While you're waiting for us to start, check out the results of HRSA's health center survey… (there is no audio for this slide)

64% of NC health centers responding

Testing Capacity	NC
Health Centers with COVID-19 Testing Capacity	92.00%
Health Centers with COVID-19 Drive-Up/Walk Up Testing Capacity	78.26%

Average Turnaround Time for COVID-19 Test Results	
Less than 1 Hour	8.70%
12 Hours or Less	4.35%
24 Hours	17.39%
2-3 Days	21.74%
4 Days	30.43%
More than 5 Days	17.39%

Operations	NC
Health Center Weekly Visits Compared to Pre-COVID 19 Weekly Visits	58.60%
Health Center Sites Temporarily Closed	29
Staff Tested Positive for COVID-19	20
Health Center Staff Unable to Work (due to site/service closure, exposure, family/home obligations, lack of PPE, etc.)	3.00%
Average Percent of Health Center Visits Conducted Virtually	39.20%

Latest Data from June 26
https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data/nc

While you're waiting for us to start, check out the results of HRSA's health center survey… (there is no audio for this slide)

64% of NC health centers responding

Number of Patients Tested for COVID-19	NC
Patients Tested	4618
Patients Tested Positive	789

Race/Ethnicity	Patients Tested	Tested Positive
White, Non-Hispanic/Latino	32.39%	27.64%
White, Hispanic/Latino	17.88%	33.89%
Black, Non-Hispanic/Latino	36.30%	17.96%
Black, Hispanic/Latino	0.79%	0.38%
Asian	1.05%	0.76%
American Indian/Alaska Native	0.82%	0.13%
Unreported/Refused to Report	1.54%	1.78%

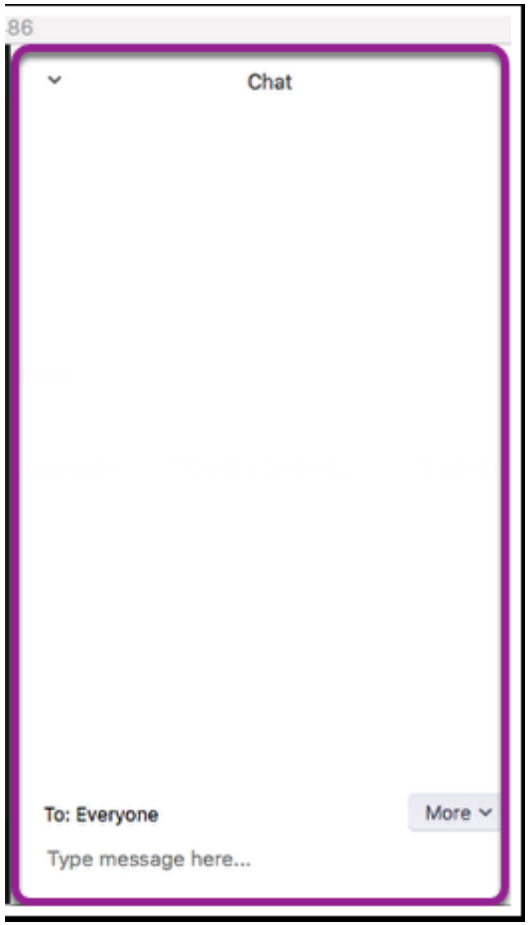
Latest Data from June 26
https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data/nc

Complete Race/Ethnicity data available, https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data

CHC COVID-19 Task Force

July 10, 2020

Zoom Help



You can also send questions through Chat. Send questions to Everyone or a specific person.

Everyone will be muted. You can unmute yourself to ask questions by clicking on the microphone or phone button.

Agenda

- **Welcome**, Chris Shank, President & CEO, NCCHCA
- **COVID-19 Testing Statewide Order**, Sanga Krupakar, Quality Integration Manager, NCCHCA
- **Primary Care in the New Normal**, Art Jones, Principal, Health Management Associates
- **Medicaid Managed Care Update**, Brendan Riley, Director of Policy, NCCHCA
- **Update on State Testing RFQ**, Chris Shank, CEO, NCCHCA
- **Planning for future Task Force Meetings**
- **Closing**

Slides & Other Info will be available on our website:
www.ncchca.org/covid-19/covid19-general-information/

Welcome from Chris Shank, President & CEO, NCCHCA

Update from NC Department of Health and Human Services

Sanga Krupakar, MD, MSPH

Quality Integration Manager

North Carolina Community Health Center Association

Update from NC DHHS: July 7, 2020

- New Statewide Standing Order for Diagnostic COVID-19 Testing pursuant to Executive Order 147
- State Health Director Temporary Order and associated Guidance for reporting COVID-19 tests results, pursuant to G.S. 130A-141.1 and S.L. 2020-4, sec. 4.10(a)(1)
- Patient guidance for Isolation and Quarantine (Spanish)

HEALTH MANAGEMENT ASSOCIATES

Primary Care in the New Normal
Part 1: Delivering Primary Care Under a New Payment Model

