Transcript for Clinical Quality Webinar Series: Behavioral Health

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5:30-6:30 pm

Presenters:

Dr. Shannon Dowler, Chief Medical Officer, NC Medicaid
Dr. Tom Wroth, CEO, CCNC
Hugh Tilson, Director, NC AHEC
Dr. Carrie Brown, Chief Medical Officer for Behavioral Health, NC DHHS
Dr. Keith McCoy
Dr. Jessica Waters
Valerie Krall
Dr. Mary Kimmel
Dr. Gary Maslow

Hugh Tilson

Good evening everybody. It's 530 let's go ahead and get started. Let's go ahead and get started with our webinar tonight for Medicaid providers, our webinar is part of the informational sessions we're calling them fireside chats put on by North Carolina Medicaid and CCNC, and supported by North Carolina AHEC to support providers with clinical and quality issues during the transition to Medicaid managed care. As a reminder, we'll put on fireside chats on the first Thursday of the month on Medicaid managed care generally, and on the third Thursday of the month like today to discuss relevant clinical and quality issues. I'm Hugh Tilson, I'll be moderating tonight.

Next slide. I see we're talking about behavioral health tonight in addition to getting relevant and timely information we have time to ask questions of our presenters. I'll turn it over to Dr Dowler shortly but let me run through some logistics, the technical assistance can see that it's technicalassistancecovid19@gmail.com, and we will do our best to respond to you quickly. We'll post the slides for tonight on the joint CCNC AHEC website should be posting a link in the q&a so have access to that. When it's time to ask questions, just remember that everybody that our presenters is muted, there are two ways to submit questions. One is using the q&a feature on the black bar on the bottom of the screen, or if you're dialing in by sending an email to questionscovid19webinar@gmail.com. I encourage you to wait until after you've heard for presenter to submit a question because oftentimes they'll get to it. Please know that we'll submit any questions we get that we don't get to, to Medicaid so that we can build them into future webinars or other communications, or record this webinar and we'll have the recording and a transcript of it. With the slides on the AHEC CCNC website as soon as possible. Now let me turn it over to Dr Dowler. All right.

Dr. Shannon Dowler

Thanks Hugh. Thanks so much and sorry I don't have my video on having some technical difficulties tonight, but I promise you I am smiling. I'm really excited about our lineup tonight and I think this might actually be our best content we've had yet on a webinar so thanks so much for joining us at the end of a long work day. I think it's going to be worth your while. You'll notice that we took out our zoom poll question after our last webinar we got some feedback that we really needed more time for questions and answers so we wanted to make sure that we honored that. So we're going to get through the content, very efficiently and leave time for questions and answers, and we have a great lineup tonight, folks from the state but also partners from around the state. And we're going to learn a lot around behavioral health tonight. So with that, I'm going to turn it over to my buddy Tom Wroth to talk about the national view.

Dr. Tom Wroth

Hi everyone this is Tom Wroth I'm the CEO of CCNC and a family physician and my task here is to sort of set us up for the rest of this conversation, and really reinforce what we're all experiencing in our clinical lives and our professional lives so it's going to bring forward some data here to set the stage. The first piece is from MMWR and came out in August that polled adults nationally in June of 2020, and really showed a marked striking increase in mental health symptoms overall, and I'll go through this in a little bit of detail so 41% of US adults are experiencing at least one adverse mental health or behavioral health symptom, and some of the really disturbing pieces are that those that are considering suicide in the past 30 days are up to 10.7% and this is a really big increase compared to the last couple years. Depressive disorder, prevalence of those symptoms 3.5 times higher than they were in 2018, 24% versus 7%. And then, as we're all experiencing and folks, we know and folks in the community that those people that are essential workers healthcare workers and others are 25% of those have increased their substance use to cope with pandemic related stress and 21% considered suicide over the last 30 days so really concerning a lot, you all in the behavioral health space are seeing this as the hidden tsunami of the pandemic. And something we'll be struggling with for many months to come. So go through a little bit more data on the next slide.

And this just shows the breaking down the prevalence rate of the different types of mental health, behavioral health symptoms so 26% experiencing COVID related trauma or stress related disorder. About a third of individuals anxiety or depressive disorder and 13% started or increased substance use to cope with the pandemic and next slide. And this is even worse with our essential workers so 13% increase compared to others that have been related trauma. 11% increase over others in anxiety depressive disorder and 12% increase in essential workers experiencing increased substance use to to cope. So next slide, and really one of the more worrying pieces here is a 2.5 times increase in thoughts of suicide in the last 30 days compared to similar data back in 2018. This is driven by a younger population 18 to 24 year olds, but very concerning. So let's go to the next slide. There's some other very interesting interactions between psychiatric illness overall and COVID. This is a really interesting study because of its size so 62 million individuals, patients on electronic medical records 60,000 of them having COVID. And what they found is this bi directional correlation. They weren't expecting it but they

found that psychiatric illness was an independent risk factor for developing COVID so they controlled for all the other known COVID risk factors they control for social determinants of health and other pieces and you can see about a 65% increase relative risk in developing COVID, and of course we've heard quite a bit about psychiatric illness after COVID illness. With increased hazard ratio there and that interaction so again very concerning and things were sort of teasing out, and we'll hear more about that later in the webinar.

