Welcome to the 2020 NCIOM Annual Meeting

COVID-19 and the Impacts of Foregone Care

December 8, 2020

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North Carolina Institute of Medicine 2020 Annual Meeting

COVID-19 and the Impacts of Foregone Care

David Sousa, JD, MBA

Chair, Board of Directors, NCIOM

Chief Legal Officer & General Counsel, Curi

December 8, 2020

North Carolina Institute of Medicine

The NCIOM was chartered by the NC General Assembly in 1983 to:

- Be concerned with the health of the people of North Carolina
- Monitor and study health matters
- Respond authoritatively when found advisable
- Respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions

The NCIOM is a separate quasi-state agency that is housed within the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill (Sheps Center)

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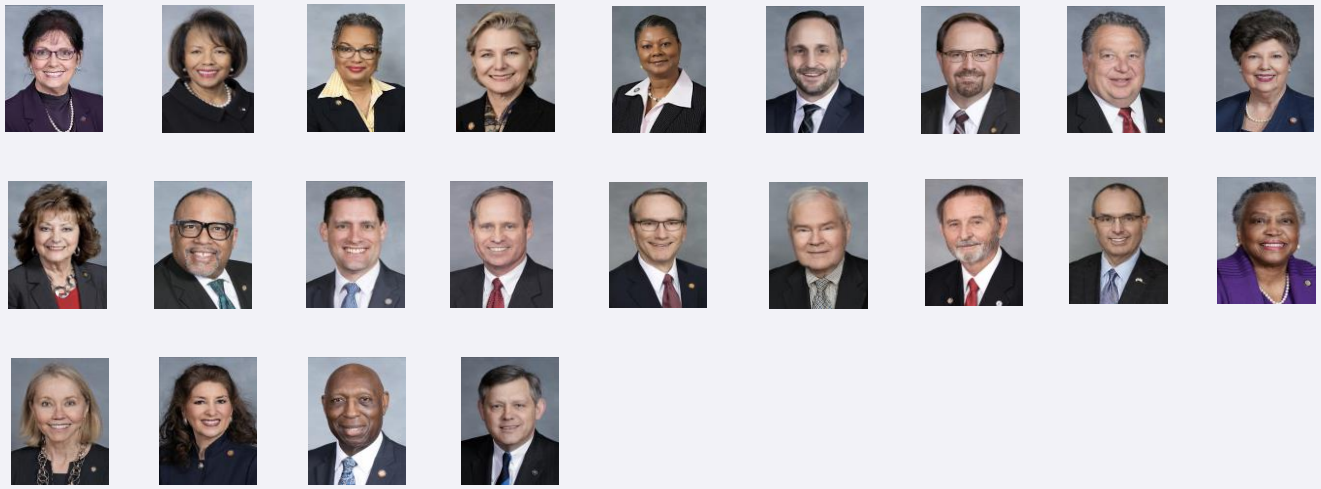
Legislative Health Policy Fellows



2018 Class

Rep. Cynthia Ball, Rep. MaryAnn Black, Sen. Angela R. Bryant, Rep. Deb Butler, Rep. Carla D. Cunningham, Rep. Josh Dobson, Sen. Chuck Edwards, Sen. Rick Horner, Rep. Pat B. Hurley, Sen. Joyce Krawiec, Sen. Paul A. Lowe, Jr., Rep. Graig R. Meyer, Rep. Gregory F. Murphy, Sen. Paul Newton, Sen. Louis Pate, Rep. Larry W. Potts, Sen. Jeff Tarte, Rep. Evelyn Terry, Sen. Terry Van Duyn, Rep. Donna McDowell White, Rep. Shelly Willingham, Sen. Mike Woodard

2020 Class

Rep. Kelly Alexander, Sen. Deanna Ballard, Rep. Lisa Stone Barnes, Rep. Mary Belk, Sen. Jim Burgin, Rep. Christy Clark, Rep. Zack Hawkins, Rep. Rachel Hunt, Rep. Verla Insko, Rep. Marcia Morey, Sen. Jim Perry, Rep. Joe Sam Queen, Rep. Wayne Sasser, Sen. Sam Searcy, Rep. Raymond E. Smith, Jr., Rep. Julie Von Haefen, Sen. Joyce Waddell, Rep. Ashton Wheeler Clemmons

NCIOM

Kathy Colville, MSPH, MSW, Named NCIOM's New President and CEO

- Kathy will step into the top leadership role at NCIOM on January 4th
- Kathy most recently led the Healthy Communities department at Cone Health which:
  - Focused on improving social conditions that improve health
  - Was the first in NC to implement NCCARE360
  - Was recognized by the CDC for its Diabetes Prevention Program
- Education:
  - Bachelor's degree in comparative literature from Brown University
  - Master's degrees in social work and public health from the University of North Carolina at Chapel Hill
  - PhD candidate in public administration at North Carolina State University

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Statement from Kathy Colville, MSPH, MSW

I'm grateful to be joining such a strong team at the NCIOM, and for the work that we will do together with you and other leaders across NC to build stronger systems of health. Let's make foregone care – whether due to pandemic, language barriers, lack of insurance, lack of transportation, whatever reason – a thing of the past in NC. We can do this.

Thank you. Stay safe and well this season.