North Carolina Community Health Center Association
Art Jones, MD
July 10, 2020

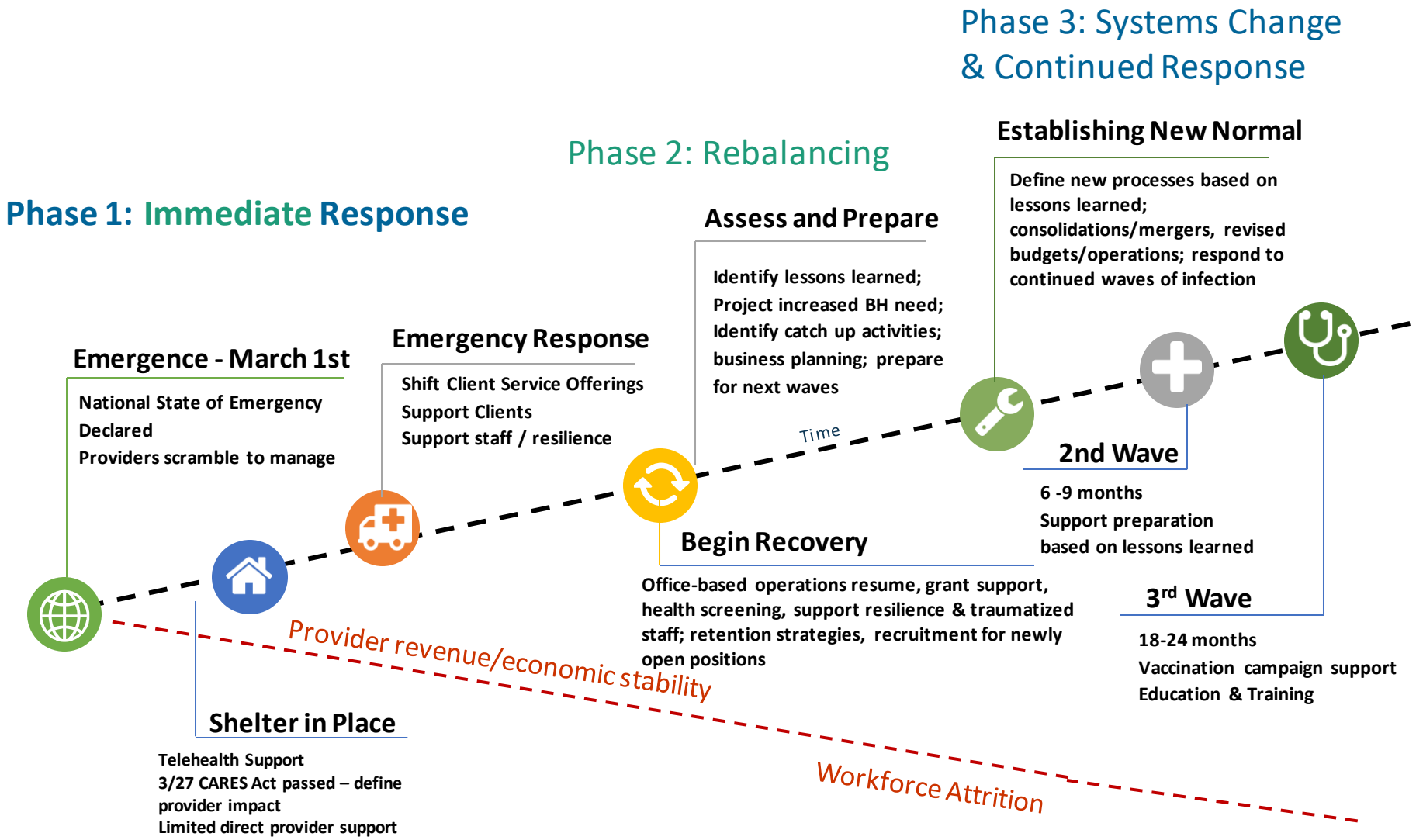
OBJECTIVES

1. Recognize the evolving market trends in primary and behavioral health care service delivery pre-pandemic and the additional impact of COVID-19.

2. Increase understanding of how strict fee-for-service reimbursement for primary care and ambulatory behavioral health care service is contributing to health disparities include pandemic-related morbidity and mortality.

3. Envision the new normal in provision of community health center ambulatory care services

COVID TRAJECTORY:



PRIMARY CARE HAS NOT LIVED UP TO EXPECTATIONS

- Primary care is ideally conceptualized as accessible, timely, first-contact, coordinated, long-term, and holistic ambulatory care for most common conditions and most people.
- Accessible: Minimal obstacles to obtaining primary care.

INSTITUTE OF MEDICINE COMMITTEE ON THE FUTURE OF PRIMARY CARE (1996)

PRE-PANDEMIC PATIENT CENTRIC PRIMARY CARE

- Are you asking patients to come in when a call/patient portal would have sufficed?
- Are you contributing to your no-show rate by how you provide access?
- What is the financial impact on your practice when you improve patients' ability to self-manage?
- Think Kaiser! More than ½ of encounters are virtual. If Kaiser ran a clinic down the street, how many of your patients would switch?
- If you offered the Kaiser model, how many patients would switch to you?

PRE-PANDEMIC: DECLINING USE OF PRIMARY CARE AMONG ADULTS

- 142 million primary care visits among 94 million member-years were examined
- ***Visits to PCPs declined by 24.2%,*** from 169.5 to 134.3 visits per 100 member-years
- ***PCP preventive visits increased*** by 40.6% from 15.1 to 21.5 visits per 100 member-years ***but still only 1 in 5***
- ***Problem-based visits declined by 30.5%*** from 154.5 to 112.8 visits per 100 member-years
- The proportion of ***adults with no PCP visits in a given year rose*** from 38.1% ***to 46.4%***
- Rates of ***visits*** addressing ***low-acuity conditions decreased by 47.7%***

Ishani Ganguli, MD, MPH; Declining Use of Primary Care Among Commercially Insured Adults in the United States, 2008–2016. Ann Intern Med Feb 2020

PRE-PANDEMIC DECLINING USE OF PRIMARY CARE AMONG ADULTS

- The decline was largest among:
  - The youngest adults (27.6%)
  - Those without chronic conditions (26.4%)
  - Those living in the lowest-income areas (31.4%)
- Out-of-pocket cost per problem-based visit for this commercial population rose from $29.70 to $39.10 (31.5%) for problem-based visits and declined from $20.10 to $4.90 (-75.5%) for preventive visits
- ***Visit rates to specialists remained stable*** (0.08%)
- ***Visits to alternative venues, such as urgent care clinics, increased by 46.9%***

Ishani Ganguli, MD, MPH; Declining Use of Primary Care Among Commercially Insured Adults in the United States, 2008–2016. Ann Intern Med Feb 2020

What do we know about the assigned BUT not yet seen MEDICAID INSURED FQHC population

- What do they want?
  - Interest in after-hours availability greater than for clinic user population
  - 75%-my own PCP
  - 69%-dental care
  - 41%-eye doctor
  - 36%-urgent care
  - 24%-mental health services
  - 22%-wellness services
  - 19%-foot doctor