And the last slide just to make the point that there's lots of concerns that if you go to the next slide around children and adolescents, so this is a really good, this will be in the slide deck but a good review of the literature that's out there already and internationally, looking at children who have been affected affected by lockdown by school closure, other economic impacts, and their families and really concerns about children especially those with special health care needs and concerning increases in incidence of child abuse and domestic violence, so lots of concerns there in the pediatric space as well. So, I want to pass it now to Dr Carrie Brown who is going to take us to North Carolina, and what we're doing here.

Dr. Carrie Brown

Thanks, Tom. So hi everyone, I'm Dr. Carrie Brown, I am the Chief Medical Officer for behavioral health and IDD. I'm here at North Carolina Department of Health and Human Services, and my team has the good fortune to provide medical leadership to two of the divisions here at DHHS, our division of mental health, developmental disabilities and substance abuse services which we usually say DMH for shorthand, and our division of state operated healthcare facilities, because actually our state operates 14 psychiatric facilities, including psychiatric hospitals, alcohol treatment centers, skilled nursing facilities and developmental centers, And we are my team also has the pleasure of working very closely with Medicaid, on, on a number of things and we're very happy to be included this evening. And Tom hit the nail on the head in terms of the national picture, and the fact that we are all experiencing and anticipating a growing tsunami of the behavioral impacts of COVID-19, North Carolina is really not any different than the national picture, we've clearly seen an increase in anxiety and depression, as well as a concerning increase in alcohol use, in addition to early on 2020, we had a marked increase in opioid overdose deaths that's reversed our progress we had made last year, the newest data suggests that we've with interventions, this summer that were maybe coming back to our prior baseline. But one of the things I want to particularly highlight is for North Carolina in specific our firearm background checks have surged since March by 58%. And that is extraordinarily disconcerting, especially given that Tom's data about increase in suicidal ideation in the, in the population. And we know that historically North Carolina is unfortunately higher than the national average in terms of suicide by firearms. So just a good reminder to all of us to screen our patients for firearm safety, as well as suicide.

Dr. Carrie Brown

Next slide please. In response, because we know that everyone is suffering throughout this pandemic we've set up a statewide 24 7 hotline called Hope for NC. And I'm hoping that some of you on this call have seen the media campaign which rolled out of the beginning of last week. It's called hope is on the

line. And it is available 24 7, also in Spanish for and or other languages. Next slide please. And what we've seen over time is that there have been slightly more female callers than male which is not terribly surprising for this sort of crisis line. However, we really made a concerted effort to reach our historically marginalized populations. And we've done a fairly good job, we've got some more work to do but over time we're showing increased participation from our historically marginalized populations which we know have been so disproportionately impacted by this pandemic. And later on when we talk about resources we will also talk a little bit about hope for healers so when Tom was mentioning that, especially high rates and essential workers. Remember that menas health care providers as well and we also hope for healers line that's designed specifically for them with our partnership with the North Carolina Psychological Association. Next slide please. And now I'm going to turn it over to Dr. Keith McCoy.

Dr. Keith McCoy

Hi there, I'm Dr. Keith McCoy, a psychiatrist and senior medical advisor to Dr. Brown in the office of the CML. I have been working a lot with Medicaid on our telehealth flexibilities specifically for behavioral health and appreciate Dr. Dowler's leadership there. I also work extensively with Medicaid around tailored plan design, as well as new foster care plan design. Just wanted to cover a couple of issues here, one please note that these slides are available for reference, we're not going to spend a lot of time on them. But a lot of the flexibilities that we've done within the behavioral health space. We're going to be keeping, especially those related to telehealth and outpatient and that's what we see here. And these all are built upon our clinical coverage policy 1H, which is our governing telehealth clinical coverage policy. And that policy has been changed permanently and posted within the past month so you can see that on our website, where there are no limitations on origination and distance site, more flexible technology rules, and some additional resources such as interprofessional consultation for physicians, the ability to do some remote physiologic monitoring and things like that. For behavioral health though we're going to keep our flexibilities around group family and crisis psychotherapy, as well as the expansion of licensure types that are able to do telehealth before it was limited to prescribers and LCSW's. We have decided to continue the use of psychotherapy codes via telephone but we will not be keeping that parody. And we will be sunsetting the ability for psychiatric prescribers to bill for telephonic psychotherapy as an add on to an e&m service and that's because the CPT code is there. We have originally enabled the assessment and management codes for licensed therapists that will be sunsetting, that's in part because we're going to be allowing telephonic psychotherapy so we'll go back to our original prior approval and reauthorization aspects, and then we're also going to continue to allow for subsequent/discharge day E&M codes for inpatient, even though that some of these permanent policies have been posted we will continue the COVID flexibilities that we posted as of past May and June and July earlier this year, until the emergency is over.

