workers out there. And a large portion of the healthcare workforce as well. There's also concerns about utilization of healthcare services. We will talk later on in the webinar about mental health issues. Some studies around the surge in intimate partner violence hotlines. And also lots of studies about increasing anxiety, depression, and sleep problems with healthcare workers who are women. So, Richard, with that, you want to go through some of this data?

Richard Kirsch:

As we review the impact of COVID on healthcare delivery services at a national level, these slides come from the Healthcare Cost Institute. As you can see, they demonstrate a reduction pretty significantly from March to April. And a slow rise. We are still 20 to 30% below where we should be based on the initial levels back in the start of 2020. In addition, there have been some problems with vaccination, particularly because of MMR. Some of the services are down 50% in the state. We've had some improvement in our delivery services over the summer. But you can see they are still not back to baseline yet.

In this one we are looking at mammograms and pap smears and how COVID has affected that. We have some recovery. There has been a pretty consistent 20% reduction over baseline. Even up until September. Hopefully some of those numbers have improved in the last few months. They think telehealth has been effective as far as allowing contraceptive services to be delivered. However, there has been a reduction in pap smears because patient screening has been reduced dramatically. There has also been a pretty significant reduction in screening and diagnostic mammograms according to some of the local radiologists where I live.

This one talks about ultrasound during pregnancy and IUD placement or long-acting contraceptives. As you can see they have been relatively steady. There was a decline that we have had with the other slides. But, we've had some recovery. I think for me, in my practice, we found that pregnant ladies are very intent on seeing the babies on the ultrasound. And the fact that it is down 20% means there are a lot of unhappy women out there is what I would suspect. Dr. Roth, move ahead.

Tom:

Richard and I just wanted to frame this back to our overall goals of North Carolina. So this is from the website. You can look at the healthy North Carolina 2030 goals. Two important ones that we have all been focused on going forward, the first one, the early entry to prenatal care. Where we are now, 68%, trying to get 80%. The bars there, just looking at the disparities and that measure across the black African-American population and the LatinX population. So lots of work to do there. We will be talking more about that.

Getting at one of our ultimate outcomes along the infant mortality rate, and again, really significant healthcare disparities across the black African-American population and the American Indian population. So a lot of work to do there. Multiple factors leading him. But as we try to recover from COVID, we want to get back to being able to focus on these key outcomes. So that is sort of the national view. And we look at our second poll question. So, what is that?

Okay, the most significant women's health issue in your office today is. And you can pick three of these. Depression and anxiety, substance abuse, domestic violence, access to insurance coverage, chronic disease management, sexual health concern, preconception planning, keeping up with prevention guidelines. Hard to just pick three of these. We will be covering several of these in the webinar later on in the webinar.

I am glad we have Dr. Carrie Brown coming up. We have depression and anxiety 41%. Number two is access to insurance coverage. We will be talking about some aspects of that. And there we sort of scattered across these other important issues.

Shannon:

Interesting that access to insurance coverage, we are all talking about Medicaid expansion in the department right now and how important that is and how important that before the women in North Carolina. So to see that response kind of help helps to fuel the fire.

So we are going to kick off the next session which is about women's health in North Carolina, specifically. And we have a hobo to different topics that we are going to fly through in here. I mentioned this in a prior meeting webinar. But I wanted to remind you again, especially as we are talking about women's health and the fact that folks are behind on pap smears and mammograms. We modified breast cancer cervical cancer criteria. It no longer requires enrollment prior to diagnosis. This is really big. For those of you that have been in North Carolina for a while and had a woman who was diagnosed before she was insured, she was excluded from that criteria. So, this is a major change in the program. This is what is facing for patients and providers. So you have to be eligible. Eligibility requirements are women with income levels of 250% below the federal poverty level so significantly higher than normal Medicaid coverage. So this is a really nice benefit for women who get a diagnosis of breast or cervical cancer. They prefer that people are enrolled in [indiscernible] before the screening. But if not, we can still get them enrolled if they meet the eligibility requirements. So big huge change. Lots of work on the part of public health and DHB to get that change through. And now my colleague over at DMH, Dr. Carrie Brown is going to talk to us about some behavioral health impacts.