Source: Survey by Text Message; used by permission

PRE-PANDEMIC 2020 HEALTHCARE KEY TRENDS

- Patients want convenient and timely access to care, coordinated care, high quality and affordability
- Payers want value and provider accountability for population outcomes, not just quality of care for those engaged in primary care
- Retailers and technology companies are entering the health care market because they feel they can be more responsive to customers and create margin by reducing waste
- Outside capital is investing in disruptive care models that provide care outside of traditional health care settings
- Health systems continue to focus on vertical as well as horizontal integration
- Aggregation and analytics of multiple sources of timely data will increasingly inform provider decisions at the point of care
- Make providers financially accountable

Reducing barriers to patient self-management and improved outcomes

CURRENT MANAGEMENT OF HYPERTENSION

- Nearly half of American adults have high blood pressure.
- About 11 million of them do not know their blood pressure is too high and are not receiving treatment.
- Only about 1 in 4 adults with hypertension have their condition under control (below 130/80 mm Hg).
- **63% of NC FQHC patients nationally with hypertension had their blood pressure controlled to less than 140/90 mmHg.**
- Depending solely on office BP readings leads to treatment errors (white coat effect and masked hypertension)
- Strong scientific evidence shows that self-measured blood pressure monitoring (SMBP), plus clinical support helps people with hypertension lower their BP and is recommended by the AHA

CURRENT MANAGEMENT OF DIABETES

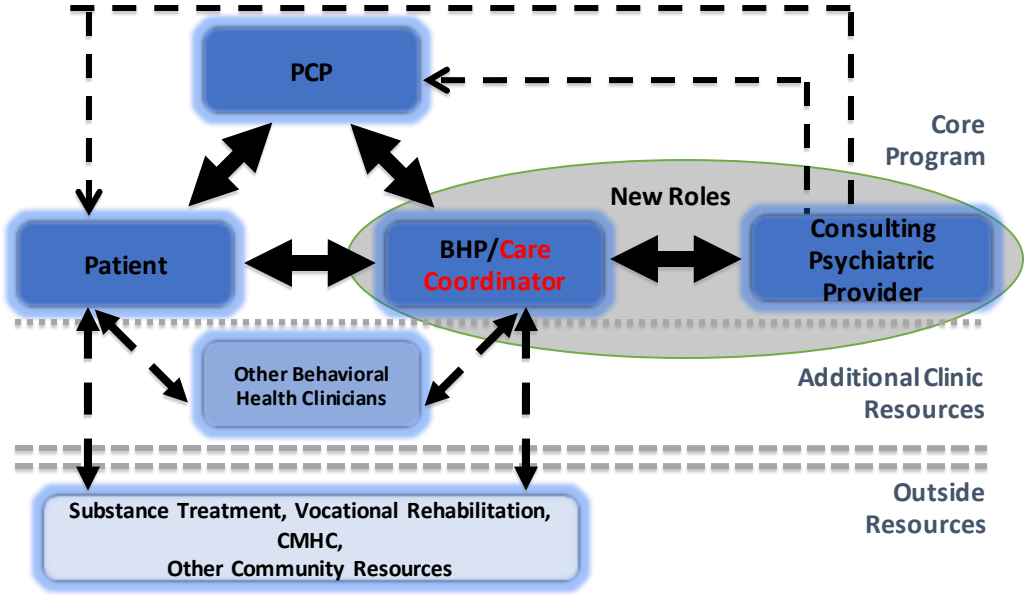
- Diabetes affects approximately 34.2 million people in the United States.
- Untreated or inadequately managed diabetes can lead to complications such as heart attack, stroke, limb amputation, kidney failure and hyperglycemic or hypoglycemic emergencies.
- Good management of diabetes has been shown to decrease or delay the occurrence of some complications of the disease.
- **31% of NC FQHC diabetic patients were poorly controlled Hemoglobin A1c (HbA1c > 9%) or had no test during the year.**

CURRENT MANAGEMENT OF DEPRESSION

- During 2013–2016, 8.1% of American adults aged 20 and over had depression in any given 2-week period.
- Major depression was most prevalent among Hispanics (10.8%), followed by African Americans (8.9%) and Whites (7.8%).
- The medical cost of treating several common medical conditions increases between 40% to more than double when there is superimposed anxiety and/or depression.
- Research evidence from over 80 randomized controlled trials have consistently shown that the collaborative care model is more effective than usual care.
- **Until this year, UDS only measured screening, not control**

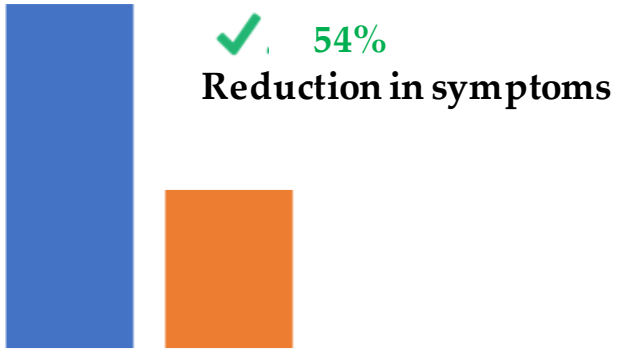
FEE FOR SERVICE REIMBURSEMENT PREVENTS USE OF SOME EVIDENCE-BASED CARE

THE COLLABORATIVE CARE MODEL OF BEHAVIORAL HEALTH INTEGRATION



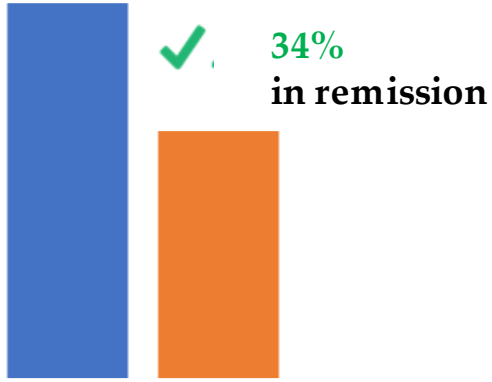
Medical Home Network Integrates Behavioral Health into Primary Care With eConsult & CoCM