Next slide. So we also had a number of flexibilities that are enhanced behavioral health services, these are things like assertive community treatment, community support team partial hospitalization, so we have allowed a lot of telehealth and telephonic capability, we will generally be sunsetting these at the end of the public health emergency. There are a couple of places that are noted where we're going to be explicit about the ability to do telehealth, diagnostic assessment and mobile crisis, as well as to allow the

physician assessment to be done for ambulatory and Hospital Medical detox. Our face to face requirements our staffing ratios our training waivers those will sunset, with the end of the public health emergency with use facility based crisis, we will add a lot of flexibility with telehealth, but the one we'll be keeping at the end of the public health emergency has to do with the psychiatrists telehealth assessment. Next slide. We also created some flexibilities for our VBHT for individuals with autism spectrum disorder. Generally we are keeping these telehealth flexibilities. Next slide. And then peer support services I believe this clinical coverage policy has been updated and are posted. We will continue to allow some telehealth and telephonic service interventions we had already allowed telephonic, we will continue to have parameters because this is really intended to be a face to face service, but we have allowed some more flexibilities, the other flexibilities that we have, will be sunset. Next slide. And now I'll hand it back to Shannon.

Dr. Shannon Dowler

Thanks so much, Keith and thank you for all your help on the telehealth space. We spent a strange amount of time together this spring virtually, of course. So just because we've been measuring telehealth utilization from day one. I just wanted to, I feel like every presentation I throw a slide or two around utilization, because I think it's just very interesting. This slide shows the use of telehealth for physical versus behavioral health as a percentage of the total claims, and you see that really significant use in their behavioral health space, a lot of very positive feedback, and success stories from that. And so, so we're excited to be able to keep some of the other things turned on permanently after the public health emergency. Next slide. This is looking at behavioral health, looking at telehealth versus telephonic versus in person. And this has been really interesting to look at behavioral health has been one of the higher utilizers of telephonic particularly in the psychotherapy space. And we've heard really good feedback but overall it's very small compared to the end person. And the real time audio visual and I think it's important to note, I think from a political standpoint and people that have concerns around fraud and abuse and other things in this space. This is a reassuring slide that yes it's an important modality and it has a place, but it's not driving the volume.

Next slide. And this is a teaser for some research that the team has undertaken looking at the data, and really scrubbing it for how using telehealth has changed the care of our patients. We are seeing that medication use related to in person or telehealth visits is significantly higher than people who bypass care, and particularly notable is that telehealth folks are maintaining medications and filling medicines for behavioral health conditions using telehealth so it seems like a very effective way to keep our patients on schedule with their medicines and in touch with us more to come on that as we continue our research. Next slide.

Dr. Carrie Brown

And here, this is, this is Carrie back again just to introduce Dr. Jessica Waters, who is the medical director for UNC WakeBrook primary care. It's an integrated primary care clinic with a really novel

approach to caring for individuals with serious mental illness and I have the absolute joy of being able to work with this clinic. Back in my old life as a psychiatrist for an ACT team, to you, Jessica.

Dr. Jessica Waters

Hi. Thanks for the introduction Carrie and thanks so much for the opportunity to speak with everyone tonight. So I think that the previous speakers have highlighted well the the mental health impacts of COVID-19 and the increased need among the general population. I think that that need is even more salient among individuals who live with serious mental illness. So when I'm discussing serious mental illness, most of you may be familiar with that terminology, but I'm referencing the, you know, one to 4% of the population who has been diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder or another Psychotic Disorder. And those folks, not only have sort of the burden of their illness, the burden of the pandemic. And then also all the social determinants of health that really drive the increased stress during this time. You've heard a little bit about enhanced behavioral health services, for instance, ACT teams. And many of you may be familiar with models of care that target individuals who suffer from anxiety or depression in the primary care setting so impact model collaborative care. Those all have really great evidence of work well for adults and adolescents, sometimes even children with with anxiety disorders, ADHD, depressive disorders, but they don't have great evidence for people living with SMI. And along those lines. Not only is it difficult to meet the behavioral health needs of that population in a primary care setting. I think we're not meeting their physical health needs so you can see on this slide the mortality gap between individuals with, with serious mental illness, which is sort of the right side so mental disorder in the public sector, folks, probably who are on disability because of their mental illness, versus on the left, life expectancy for the general adult population. And there is a 25 year gap in the life expectancy and if you remove things that are sort of directly related to mental illness, suicide, homicide overdose. Then, that accounts for only 15% of the mortality gaps the samsa estimates that 85% can be attributed to physical illness so basically folks who are suffering from, who are dying of cardiovascular disease COPD, tobacco related illness diabetes complications, cancer, the same things that the rest of the adult population is dying from just 25 years earlier. So to try to address that disparity we can go to the next slide.