Carrie Brown:

Thanks. I appreciate everyone being here today. Unfortunately I am not at all surprised with the 41% concerned about depression. Women presenting with depression and anxiety, we are just seeing that nationally everywhere. My initial data, I would like to set the scene looking at the

behavioral health impacts on North Carolina in general. Then we could spend a couple seconds talking about women in specific. But, three fold increase in reported symptoms of depression or anxiety. And, that was dated back in June. So I only imagine that has increased further. Younger cohorts, this is again data from June, reported a higher prevalence of anxiety and depression. Actually the problem among racial groups was relatively consistent. I would be curious if you guys are continuing to see that too. Newer data that has come out looking at things through October, has shown a significant increase in pediatric ED visits related to mental health. In North Carolina specifically we are seeing trends, it's still at the trend level, but of increased presentations of youth to emergency departments for self-harm. So the acuity is going up in general.

Similarly to anxiety and depression are substance abuse-- particularly alcohol and opioids. Liquor sales have increased in North Carolina pretty significantly. Also, nationwide respondents are reporting more binge drinking. And then as we talked about earlier in the pandemic, we saw a pretty significant increase in opioid overdose ED visit which has continued. It was up 21% after the progress we had made in 2019 with opioid action plans. Some of that was reversed with the stress of the pandemic.

I wanted to make sure we spend a few minutes of suicide. Particularly because we all need to be thinking about it as the entire world has gone through this trauma of COVID. Particularly I worry about our healthcare providers. And remember we are entering the shortest days of the year. So those with seasonal affective disorder just get an added concern. It is too early to have any data about upticks in suicide in North Carolina post pandemic. But, I am particularly concerned about the increase of firearm purchases. One thing that we know, unfortunately suicides by firearm in North Carolina are higher than the national average. Since March 1, we have seen almost 60% surge in background checks. Obviously, that can be for any number of reasons but there's more firearms out there in people's homes. It is a great reminder to us all to really review firearm safety with our patients and our families and loved ones. I love this graph about the phases of disaster and reactions. And I couldn't modify it unfortunately. It shows you where we were at the end of July. But if you can fast forward to where we are now, we are pretty much right at the bottom of the red. We are hitting the bottom of disillusionment. Again, this is going to be a particularly hard time. All the more important reasons to have our ears perked. And make sure we are taking care of ourselves.

Women are uniquely and particularly impacted by the pandemic. There was a recent Kaiser poll that shows that 53% of women reported a significant negative impact on their mental health since the beginning of the pandemic. Compared to 37% of men. Women without a college degree have more job loss than men. Particularly in our service sector positions. Obviously due to school and daycare closures there has been significant women leaving the workforce due to childcare needs. Also that bringing them significant social isolation. And then for our older women, who are in our skilled nursing facilities and they often outlive their partners, there is an extreme risk for isolation and fear. And, as we have mentioned, intimate partner violence definitely increases with quarantine during COVID-19. Another reason to be asking and thinking about firearm safety.

There are lots of resources available. I apologize that people have already heard about this. If they are tired of me talking about it, but I'm going to talk about it until I'm blue in the face because it is important. The help for NC helpline available 24/7, 365 days a year. That is available for anyone in North Carolina. I encourage you to share the resource with all of your patients.

And thinking about how to talk about managing stress-- SCOOP. Stay connected to family and friends. Compassion for yourself and others. Observing your use of substances. Okay to ask for help. Physical activity to improve your mood. We know that there is really good evidence that mild to moderate depression and anxiety, physical exercise is an effective treatment. However, we must take care of ourselves. We have to remember to put on our oxygen masks before we try to put it on others. And so there's a hope for healers hotline. This is specifically for front-line workers. It doesn't necessarily have to be health care workers. It was originally geared towards healthcare workers but anyone that is on the front line of the pandemic, it has been brought in to include childcare providers and now our community health workers who are out in the community doing lots of tracing and exposed to significant stress. This is a wonderful partnership with the NC Psychological Foundation. And it is free. There are licensed therapists that are available for our healers. Also available 24/7. Please advertise this for your staff and colleagues as well. And I think now I turn it over to somebody else.

Velma Taormina:

We are going to talk about changes to the family-planning Medicaid program. So the North Carolina Medicaid be smart family-planning program covers men and women that are eligible for the program. The goal is to reduce the number of unintended pregnancies. So we are making some permanent updates to this policy. That includes, we are going to continue telehealth services for the established patient E&M visits and the consultation code that you see here. We also added US preventive services task force recommendations. There are referral guidelines and interventions for HIV by prophylactic prescription meds that are going to be available through the ready set prep program.