- MHN recognized the need to integrate physical and behavioral health in the primary care setting, while also reducing strain on, and improving access to, psychiatry services
- MHN self-funded a roll out of an evidence-based approach to enhancing behavioral health access for our population
- 3,659 patients have been enrolled in the Collaborative Care Program. **54%** of patients actively engaged in the program demonstrated a **50% reduction** in depression symptoms and **34% reached full remission from depression**



Patients with Depression: Reduction in Symptoms

54% of engaged patients achieved a clinical response to treatment



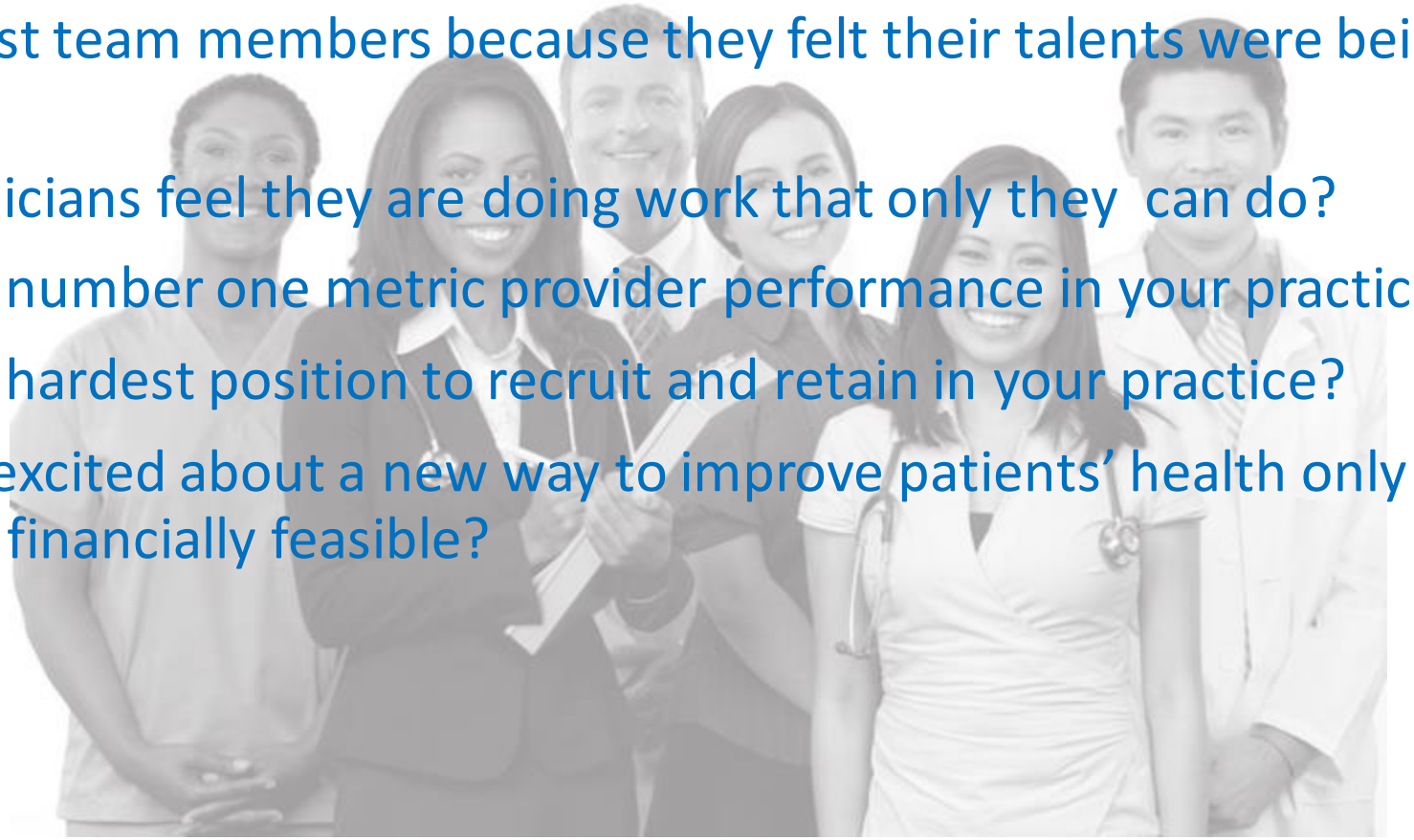
Patients with Depression: Full Remission