My great mentor, Dr. Beat Steiner and Dr. Brian Sheitman who is a previous medical director at WakeBrook, a family physician and a psychiatrist put their heads together and said we need enhanced primary care services for people with serious mental illness. So they openned WakeBrook primary care in 2014. It's full scale primary care practice and on the left side of the slide you can see we sort of meet all of the traditional PCMH Patient Centered Medical Home criteria about patient centered care, continuity of care comprehensiveness, the things that we think are necessary in order to take good care of people with SMI in the primary care setting, are the three things on the right. So the first is additional time and care. Our average panel size for a family physician at least for primary care is around 750 patients, which is about half of what a primary care physician might carry in the community. This allows us to have longer visits with our patients so 30 to 40 minute visits, on average, an hour often for new patients, just gives us the time to create the rapport that that it can be more difficult to achieve in individuals with SMI and then also time for coordination of care with guardians pharmacies caregivers, etc. and psychiatry, which we'll get to in a minute so the second part is sort of specialized training for

the team all of our providers as well as our staff, our front desk, our LCSW's they're also cross trained in both physical and behavioral health and have a strong interest in integrated care.

And then the third thing is protected time and and scheduled time for communication between primary care and psychiatry. So, all of our patients also have a psychiatric team often that's an ACT team or community based mental health provider, and we keep in close communication with each other. So when Dr. Brown was working with the ACT team we actually have face to face meetings every month where we could discuss patient shared patient care. And that I think was really one of the keys to this. Colocation, which we have the luxury of at WakeBrook because we work as a psychiatric campus. The primary care clinic being housed there gives us additional opportunities to collaborate with psychiatry. I don't think it's necessarily a requirement for this model I think you could consider a model that has enhanced services for individuals with serious mental illness embedded within a primary care clinic for instance in a more rural setting that might not have large psychiatric practices. Next slide.

So, of course, the next question is whether this works whether it is in fact improving health outcomes and we're proud to say that our rates of preventive screenings, our rates of diabetes and hypertension control now approach those of control in other primary care practices at UNC. Whereas when we first opened our doors, the rates were far lower. So I think that it is improving quality of care. We have excellent patient satisfaction ratings. Many practices do. But we're glad to see that we're able to achieve that we've had very little provider and staff turnover, which I think speaks to the fact that folks are satisfied and sort of gratified by doing this work. We do have data starting to show sort of the holy grail of decreased ED utilization for individuals who enroll in our services at our clinic. So folks with SMI may have higher than average utilization of the emergency rooms either for their psychiatric illness, their mental sorry their physical illness or some combination along those lines. We have also been able to show a cost savings in terms of inpatient medical days so hospitalizations, for medical illness that are two over the first 18 months of care with WakeBrook primary care compared to enrolling in another primary care practice so traditional primary care practice. Individuals with SMI, end up, requiring $8,000 less of inpatient hospital stays. So for us, you know, these are sort of the keys to both showing that this model is working for this population, and then also making the argument for sustainability we're moving toward, you know, how is this funded. Currently it's partially grant funded and partially funded by revenue billing for service model, but we would love to move toward more of a capitation model where we take care of the certain number of individuals as opposed to completing a certain number of visits. And we very much have our eye on Medicaid transformation and working toward becoming an advanced medical home, plus, within the tailor plans for individuals with serious mental illness as well as serving individuals who have the standard plan under Medicaid. Finally we're hoping to replicate this model in other sites. We are already in conversation to create a similar clinic in Carrboro, and would like to investigate doing this in rural settings perhaps and perhaps in FAHC settings. So if anyone has questions or has interest in enhancing you know primary care services for individuals with SMI, please reach out to me after the talk. Thanks so much.

Dr. Tom Wroth

Thank you so much Dr Waters just amazing to hear more about the WakeBrook model. So, again, my pleasure to introduce Valerie Krall the director of behavioral health at the MAHEC family health center.

Valerie Krall

Thanks, Tom. Happy to be here. Yes, I was asked to just provide a little bit of information about what it's been like to do, integrated behavioral health, with the telehealth format. Next slide please. So, MAHEC is located in Asheville, North Carolina. And prior to COVID, we were pretty much 100% doing appointments in person in the clinic with scheduled patients as well as covering our consulting years where physicians are doing primary care, and we are available for warm handoffs and short consultations, brief interventions. So, when the pandemic hit we pretty quickly, were able to switch, luckily, we're in office too almost entirely telehealth modality. So after learning the platform that went off pretty well. And then we were able to were able to do these scheduled regular psychotherapy sessions, telehealth as well as being able to do the unplanned consult and warm handoffs with the physicians and the clients. So that was very helpful we were able to maintain all the elements of our model, and to reach patients. Despite all the barriers that came along with COVID. Next slide please. So I was asked to just share a few examples of what went well with this, and as you might expect, one of the biggest benefits was that the no show rate for behavioral health appointments, decreased significantly. And that had been a very, very big issue and an ongoing challenge to try to figure out how to address that and not be wasting appointment slots. So, that has been a game changer as far as our model, and being able to sustain that more easily and have appointments kept, and we can be much more flexible as well, and have to work somebody in, and they don't have to drive to the physical location. And then from the patient perspective. It's really, as you would imagine been, wonderful, or patients who have to use public transportation or are reliant on a wheelchair. I've worked personally with a patient who prior to telehealth used to have to wait a good bit of time for the public transportation that could accommodate him to get him have his appointment, wait again, go home and they were pretty difficult days for him and very grueling. And now, the appointment starts on the dot delivered right to his home, and he is this is a direct quote from him. He was so excited when that started. He really wants that modality to be able to stay in place. And then another, you know, kind of, pleasant surprise was that, as you know, many parents have been suddenly put in the role of being teachers at home, their kids, and it's made it possible for them to be able to continue to have their behavioral health appointments and be able to kind of juggle both things without having to find someone else to substitute teach or do childcare for them. Next slide please.