[Unknown]:

I think I shared this in a prior slideshow as well. The changes we have made in the family-planning Medicaid are significant. Trying to just get up-to-date on things and make sure that we are really hearing the feedback from the field on what needs to be covered. One of the unique things we have done is we have modified our coverage, so that everything you need to prescribe prep for someone who has family-planning Medicaid is now going to be covered from a lab standpoint, STD test, including office visits, annual physicals. The only two things that are not going to be covered is the hepatitis B test which is through the state lab for high risk patients. So if they are taking prep they meet that criteria. And then the actual medicine itself which you can get through the ready set prep program or other drug assistance. This is significant. We are seeing that our prep utilization in North Carolina is way lower than other states. We want people to be prescribing it but we don't have Medicaid expansion. So we have a lot of people who don't have coverage. So if you could talk particularly, your young men, even though we are talking about ladies tonight, on getting on family-planning Medicaid. We can make a cost-effective or even a positive ROI for your clinics to begin doing prep. So for letting me jump in on.

Velma:

Dr. Dowler covered some of these items here. Of note, we have also added a prophylactic [indiscernible]. We have added Kyleena IUDs to your options when you are looking at devices. And as she said, the comprehensive metabolic panel. So if you identify somebody that is eligible for the program you can do based on labs. We have updated all the diagnosis codes for all of these services.

So let's move onto our sterilization update. Of note, CMS did not extend the 180 day signature requirement. So, we do recommend that you re-sign the consent forms if you are 150 days post signature, just in case somebody ends up having to reschedule their surgery. You want to make sure they still have coverage. In order for your claims to be paid, the type of surgery that is listed in the physician statement section must match your billing claim. The bottom right-hand corner is the part that you need to pay particular attention to. As always, make sure you use the SP modifier.

So this is just a list of the clinical coverage policies that were updated back in August and then an update was recently posted on November 10. Those are the links that take you directly to that. We do ask that you share this information with your office staff. Because all of the staff members that are involved with obtaining consent, or discussing surgical sterilization or participating in the building process, need to be aware of the guidance. There are step-by-step instructions available to them on these websites. So this slide is included in the last update. This is great because this tells you exactly which abbreviations are preapproved. What is the acceptable written wording and the associate is CCT codes that you can bill associated with each of those cases. Again, please share this information with your billing staff so they can make sure the information that is in the bottom right section in the consent form matches the CCT codes that are on your actual billing claim.

Shannon:

So this is a reminder that we are not vaccinating as much this year as we did last year. September started out pretty strong when you compare 2020 to 2019 and we were feeling good about it. But 19 and 20 in October is not good. So there is some billing lag that might be at play. But we are significantly below where we were last year. So really pushing folks for the flu vaccine and how important that is this year. We are not getting enough claims for that. We want to pay more money for flu vaccines because more people need it.

I like all meetings where I get to talk about STDs. So I am really excited to be able to insert STDs into our webinar tonight. Some of you have heard, many of you have not heard. But there is a shortage of the reagent that we use in NAATs, Nucleic Acid Amplification Tests. Specifically for chlamydia and gonorrhea. That's because it is the same reagent that is used in COVID tests. So we are right now having a shortage around the country of actual chlamydia and gonorrhea tests. There is a letter from the CDC that has very explicit details that modify our screenings and even diagnostic choices we make around STD screening. So right now, the 2015 guidelines are the guidelines to go for from a theoretical standpoint. The 2020 guidelines, I have heard they have been done but have not made it through the formal vetting process because COVID got delayed so it will still be a few months before you get to see those. Might be having trouble sleeping with not having the chance to read them yet, but if you go to the next slide. What I did on these two slides, and you will have them in your bag, I listed the new recommendations. It is a bummer. So it is really kind of focusing on just high risk individuals. Unless routine screenings. We have been working so hard to get people doing extra genital testing for women and thinking about oral and anal exposures. But now the CDC is saying, let's not screen those areas because we just don't have enough swabs. We are not screening asymptomatic men who have sex with women right now. So it is focusing on high risk. Systematic patients. So not screening, and how you want to manage those now. If you look at the man with systematic urethritis for instance, they want you to do a Gram Stain. We are going old school. Which at the health department I get to do that and I love it. It is very satisfying because

you get a diagnosis right away. Most of us don't have that capacity in our office, so they're saying send that out to the lab for a Gram stain. If you can't do that, then treat empirically. I would encourage you to look at these guidelines because you will probably hear from patients that they are going to health departments and not getting screening. Rather than getting frustrated with the health department, it is because they literally do not have tests. I believe that the state has sent out all of their chlamydia and gonorrhea tests that remain for the year. And so it is not that the folks from the health department don't care, it is that there is literally a testing shortage. A reminder that November is diabetes awareness month. It is also American Indian heritage month, I believe. One and three people have prediabetes so a reminder to be thinking about who in your patient panels might be at risk and need to be looked at for prediabetes. Particularly in North Carolina we have very high rates. I just wanted to flag that and put that on your radar for November diabetes awareness month.