34% of engaged patients achieved full remission from depression

MEDICAL HOME NETWORK

NCCHCA

Primary care Capitation AND Use of the Full Care Team

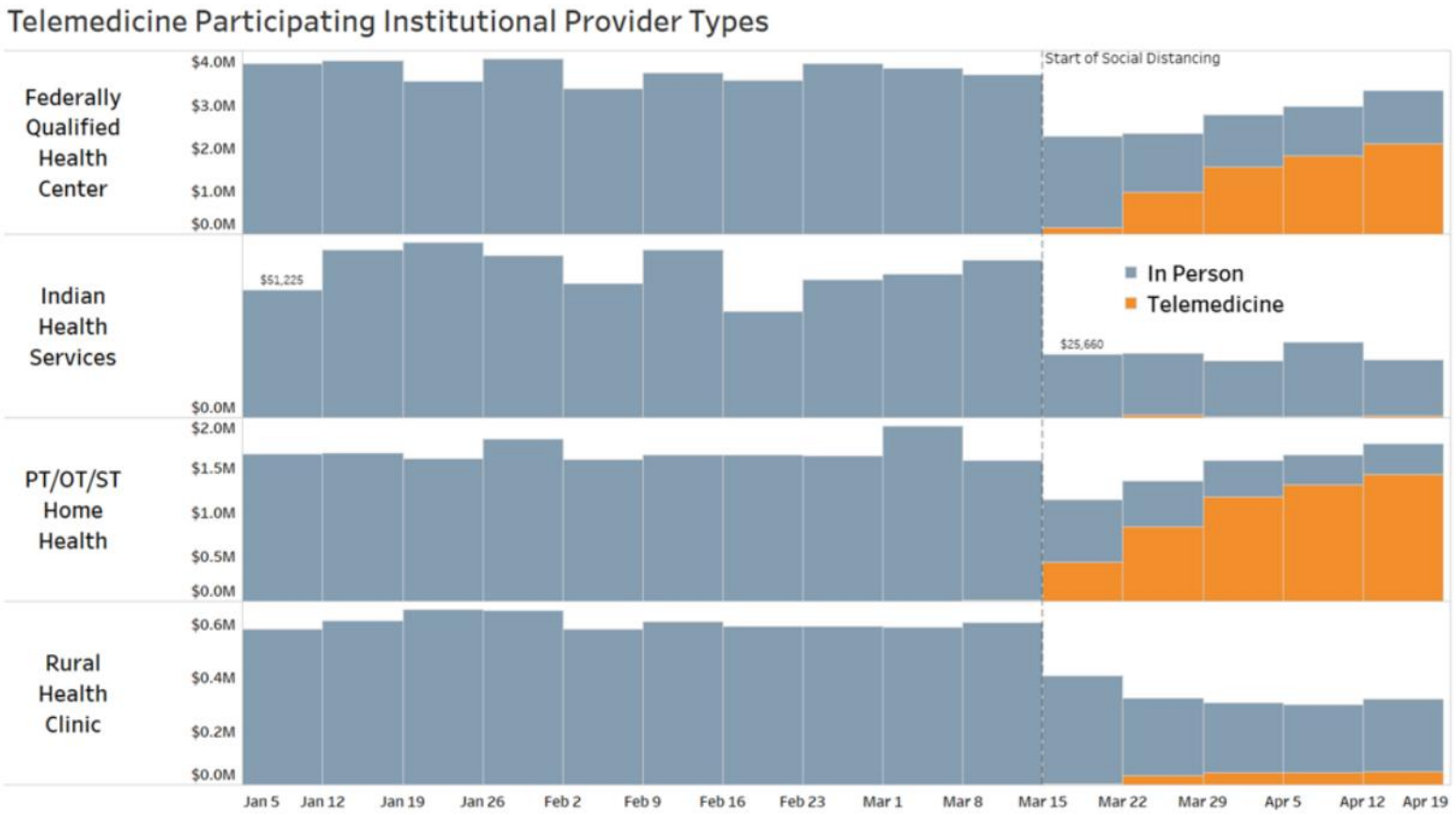


- Have you lost team members because they felt their talents were being under-utilized?
- Do your clinicians feel they are doing work that only they can do?
- What is the number one metric provider performance in your practice?
- What is the hardest position to recruit and retain in your practice?
- Do you get excited about a new way to improve patients' health only to be told that it's not financially feasible?

WHAT FQHCS HAVE LEARNED IN THE PAST FOUR MONTHS

- We were under-prepared for a pandemic (as was all society).
- Despite our past efforts, our patient populations were disadvantaged to survive a pandemic.
- Broadband access and data plans are social determinants of health; for many, the choice is not between a video visit and a phone visit – it is the choice between an audio visit or no visit.
- Crisis periods often bring out the best in people and organizations and broke down CHC barriers to change as demonstrated by rapid adoption of telehealth.
- Fee-for-service reimbursement doesn't work in a pandemic.
- Patients view health care provider offices and hospitals as a place of risk for infection and to be avoided when possible.

VARIED EXPERIENCE WITH TELEHEALTH DURING THE PANDEMIC



IMPACT OF COVID-19 ON HEALTH CARE ACCESS IN COLORADO

A CONTINUING CALL TO ACTION

- Optimize the impact of primary physical and BH care in the new normal environment through ongoing redesign of access to care.
- Adopt a population health approach that will proactively respond to the needs of patients and reduces disparities.
- Continue to minimize the transmission of COVID-19 to previously uninfected patients and health care staff while still effectively managing other health issues.
- Prevent and better manage the chronic conditions associated with poor outcomes from COVID-19 infection.
- Preserve the safety net primary care infrastructure for the post-pandemic period, the next wave and next pandemic.
- **MEET PATIENT SERVICE EXPECTATIONS**

Poll: Experiences/Future Plans for Telehealth

When you think about your health center's recent experiences with telehealth and your plans for the future, which of the following best describes your experiences and ongoing approach?

OPTIONS FOR THE NEW NORMAL

Return to Usual Care ASAP

Continue Modified Telehealth

Expand Virtual Care

OPTION #1

Return to Usual Care ASA

- Follow OSHA Guidance on Preparing Workplaces for COVID-19
- Keep health centers adequately stocked with the appropriate Covid-19 supplies
- All staff and visitors required to complete a brief Covid-19 symptoms health questionnaire.

A DIGITAL FRONT DOOR FOR PATIENTS

Before the Visit

- Digital self schedule
- Fill medical history
- Get reminders
- Get pre-visit tasks
- E-sign consent forms
- Pay balance / co-pay

During the Visit

- Self-check-in
- As clinically appropriate practitioner responds via secure message, telehealth or in-person

Post Visit

- Remote monitoring with peripheral devices and commercially available wearables
- Post-procedure tasks
- HIPAA compliant secure messaging
- eConsult specialty care
- Telehealth follow-up care
- Notifications and health tips

OPTION #2

Continue Modified Telehealth

- Develop a team-based approach to telehealth visit that minimizes cycle times
- Develop a hybrid visit approach with all encounters starting with a call
- Develop clinical criteria for in-person visits
- Appointment times for lab and/or immunization-only visits

Poll: Focus of Telehealth Visits

Our health center's ongoing telehealth visits (audio/visual or telephonic) will focus on:

Outreach Lead

Outreach lead is main point of contact and coordinates outreach efforts across teams. As POC, outreach lead provides weekly reporting on agreed-upon metrics, as well as key trends and concerns identified during outreach.

Outreach Team –comprised of care coordinators, CHWs and repurposed MAs, lab techs and receptionists

Conducts preliminary outreach to priority patients; screening; based on screening, referrals to other care team members and community resources.

Nursing Team

Receives referrals for medication refills and for patients with symptoms potentially requiring telehealth or face-to-face appointments.