Another, a few other examples were patients that were pretty isolated, or who had to slf quarantine for a long time. Really, just very. They're thrilled to be able to do telehealth and have that, that communication and that lifeline directly to their home. Patients have been very creative, sometimes a little more creative than we'd like with their ways that they've kept their appointments. Some unexpectedly, log on to the appointment and they're at their workplace and they've obtained permission from their employer to go into a private room and and have their behavioral health appointment, like, Wow, that's a lot of good things coming together, not missing much work. So that was a really kind of pleasant surprise. Then there's been a few examples where, you know, real life things have happened during the appointment or a patient who's being seen to work on parenting

issues actually has, you know, a parenting challenge occur during the visit, right in her real home. So we're getting to practice things in real life scenarios. So that's been a pleasant surprise also. Next slide.

And as far as the integrated care model and the being available for unplanned consults and warm handoffs their position that's actually worked really well also, even. We have a way to just have it listed, who is covering the consulting area, each day. And the physicians can add us in to their tele video, visit with the patient if they want or they could call us and get input. Oftentimes, they've been able to just add us into the video appointment, and probably one of the best examples that ever occurred so far was a patient who was brand new to the doctor, brand new pretty much brand new to the practice had pretty significant suicidal ideation. The doctor was able to add me to the session, and we were able to actually bring up the visual of the safety plan that we all filled out together. Then the patient could see it being filled out on the screen. And it was just very nice to be able to do all that. It felt like it was almost more seamless than it would have been in person, in some ways. And then, you know, we're thankful that you know in western North Carolina, there's a fair amount of snow days and often patients can drive to get where they need to go so that's going to be a perk to be able to offer this during winter months for patients as, as well as employees not having to travel. Next slide, please.

Of course, a couple challenges here and there is of course expected technology difficulties every now and then. It's been extremely helpful to be able to resort, if needed, to aphone call. Several efforts are made to video and occasionally something just doesn't work, or patient can't figure something out. internet is bad, and it's good to have that, that backup, most patients have been very understanding. And it's been a mutual bonding experience to navigate technology together. And all these new challenges. Some of the systems and some of the platforms don't have ideal features for sharing and signing documents. So it's always good to have a system that has all of the things that you need. And there's a small amount of people who don't feel come as comfortable doing psychotherapy in a video format, and prefer to wait till they can do in person again, but that's a pretty small minority. And, of course, a few odd situations every now and then where you have to, we have tried to always remind people before they even schedule their appointment about privacy and confidentiality, and please don't be driving your vehicle during your appointment. But those things continue to happen. And we continue to reiterate. Next slide. But all in all, just to sum up, the benefits are so great, and there's been a lot of really wonderful experiences, thanks to having telehealth available. And we're just hopeful that we'll be able to have the same kind of access moving forward. And that's all I had for today. Thanks for listening.

Dr. Tom Wroth

Thank you so much Dr. Krall. And now we are going to hand it off to Dr. Mary Kimmel and Dr. Gary Maslow. Dr. Kimble is the Codirector of perinatal psychiatry program at UNC and a psychiatrist specializing specializing in treating and studying perinatal mood and anxiety disorders. She is the medical director for the HRSA funded NC matters program, which we'll learn about here in just a few minutes, which is a joint effort with DHHS, Duke and UNC. And Dr. Maslow is a practicing pediatrician and child psychiatrist as well as the CoDirector of the Division of Child and Family mental health and

community Psychiatry at Duke. He is the director of the North Carolina psychiatry access line also known NC PAL which we'll be talking about and is interested in supporting primary care providers across the state in to assist them in providing care for children, Drs. Kimmel and Maslow.

Dr. Gary Maslow

Thank you for for having us today, it's been really nice opportunity to talk with you about supporting these important behavioral health consequences of the COVID-19 pandemic. One of the things I think we hope to share is that this is a program that's available to all primary care providers actually pretty much any, any, any research children or, you know, women in the perinatal period, have to call and get help around pediatric or maternal mental health. So I think this is a program we'd like to share and ask you to share with others as we are available to help address partly some elements of this crisis. On Next slide, please.