The poll question.

Tom:

I think this one is about telehealth. The virtual and telehealth provisions for pregnancy have been widely used in my practice including the hybrid home telehealth visit have been: widely used for telephone and telehealth, widely used for telephone only, have been used some but not replacing standard work, are used under duress but not preferred, or are not being used.

Shannon:

So as people are answering, CPC came out last week with news about pregnancy risk around COVID which I'm sure you're going to hear more about in a minute. So we are curious, are you using telehealth? How does that work for your practice for the care of pregnant women? A few of you are brave uses of my hybrid home telehealth visit. But I'm so excited, it's actually going to be in a national paper soon, so I need folks to actually use it. But that's great. Maybe we will get to it on the future call to talk about how that works.

Velma:

The poll did show that we are using a variety of methods to provide maternity care. And this shows information on where the broadband deserts are all across our state. So the deeper the blue, the better the broadband availability. And the deeper the red shows minimal availability. So as you can see across the state, we have a wide variation with that. So again, that is going to impact your ability to deliver that care. They may create some potential barriers.

Shannon:

If you are like me and you live in Madison County which is sort of pinkish, that's great and all but we have very little at my home. So across the county, you have a lot of variability.

Velma:

As you look at this, this is data that is comparing women in black and med in green. As you can see, men were actually using it a little bit more than women were but it is great to see that they both are utilizing the services and again this is from February to October.

Tom:

Our next poll is about early entry to prenatal care. For our practice the biggest barrier to early entry prenatal care is you can pick three. Slow delayed Medicaid enrollment, patients don't know they are pregnant early enough, patients don't understand the importance of early prenatal care, limited appointment availability at practice, reimbursement limits ability to take Medicaid, and patients not having transportation.

Shannon:

What are the top three reasons you think our numbers are not where they should be for early prenatal care in North Carolina. Based on your experience. What are you seeing in your practice? Hopefully this will allow you to do multiples.

Tom:

So, patients don't understand the importance of prenatal care. Maybe something can be done here around patient education and marketing. Number two is transportation. So, maybe healthy opportunities can help us there.

Shannon:

Or telehealth. If transportation is the issue, a lot of practices are doing the first prenatal visits via telehealth and having the woman come in 2 to 3 weeks later to have labs and other things done. So you can get that early prenatal visit by telehealth. Let's shift it over, and if you would share why are you on this call and what is your relationship to Medicaid?

Kate Menard:

This is Kate Medard. I have been and continue to be the physician lead for the pregnancy medical home. I am going to present the next couple of slides and then turn it over after that. We heard it in an early poll that support is needed related to quality metric and reporting. And support is needed related to AMH care management readiness. And I'm just here to say that for seven more months, we have a whole team of pregnancy medical home support available to your practice to help with his work.

This is data that if you are not seeing it, you can at the practice level on timeliness to prenatal care. 68% was the level for the entire population that Tom showed us earlier. This is data specific to the Medicaid population. It is available by quarter. So the most recent quarter, in the Medicaid population, 66.5% sought prenatal care before 14 weeks gestation in the first trimester. This comes off the vital records, it comes off the birth certificate. On the left you will see the chart that shows the practices that are enrolled which is the majority of the practices in North Carolina. The scatter that you see in how well different practices are doing in meeting that metric of getting women in for the first trimester here. The bigger the bubble, the larger the number of patients, the smaller the bubble, this may be even low-volume practices or that just don't do much Medicaid. And you can see there's a very wide range. A lot of reasons and opportunities for making progress on this particular metric which is here now and will be after Medicaid transformation.