Social Work Team

Receives referrals for patients who have very complex social needs

Behavioral Health Clinicians

Receives referrals for patient screening positive for anxiety or depression or those with chronic BH conditions

Primary Care Providers

Receives referrals from triage nurse and proactively outreaches to patients with chronic conditions including those amenable to remote monitoring

OPTION #3

Expanded Virtual Care

- Develop virtual care models of care that capitalize on remote monitoring
- Develop a staff recruitment strategy made uniquely feasible by this model of care
- Leading with those models of care, negotiate a capitated FQHC APM

THE LIMITATIONS OF RECENTLY EXPANDED TELEHEALTH RULES

- Currently only approved for the emergency period
- Restricts PPS payment to visits with both video and audio
- Video telehealth use often not applicable due to patient access to a device, broadband internet or an affordable data plan
- Restricts billable care to certain clinically licensed professionals even when use of other care team members may be preferable
- Doesn’t provide funding for some remote monitoring devices like home BP monitors, digital thermometers and simple pulse oximeters

MHN's Hypertension Management Program: *Self Monitored Blood Pressure & Resources*

Medical Home Network has created a hypertension management program (HMP) to support identified and at-risk members by using a dynamic and personalized approach.

The program has several offerings including:

- Utilization of risk screens for proactive member identification
- Machines for home Self-monitored Blood Pressure (SMBP) at no cost to the member
- Infrastructure for data collection
- Established care team relationships for outreach and a key factor for success; Provider and care team engagement.

The Script Includes:

SMBP	Outreach	Toolkit	Scheduling Follow-Up	Ongoing Monitoring
				MHNconnect

Adult Outreach Workflow: *Hypertension, BH & Diabetes (17,916 Adult ACO patients)*

"Hello, it's your care manager. Because of COVID19, I'm calling to check in with you to see how you are doing. I want to make sure you and/or your caregivers are prepared and have everything you/they need!"

HYPERTENSION | **BEHAVIORAL HEALTH** | **DIABETES**

MEDICAL HOME NETWORK ACO: COVID + HYPERTENSION AND/OR DIABETES + BH + HOME BLOOD PRESSURE MONITORING PROGRAM ENROLLMENT

Introduction: *Hello, it's _____, your care manager from _____(name of medical home). I'm from the clinic where you are assigned and (if applicable) where your provider, (provider's name) sees patients. Because of COVID19, I'm calling to check in with you to see how you are doing. I want to make sure you and/or your caregivers are prepared and have everything you/they need.* ***Do you have a few minutes to talk with me? If no, when can we reschedule this call?***

Current State of Health Regarding COVID-19: Are you experiencing any of the following? *(if you completed a COVID call with this patient in the last 7-14 days, then confirm patient is still doing well.)*

a) Emergency warning signs:(any of these-medical attention immediately: 911)
1) Difficulty with breathing or shortness of breath
2) Persistent pain or pressure in the chest
3) Confusion or severe sleepiness
4) Bluish lips or face

***This list is not all inclusive- if unsure about the symptoms or follow-up needed** (escalate to Care Team per clinic protocol)*

b) Non-emergent symptoms:
1) Fever
2) Cough
3) Mild discomfort; some shortness of breath while moving

- If patient reports any other symptoms; *(escalate to Care Team per clinic protocol)*
- Give instructions if symptoms present later to call clinic

Only go to ER/call 911 if you're having the symptoms in section 1a above (read them again)

c) Are you in need of food or shelter?
If yes, *(escalate to Care Team per clinic protocol)*
If no, no intervention necessary
[discontinue remainder of script if COVID issues are identified and address COVID issues]

[If patient does not have diagnosis of hypertension, move to Diabetes]

High Blood Pressure:

I know we have (or haven't) spoken before about your high blood pressure. I just want to check in on how you might be monitoring your blood pressure and managing your medications. Just as a reminder, people with high blood pressure can be at risk for developing worsening health conditions if their blood pressure isn't in control. I'd like to work with you to help avoid that (or skip this statement if you are already working with them on this).

1. Do you have a Blood Pressure (BP)Monitor at home? (skip if already known)

Yes: Just checking that it is still in good working order and that you are using it.

Yes; that's great. We are starting a new program here at the clinic that Dr. ____ would like for you to join. It will involve you writing down and tracking your blood pressure readings and your Care Manager calling you every 2-4 weeks to review your results. Would you be willing to join, it's really simple and it will help us keep in touch. (encourage patient to confirm their willingness)

Yes, Name will contact you to review your readings and set an outreach schedule (add patient to enrollment spreadsheet)

Script Questions Include:

- Current State of Health Regarding COVID
- Specific Screening Questions Regarding Hypertension/BH/Diabetes
- Domestic Violence Questions
- Substance Use/Medication Assisted Treatment
- Medications
- Interventions
- General COVID Reminders & Wrap-Up

CAPITATION FOR PRIMARY PHYSICAL AND BH CARE

+ Provides the unique opportunity to focus not on what is reimbursable, but rather on what our patients need:

Longitudinal primary care from the safety and convenience of their homes as clinically appropriate using the most appropriate member of the care team.