Dr. Mary Kimmel

And, and so this is a federally funded access line. And so this was actually in the works. This is actually our third year. And we were very fortunate as a state to be able to get actually both both grants to support both child mental health as well as perinatal, which I think gives us a unique opportunity to really focus on family mental health. And although this program was in the works before COVID, with COVID, I actually think that this has really highlighted even more so the needs for this program and for and has helped us continue to adapt and evolve what we're doing in both programs. And you know, already they highlighted the amount of increase in social factors that we know of that depression and anxiety and mental wellness across families, the biological risks in terms of the immune factors that that we know can lead to greater depression and anxiety and obviously the safety issues that families have and helping frontline providers navigate that and really the goal of this program is to be able to help and adapt frontline, to support help like frontline providers adapt to the changing mental health needs of their of their patients, particularly families. Next slide.

So our as I said, we our matters programs program I'm making access to treatment, evaluation, resources and screening better and I can't take credit for that. Belinda Pettiford helped create that. who helps who is helped us with this program from the state side. And so our our focus is on pregnant and postpartum women. But I want to say I think this is really important for a couple reasons. One, it is this really critical time for intervention. This is one of the few times that families really have are engaging regularly in mental health services. And so even though we're targeting pregnant and postpartum women, we're really able to access families this way. And, and I think going forward, as we continue to see the tsunami of the COVID impacts, this will be a way to continue to access families and to help them continue to deal with all the effects that have come out of COVID. And, and then also, I think this is a great model. And along that I'm gonna turn it over to Gary.

Dr. Gary Maslow

So the pediatric program is the North Carolina telehealth partnership for children, Child and Adolescent Psychiatry access, and it's both educational as well as providing direct care. Next slide. So when we think about what the goal of this program is to provide support to providers, so that they can, themselves care for screen in screen, assess and treat patients where they are, but with specialty support from child psychiatrist or perinatal psychiatrists to where they are, and also provide continuing education for the pediatric program, we spend a fair bit of time doing lectures and outreach, as well as doing more intensive continuing education. One is a program called the reach Institute where family doctors, physicians assistants, NPs, pediatricians can come for a three day training, and then have a biweekly follow up to discuss pediatric mental health care. And there's a real anyway, it does seem to really gauge providers and learning how to take care of patients. And then they have the consultation line available for when they have questions.

Dr. Mary Kimmel

And in terms of the aims of our program, it's very similar. Our goal is really to to help frontline providers in their best practices around screening, and then through that screening, help them identify, improve their ability to identify, assess, and then help both in treating their patients. So they can call us to get, you know, in real time support around medication questions, therapy questions, diagnostic questions, and then what and then in terms of continuing the wellness care planning for their patients, we work with our partner with them to get patients to higher levels of care when they need that. And then we have our you know, our primary goal is really education to try to increase the number of people that can be providing mental health services, and so through frontline providers, and so helping them feel more and more competent, and actually behavioral health providers as well feeling more comfortable supporting pregnant and postpartum women during, in their mental health. Next slide.

And so our team, so this is the both sets of teams. And as you can see, it takes a lot of people to do this kind of work. And across our team, we have, we have, we have our care coordinator, we have our psych our mental health specialists, we have who man the line and also provide in the perinatal program, we provide telehealth assessments to help providers and furthermore, in terms of diagnosis and care planning, we have our coordinate our health, behavioral health consultants, and those are LCSW's who can provide some resources, help think through next steps and care. We have data specialists. And so we're really trying to gather data about what is happening with mental health, you know, in terms of screening, what is happening in terms of getting people access to care, particularly in the patient populations we're focusing on, and then our program administrators that are at Duke, UNC and at the state, next slide.

Dr. Gary Maslow

So these are the counties where we get calls from so you can see really the these programs are both open to the whole state. And we'll show you how to call and how easy it is to speak with one of us and how fast we respond, you know, at the end, but pretty much this is open and available to providers across the state. And so far, there's almost 1000 calls across 35 counties. And that's been definitely

increasing during during this period. We go the next slide. So the model basically, as I'll describe the pediatric model and then Mary can briefly just quickly describe the models of essentially if you have a primary care provider in practice, and you're seeing a child and you haven't Question about ADHD or could this be autism? Or why are they taking five meds, you would call the line, speak to a behavioral health consultant. And they can help provide referrals and resources for that patient. Or they can connect you to the child psychiatrist where they can talk through diagnostic questions. The goal is to respond within 30 minutes, but typically, we're responding within less than five minutes. So it's kind of real time you can patients, providers will call when they have a patient in the office and we're able to help talk through talking through what's going on and make complete decisions. The most exciting thing for me is when someone calls back in, they actually already know the first step. And now they're asking what the second step and so it really is kind of this adult education model.

Dr. Mary Kimmel

And we also have similar kinds of questions that come to us when we work with prescribers, and providers. We also are continuing to think about other ways to harness telehealth and technology, you know, whether that be ways to do kind of have us all share within a HIPAA compliant telehealth thing for us to have a three way conversation with the patient, the provider and ourselves. We're talking about, we're working with the state and the health department to figure out how to better support the the high risk pregnancy case managers, the rural health coordinator, counselors that are embedded with health departments. And so that that in that model, it's more of a kind of collaborative care model, where we're giving support to them, to connecting them to services, and figuring out what are the right services. And then finally, we are providing one time psychiatric assessments through telehealth and that I think has really taken off because of our ability to meet to do that with patients in their home. And then after we talk with them, we move back with the their their frontline provider provider. Next slide.