This is our pregnancy risk screening data. I think we can all be pretty proud as a state to say we approach 80% of our Medicaid population actually get a risk screen that allows us to identify many of social determinants of health that are impactable potentially through care management and through the care management services that are provided through our local health departments. Again, on the left you are going to see, we are hovering around 75%- 77%. But on



the left you can see there is a wide range of how well practices are doing with getting those risk screens done and getting them to the health department so they can be eligible. This is here to stay. This is going to go with us into Medicaid transformation and the care managers that you have now and have always had, are going to be there after transformation. So don't give up on this. Keep working on it. If you are one of these in one of the bubbles in the lower part where you're at risk screening rates are low, their support to help you kind of think of ways to improve that.

COVID has affected the risk screening rates. The care management has been, for reasons you all well understand, has not been in your office as it might have been otherwise and is offered through different pathways/ remotely. This shows us the rates of the actual numbers of risk screens over time. This is kind of pandemic, this is lockdown and the number of risk screens that were actually received dropped off, and then some recovery but we are still not level where we were prior to the pandemic.

Next is the postpartum visit rate. This is available through the Scode that you get compensated for if you provide the postpartum visit and code the S code. This is not the actual postpartum visit rate. Audits show us we are more like in 70% range in most practices. but 50% of the number that actually filled the Scode. Postpartum contraception is obtained from claims data. This is how many women, what percentage of women have a prescription filled for postpartum. Unintended pregnancy rate is a measure unique to the pregnancy medical home program because it is a question on the risk screen. Over time we were more like 50 to 52%. We are now in the 45 to 47% range.

Cesarean birth rate, and the variation by practices is what I wanted you to look at. Only 24% [indiscernible], down to 21% over time. The picnic project this year has helped with that rate. But, practice variation, you can see there's opportunity. This big practice is at 42% for first time moms, but this practice down here is around 10%.

And then I'm just putting up low birth weight. This is where we are for our Medicaid population in low birth weight. 11.2% in the most recent quarter. And you can see variation. A tough thing to move, but something we are all motivated to move.

Velma:

As we transition over to the North Carolina program data, Kate went over the pregnancy medical home data with you. This shows that despite the work that is being done in the field with several initiatives, our work is not done. Our numbers are still slowly trending upward. So we need to continue to engage in conversation. So that we can work with those who are most at risk to address any of the barriers they may be facing to receive adequate prenatal care.

So one of the ways we can address this is to make contraceptive services available to all women, in between pregnancy specifically. This slide is showing the types of contraceptives that patients chose in 2019 by race and ethnicity. So the time periods you are going to see on this slide is showing women who received most or moderately effective contraceptives within three days of delivery. And then the other time period is the 60 day mark. It is reassuring to see that women are using effective types of contraceptives. But that utilization is going to continue to assist them with delaying that next pregnancy.

This slide, again, going from 2016 to 2019 shows a slow upward progression in all three groups across the state. So that has been reassuring. We are expecting that that is going to drop a little bit in 2020. At least the historical norms are looking good.

So this slide is a little deceptive in the numbers there. This is actually the timeliness of prenatal care. It appears that only 36 to 38% of Medicaid women are beginning prenatal care in the first trimester or within 42 days of enrollment. This measure, we feel is artificially low. Our data team feels that our rates are 30 points higher than this. We are continuing to work on that data, but for now that is what our rates look like.

Kate:

We bring this up to everybody because we have to report rates to CMS. So you will see in public facing CMS reports by Medicaid say certain things. This is one of the things you might see and you might say, wait a second we just heard it was much higher than this. So we are digging deep in our data to try to understand how we can get the best and most accurate number because we know the integrity of data is so important to all of us. Just know that the team is really working on this and trying to discern what the real rate is in making sure that we are able to tell CMS that.

Velma:

These are metrics that are going to continue to follow us into managed care. If you are not engaged with your pregnancy medical home or OB coordinators, please reach out to them and they will help you to start putting processes in place for this. So, as we are looking at that, we are going to move forward into what does the future look like for us? So the department has transition goals for maternity services. We do want to continue to provide high quality services to the women and children in close partnership with all the providers, providing prenatal care across the state. We want to help provide a pathway for current providers for these services so that they can transition to managed care. And we want to definitely ensure that this is as seamless of a transition as possible for the beneficiaries as we move forward into this managed care environment.

So, the pregnancy medical home as we know it now is going to be renamed the pregnancy management program or the PMP. All pregnant women are going to be enrolled in the managed care through prepaid health plans. It will be a partnership between them and their local maternity care providers. We will continue to use the same screening tools. We will continue to have the same incentive payments in place. If we identify women who are at risk for an adverse birth outcome, we will be able to transfer them to the care management for high risk pregnant women program. We currently know it as the obstetric care management program. But, that will be renamed also.