Legislative Update
Brendan Riley, Director of Policy

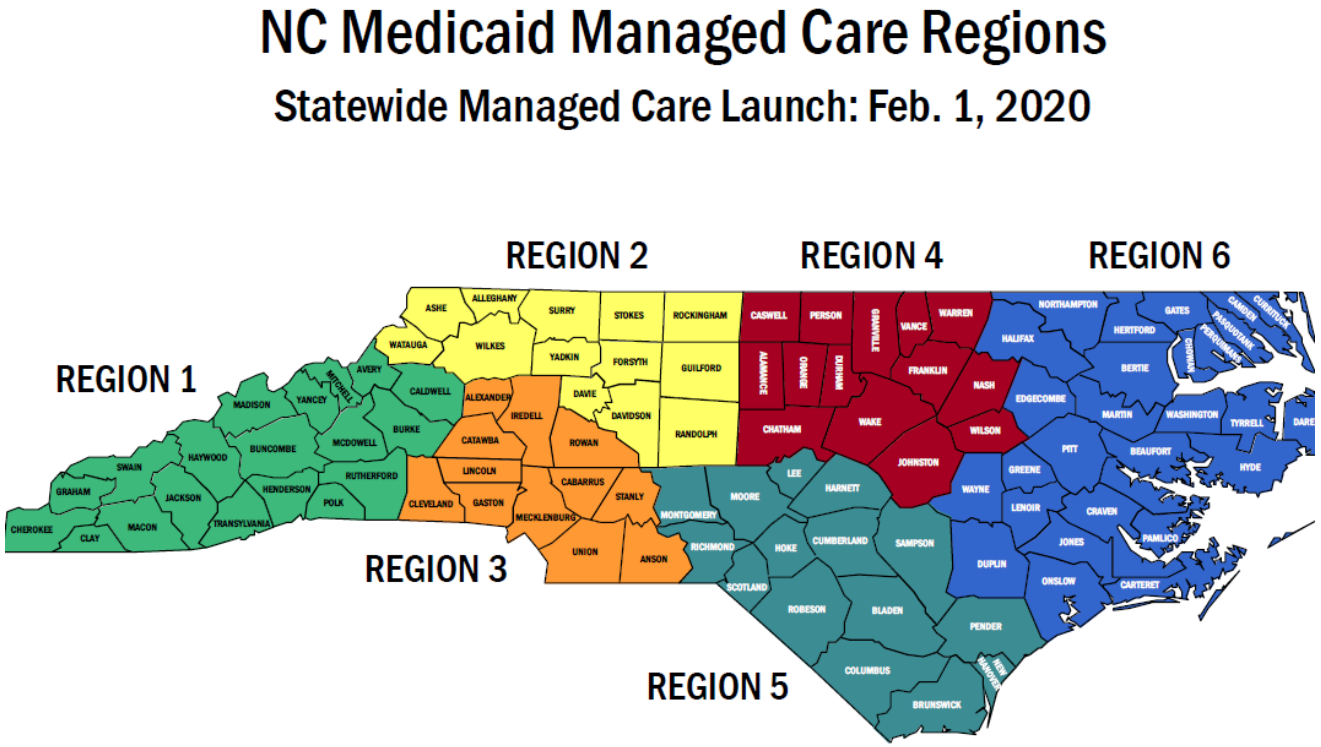
Medicaid Funding Act (S.B. 808) Signed Into Law

On July 2, Governor Roy Cooper signed Senate Bill 808, the Medicaid Funding Act, into law.

- The final legislation was fairly different from the introduced bill. The law requires Medicaid Managed Care to begin **July 1, 2021** (though the final bill removed a provision that would financially penalize DHHS for not meeting this timeline).

As they prepare for a July 1, 2021 launch, NC Medicaid wants stakeholders' perspectives about how Managed Care should roll out.

DHHS Seeks Feedback: How to Roll Out on July 1, 2021



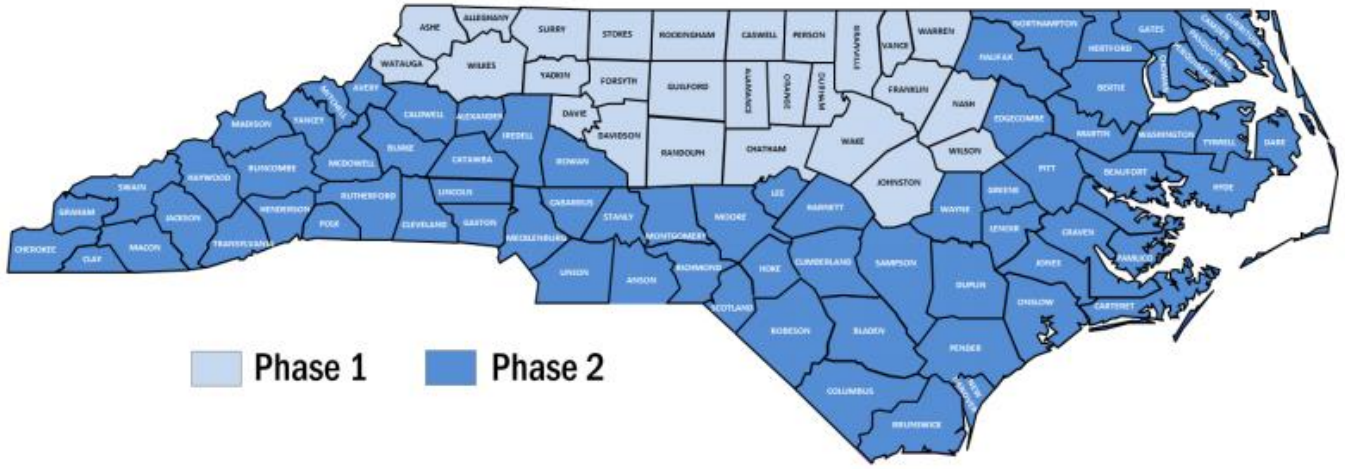
Prepaid Health Plans

- Statewide: (1) AmeriHealth Caritas; (2) Blue Cross and Blue Shield; (3) UnitedHealthcare; (4) WellCare of North Carolina
- In Regions 3, 4, and 5: Carolina Complete Health

DHHS Seeks Feedback: How to Roll Out on July 1, 2021

DHHS' Original Plans for Managed Care: Phased Regional Rollout

- Phase 1: Regions 2 and 4 go live November 1, 2019
- Phase 2: Regions 1, 3, 5, and 6 go live February 1, 2020



YOUR FEEDBACK: Pros and Cons

PHASED, REGIONAL ROLLOUT

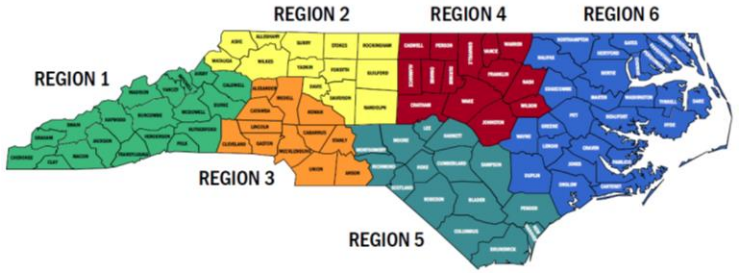
What are the advantages or benefits?