So these are some you know, so we really get the gamut of questions. And really, uh, you know, from depression, anxiety, in our case, substance use different types of psychiatric illnesses, ADHD, you know, kind of across different, different things that issues that patients may be dealing with. And we get diagnostic questions, medication, specific kind of questions about certain medications in pregnancy, whether they're, you know, talking about how to counsel their patient about the risk benefit, discussion about different medications, and then also thinking about different forms of support different types of their, you know, helping them identify what might be the type of therapy most helpful? And then what are different resources?

Dr. Gary Maslow

Um, I think they, I think, there really is a range of these different types of questions that we can answer, so we can move on to the next slide. Um, the educational piece of this, again, is really important. We are open to coming out and virtually coming on providing Lunch and Learn sessions, webinars, newsletters, and really, again, helping to support provider education.

Dr. Mary Kimmel

And we are developing CME credit webinars through AHECof them. So those will be rolling out fairly soon. Next slide.

Dr. Gary Maslow

So just to give you a sense of the satisfaction, you know, this is a just a snap snapshot of NC PAL, we do you ask you folks are satisfied. Essentially, there's 1%, that isn't the most providers that are very happy with it. I mean, I think one of the best compliments that we have, which again, is something that is captured in this code, is that it's an extremely valuable service to our state. And they they feel the providers went above and beyond. And often we get feedback that after they've had this consultation, providers are more comfortable asking about mental health and thinking about it as as something and potentially also, it's a way to help avoid kids going to specialists or to higher levels of care.

Dr. Mary Kimmel

Next Slide. And just this is our contact information. We have, we have email, there's the phone lines, that's the most important part. And, and you can either one for the pediatric, two for the perinatal, and you will get connected to our behavioral health consultants, and then to a parent to a mental health specialist as needed. And you know, where it's available eight to five, we also have a matters website, if you'd like additional information from there as well. So thank you.

Hugh Tilson

Thank you. I know we're gonna move on before we do we got a question for y'all. Do you partner with any Early Childhood Mental Health consultants to support the infants and any other young children in the home?

Dr. Mary Kimmel

Yeah, that's a really exciting question. So So we're also working with I should have mentioned, when I was talking about kind of the new models that we're looking at, we're looking at working with baby love plus. And then also we have talked with, we have been talking with Durham family connects with Nurse Family Partnership. So a number of different groups, we actually are looking at providing mothers and babies which has been used by home visiting groups of many places well validated and evidence base to support mental health. And so that kind of infant mental health is where we actually have an attachment group, where we're beginning to talk about mother infant mental health and how we can best support that. And we want to think about how we can maybe even create a taskforce around that and think about next steps.

Hugh Tilson

Thank you. Next slide. Dr. Brown is this you?

Dr. Carrie Brown

Yup can jump in here. And I think we'll kind of speed through this. So we have some time for questions. But going to the next slide. Here, there are a there's a wealth of information out there in terms of behavioral health resources to cope during COVID. The American Psychological Association has a bunch of things the World Health Organization SAMHSA does. And if and what next slide please. And actually all in and there's additional on the National Association of School psychologists actually has a really neat tool for helping children cope with changes resulting from COVID. And all of these resources, including direct links are in our new brand new reveal this week mental health toolkit, which you'll find under wellness resources at the DHHS website. Next slide, please. And and this is just a reminder about our hope for NC helpline that I mentioned in the URL in the beginning of the presentation 1855873463. And our evidence based behavioral health message messaging in prevention, which is the scoop on managing stress, staying connected to family and friends, having compassion for yourself and others, observing your use of substances, remembering that it is okay to ask for help, and engaging in physical activity to improve your mood.

Next slide, please. And again, our partnership with the North Carolina psychological Foundation, and DMH to stand up for healers hotline, which is also available 24 7, and followed by licensed professionals for brief therapy three or four sessions. And that number is 919-226-2002. And ideally, you all could print out the slides, print out some flyers and put them in your offices because again, as Tom mentioned, in the beginning, our essential workers, which include our frontline health care workers have had to bear the brunt of this pandemic. And we really want to make sure that we're there to support them. Next slide, please. And I think I get it back to Dr. Dowler. She was in connection problems. So I'm happy just to, to I know what she was gonna say was which our next Medicaid fireside chat is January 7. And we will be talking about behavioral health in standard plans. And also remember, there's an AHEC, advanced medical home webinar series number two, January 14, at 530. And next slide, please. And then I'll hand it back to Tom and Hugh to guide us through the questions that thanks, everyone for for some really impressive work.