This slide here, gives you the highlights of the new program. The prepaid health plans will continue to contract with the local health departments or other local case management agencies to provide services. So again, this is the program features that will be in place for the first three years of the transition period. We just encourage you, that if you haven't started to contract, that you begin the process and you continue to work with us to assist you in meeting the timelines that are necessary so they come next July, you will be able to roll forward with everything.

Tom:

All right, our next poll question. When COVID-19 vaccines become available, will you take it? Yes, probably not, no way I don't want the government tracking me, no way it has been fast-track and I don't trust it, or I would consider it after more data is available.

Shannon:

As you are answering this, we asked last month about perception around your patients. If they are going to take it, particularly among marginalized demographics. What are you thinking about the COVID vaccine when it comes available? We are curious to see what you are thinking.

Tom:

Interesting. I would consider it after more data is available about 50%. About 40% yes. About 10% of no way. Shannon, there is a comprehensive effort around how to market the vaccine, educate providers, and educate the public.

Shannon:

More to come. The DHHS has been working hard on this, getting ready for the day. And this is going to be hard. It is going to be challenging. I think the fact that 49% of you are saying I need a little more data. That is very telling. What an interesting year 2020 has played out for all of us! I know I'm five years older this year.

Resources, we are going to go really quickly because I want to make sure we have Q&A time. We are going to do speed resources. We've got some links to the COVID resources in the triage plus line.

Tom:

Remind you quickly about CCNS and North Carolina AHEC-- multiple COVID resources here.

Velma:

For those of you who are looking to assist your patients with tobacco and vaping cessation services, as a reminder, telehealth services are covered by Medicaid. And then the two other services available in North Carolina are the NC quitline and the you quit to quit program and there is training available for you and your staff through both of these organizations.

Shannon:

They do have resources again. There was a time they ran out of supplies so they could not send nicotine replacement but they have it now. So have your patients use this.

Carrie:

Here are a bunch of resources for women's behavioral health. I just want to highlight the national child traumatic stress network that has a really good document on trying to help parents and caregivers cope with COVID-19. As well as the resources for helping kids and parents from the American Academy of Child and Adolescent Psychiatry. Also, I do want to remind everybody about the NC matters program here in North Carolina. It is a partnership between UNC, Duke, and the department for mental health for pregnant and postpartum women. And I will verbally tell you that phone number: 919-681-2909. This is a conversation service available for primary care providers and actually on the website is a wealth of information including toolkits and screening.

[]):

What we have you put that as a Q&A section so folks can see the number.

Diabetes specific, it is diabetes awareness month. There are some really great resources for the diabetes task force available for your patients-- including a risk task and all sorts of things. So

this is from us. We have created a new way for you to give feedback to us. We want to hear it. If you have things we should change around clinical policy or coverage, we want to know what you are thinking. There is an easy button. I say it is easy but you have to provide a fair amount of information. But it is easy for you to find it on the website and formally submit a request for coverage. That is something different that we don't cover yet, so I think that is a real win.

So our final poll question is really, this is a free response that we want you to put in the question and answer section. December clinical fireside chat topics is behavioral health. What would be the most valuable to hear about from the Medicaid perspective related to behavioral health. What is it that you in the field would spend an hour of your life at night to hear about behavioral health that the Medicaid team can share with you next month? In the Q&A section if you will but that in. The first Thursday, our first fireside chat is going to be super exciting. The team from the tribe is coming to talk about the tribal option. In that we are going to talk about attributions. How your beneficiaries end up in plans and how they end up assigned to a primary care provider and the methodology is complex. I think it is going to be important for everyone to understand how that works because you are going to need to be able to explain it to your patients and also to each other. So while you're thinking about what you want in the December fireside chat, Hugh will take us to questions?

Hugh:

We have a couple questions and we are getting lots of good comments for the behavioral health side. Let me start off with some of the questions that have come in. **Can you address what can be or will be done regarding access to mental health services for private insurances, employer insurances but the co-pays or rates preclude access for services. Do you have any comments about that?**

Carrie:

First thing is please call [indiscernible] because all those resources are available to everyone regardless of insurance status. But I think the other thing is that you highlight the push that we really need to make about parity-- we don't really have it yet. And I am hoping that given the substantial behavioral health impact of this pandemic, that we are in a unique moment in time to really push DUI and others to really make sure that we have true parity in North Carolina.