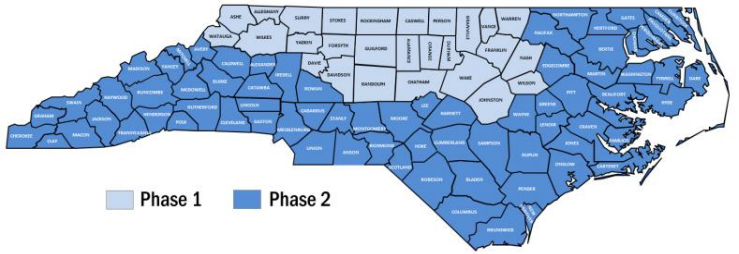
What about the challenges/drawbacks?

ONE-TIME STATEWIDE ROLLOUT

What are the advantages or benefits?

What about the challenges/drawbacks?





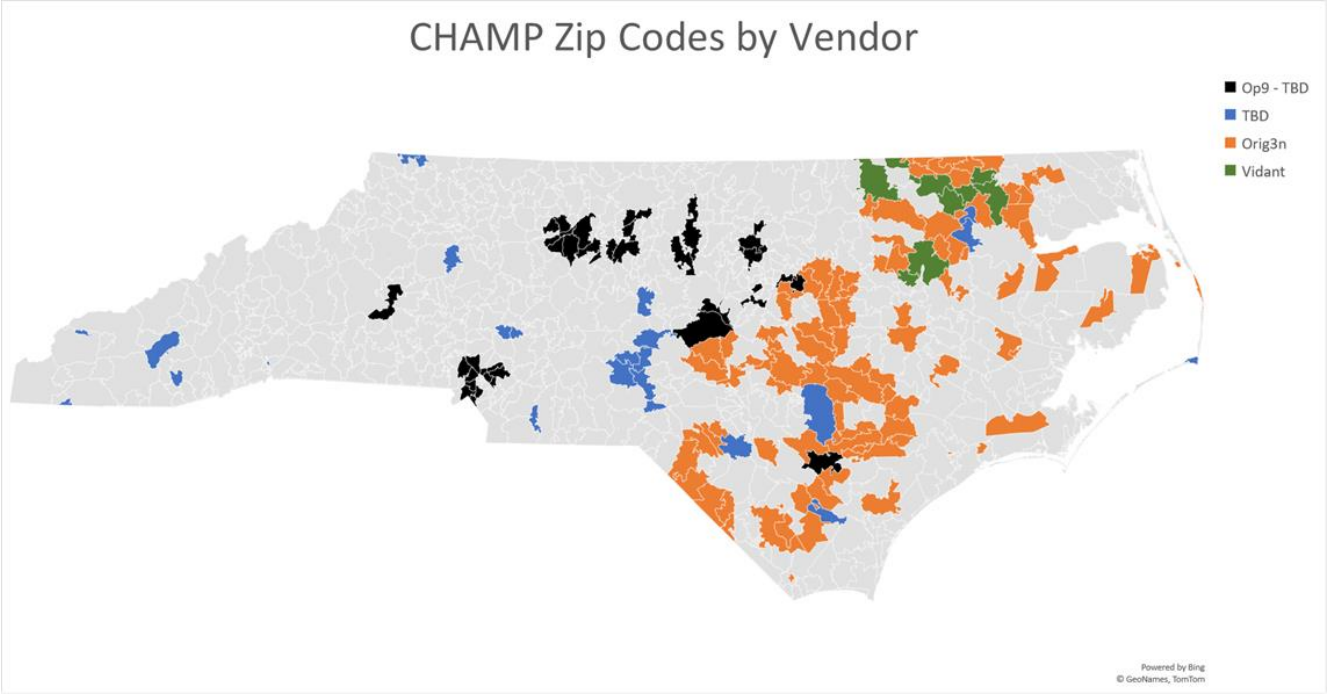
YOUR FEEDBACK

POLL: Do you prefer a regional phased rollout of Medicaid Managed Care, or a statewide rollout?

Other comments and considerations for the rollout that you'd like to share with DHHS?

State RFQ Testing Process
Chris Shank, CEO

Update on DHHS Testing Opportunities



- Select zip codes around the state. Not all zip codes fall squarely in one county, so you will see *several counties listed for some zip codes.* In DHHS current task order - awarded many of our desired zip codes to Vidant or Orig3n. Contacts for the vendors are Jacob Parrish (Jacob.Parrish@vidanthealth.com) and Kate Blanchard (kate@orig3n.com).
- The remainder will fall under DHHS' next task orders (referred to as Op9-TBD or just TBD). DHHS will continue to look for a vendor approved in the RFQ process who can provide that testing.
- Attached are the zip codes that were awarded and should expect testing sites in the coming weeks at no cost to the community.
- If a person has insurance, the testing partner will file insurance, but patients will have no copays or cost sharing. If insurance does not cover, or the patient is uninsured, there will be no cost to the patient. Testing will follow the published.
- No lab order is needed to attend a testing event.
- There are specific requirements of these testing sites including linkage to primary care, providing culturally and linguistically appropriate services, and partnering with local community leaders in the events.

Planning for Future Task Force Meetings

Poll: Future Task Force Topics

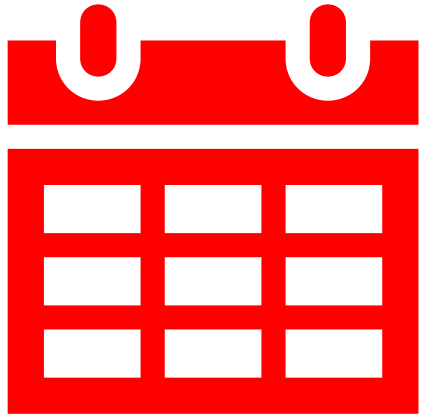
What topics would you like discussed during future Task Force meetings?

Poll: Frequency of Task Force Meetings

How often should NCCHCA host Task Force meetings?

Upcoming CHC COVID-19 Task Force Call

July 24, 10:00-11:30am



Stay connected!

www.ncchca.org/covid-19/

covid19@ncchca.org