Dr. Tom Wroth

Great, thank you. So to get several great comments in the chat. There's one question I have a question for the group as well. I think this might be around policy. So there's a thank you. And it says the therapist would need to add their home address as a location, we would use the pre approved location to build from as a distant side and that might go back up to the Medicaid policy changes anyone on our panel and the answer to that.

Dr. Keith McCoy

Oh, go ahead. If somebody knows the answer, I was gonna say this is a Medicaid policy question that's a bit in the weeds on the way that providers register themselves and I'm happy to take that back.

Dr. Shannon Dowler

Yeah, I think that's definitely I would refer to the special bulletins to bulletins on that on that. I think it's too meaty for to trust us to answer right now on the fly.

Dr. Keith McCoy

If y'all want to email that question, feel free to email that to me and I can try to find it for you. If you guys have a lot of special bulletins and so I'm just keight.mccoy@dhhs.nc.gov

Dr. Tom Wroth

So it was thanks to you, it was great to hear the different models that are out there. And we're really fortunate to have these leaders innovating. And I'd love to ask Jess and Valerie kind of a hybrid question. So for Jess, I'd love to ask how you all are using telehealth and if you've seen the model working, as Valerie described, and also maybe make some comments about if you're in Valerie's setting or if you're in a primary care site doing an integrated model, you know, what would be the next step on the roadmap in terms of lessons learned from WakeBrook? And what would your advice be to folks that are out there? Thanks.

Dr. Jessica Waters

So in terms of telehealth, we also embraced that that transition, abrupt though may have been more abrupt than we had expected. But in the spring, our we went almost all virtual, which, you know, for primary care, there are a lot of things you can do well, virtually, and then we learned there are a few that don't work as well. So we are now a mix of in person and virtual visits. But still a good mix, about two thirds in person and a third are virtual. And in terms of integrating I actually think, you know, in some ways, it actually enhanced our ability to integrate with behavioral health, I've had a few visits where we teleconference in both the primary care provider and the psychiatrist and the patient, and so we're all three were in remote locations, but able to work together. And I also think that, you know, in terms of patients, it has increased, we had the same concern that perhaps would be difficult for people to access to technology. And that is true for some folks, even even me some days. But I think we found people were a lot more facile than we had expected. And now we have have a program to start to make more accessible for people the the just the devices that they need, because that was seemed to be the main barrier was whether they had a smartphone or had a computer. So we have a we are now loaning Chromebooks to some of our clients who are participating, for instance, in our in our wellness groups or

peer support services. And then the second part of your question was around, what would next steps be? I think, you know, it probably is setting dependent. So if you're a primary care clinic, thinking about offering some enhanced services to folks with SMI, versus if you are a mental health team wanting to bring in more primary care to meet that need. Either way, we would, you know, love to just have a conversation with anyone who's who's sort of experimenting with novel models of enhanced primary care. I think that and to share our outcomes if you're looking to make an argument to stakeholders that, that this is worth investing in and getting started. Does that answer the question? Great. Yeah,

Dr. Tom Wroth

It's wonderful. And yeah, you have done a great job on the evaluation, that's really important to bring that back to the stakeholders and payers we've got another question, go ahead Hugh.

Hugh Tilson

Can I just ask a real quick one, which is where do we find the mental health toolkit? Where can where can people who are listening go to get that?

Dr. Carrie Brown

I let me see if I can drop it in the chat. It's on the DHHS website, and on the COVID resources under wellness, but let me see if I can get the exact link for you. Great.

Hugh Tilson

Thank you. Tom, you can ask the smart questions.

Dr. Tom Wroth

Great. Well, let me put a got one here. A question. Are you assuming that the SMI folks in WakeBrook will be Tailor plan folks only as you Dr. Waters and you're on mute.

Dr. Jessica Waters

There we go. I'm sorry, my my navigator froze. So we did an analysis of this last month to try to get a sense of what percent of our patients will be on the tailored plans. And no, not all will be on tailored plans, because it's driven not just by diagnosis, but by utilization. So folks who are actually, you know, might have a diagnosis of schizoaffective disorder, but have been or have been quite stable and are not, you know, not been utilizing, for instance, to high level crisis services or being hospitalized, they may not be recipients of a tailored plan. And so for those folks, we'd be looking at standard Medicaid or actually,

we serve a large number of uninsured folks. And of course, Medicaid expansion would help to meet the need for for those folks to seek insurance.

Dr. Tom Wroth

Thanks, Doctor Waters. So it's 631. And, Shannon, will you wrap this up? What a great panel on wonderful presentations tonight. Absolutely.

Dr. Shannon Dowler

Great content tonight. And just a reminder that our next our first Thursday in January is going to actually be all around behavioral health and the standard plans. So that entire fireside chats will be focused on behavioral health services and standard plans and what we can expect to be different and change when we transition to managed care in July. So really important webinar a lot to learn there. Of course, tailor plans will be honest before we know it, so lots of changes in the behavioral health space. Thank you everybody that joined us tonight. Both listeners and speakers. It was fabulous to have you here together. And we look forward to seeing you all virtually the first week of January.

Hugh Tilson

Thanks and take care everyone