Hugh:

**A question that asks what explains that 41% of doctors think their number one problem in women's health is anxiety and depression. Is that a COVID issue or more broad?**

[Unknown]:

That's an excellent question. Any good researcher would say I would just be guessing. I do think that COVID pandemic has a lot to do with it but I also think that we have been, it has been a stressful time. We've also had unprecedented racial tensions in this country. I think there are many reasons why people, very understandably, are depressed and anxious. In one of the most important things is the first normalize response to the level of trauma that individuals are being exposed to. It is perfectly understandable that people are experiencing anxiety and depression. What is important is early intervention and to make sure it doesn't advance to something further.

Hugh:

**Can you get us prenatal providers a list of diagnosis codes for social determinants of health? I find it nebulous to know which ones to pick when someone has transportation barriers and no access to a working phone for example.**

Velma:

We can certainly try to put a list together.

Hugh:

I have the disadvantage of not being a doctor. COVID infection in pregnancy is resulting in some women [indiscernible] and fetal growth restriction even a month after infection. Low birth weight may be worse in 2020 related to COVID.

Carrie:

That's a great flag. We are actually finding several of our metrics that are important to us like chlamydia screening, are going to be affected by COVID in these bizarre ways we were not expecting. So yeah, that is a great flag. We will probably see it around the country and that is unique to North Carolina. But really good flags.

Hugh:

**Couple comments about social determinants of health, one is NC Care 360 could help with social determinants of health and the other one is the NC AHEC practice support folks can help.**

[Unknown]:

That is a great point. We will lean on you guys as well. Just a flag, if you are not in NC Care 360, if your practice isn't signed up with them, I really hope you will think about doing that. One, because it is amazing. Great resources in every county now. But also to let you know we are working on a payment, a social determinants of health screening payment. That is sort of like the pregnancy risk screen where it is a higher reimbursement than your average thing. And we would like to have that turned on to the first half of next year of January through June. So we are still working on authority issues and other things. But it will require linking folks who have social determinant needs through NC Care 360 to resources. If you are not on it, go on and work on that over the next 4 to 6 weeks to get yourself on. Because I think if we are able to get this turned on it is going to be a real positive for practices.

Hugh:

**As a health plan, who do we reach out to in pregnancy management programs to put the tools in place to help our providers achieve the goals we discussed tonight?**

Kate:

The question is from the health plan. So, what we need to do is kind of coordinate the transition from the program we have in place now. And it involves our current PMH team plus the public

health leadership that's managing the care managers at this point. And the new prepaid health plans together to make that transition happen. I think it is a matter of putting the team together.

Hugh:

**Has there been any discussion on changing the scoring system for pregnancy care managers?** I'm a clinical RN supervisor in a health department prenatal clinic, and I noticed a lot of patients deferred that have needs and have been told it is due to their score.

Velma:

Initially when we initiated the risk screen, 70% of women triggered as high risk. And we just did not have the resources to do intense care management of 70% of the Medicaid population. About four years ago, three years ago, we transitioned to identify those who would benefit most through care management through data analytics that was done in our own data sets. Now about 25% are triggering as high risk. And we are concentrating the risk management through the case management services to that group. So 75% are not assigned continuous care management unless there is a special need. If there is a special need, any of the providers can say this woman needs care management and they will be included. Going forward, I am told in conversation with many of the prepaid health plan leadership is that the prepaid health plans will have the option of having women in the highest risk category get care management through the health departments, but then they can add additional resources through the particular prepaid health plan. They can add resources for other women.

Hugh:

I think we are just about out of time. It looks like most of the questions or comments we have relate to the next one. So Shannon and Tom, let me turn it back over to you and thank you everybody for your participation both as panelists and as participants.

Shannon:

Special to get everybody. This was a tremendous amount of content and really important stuff today for those who are listening to this as a recording. In a future time, we are sorry we missed your responses to the zoom polls. I find those really interesting and helpful. So thanks to those who participate in those. Tom, do you want to have closing remarks?

Tom:

I want to thank everybody for getting together on a Thursday evening. And we love getting your input. Feel free to reach out to me directly. CNC is really trying to support DHB and work with AHEC to make these webinars useful to you. So thank you all.

[ Event concluded ]