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2020 Annual Meeting

- Beyond the direct impact of COVID-19 on individuals affected with the virus, what is the broader population health and financial impact of this foregone care during a pandemic?
- Today's speakers will examine the national and North Carolina context
  - Population health impact of foregone care, including impact on health equity
  - Financial impact of foregone care to health systems, providers, and payers, and continued effect of changes to payment policy (including guidance on low value care and changes to telehealth policies)

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Welcome to the 2020 NCIOM Annual Meeting

Tuesday, December 8, 2020

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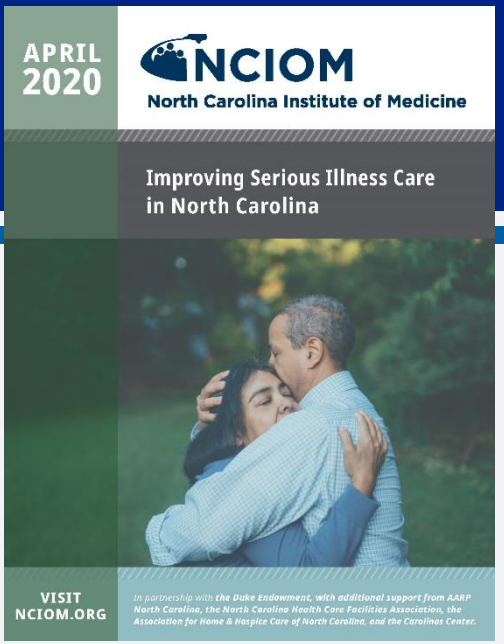
Agenda

- **Overview of 2019-2020 NCIOM Activities**
- **Recent and Current Work**
- **North Carolina Medical Journal**
- **Overview of Today's Agenda**
- **Special Thanks**

Improving Serious Illness Care in North Carolina



Task Force convened April 2019-January 2020; report published April 2020. Funded by the Duke Endowment, with additional support from AARP North Carolina, the North Carolina Health Care Facilities Association, the Association for Home & Hospice Care of North Carolina, and the Carolinas Center

Vision Statement: A system and culture that prioritizes quality of living for people with serious illness, their families, and their communities.

Task Force developed 30 recommendations across the following areas:

- Health system and social change to address serious illness care
- High-quality person-centered care
- Engagement with patients and families to meet goals of care
- Development of the health and human services workforce and infrastructure to support serious illness care

NC Serious Illness Coalition launched in February 2020 to coordinate implementation of the Task Force recommendations. The Coalition has several work groups and over 130 members across the state. NCIOM currently working with Coalition to develop a white paper with additional background research to support the advance care planning recommendations from the Task Force

NORTH CAROLINA SERIOUS ILLNESS COALITION

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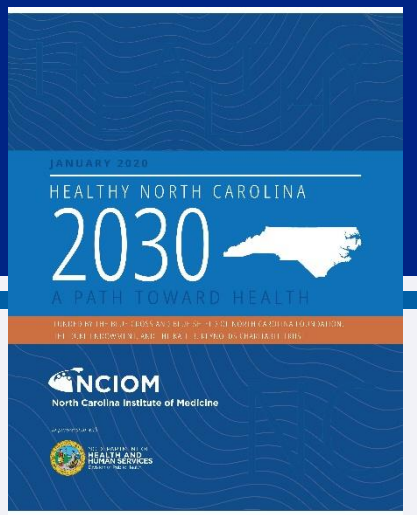
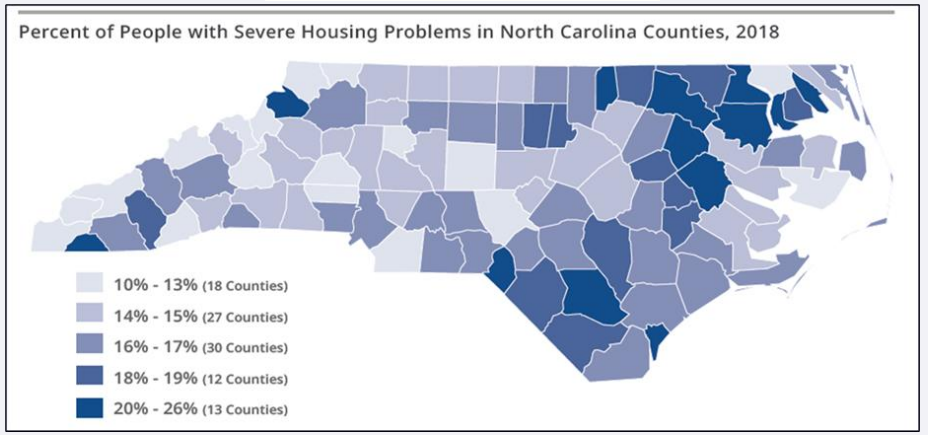
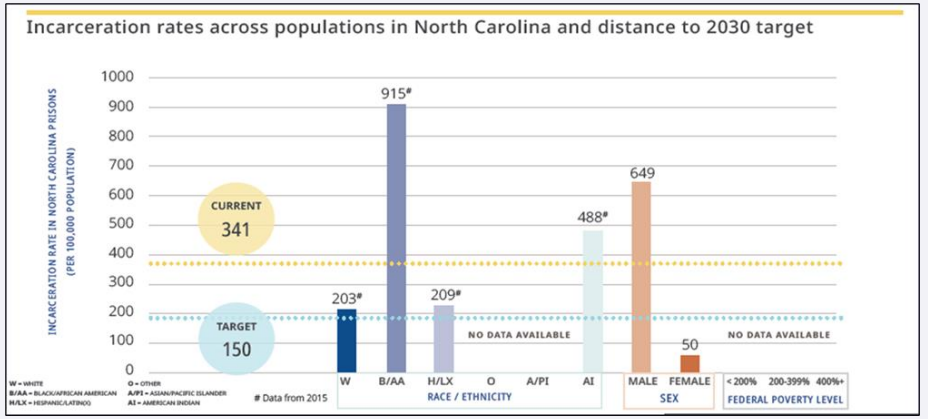
Healthy North Carolina 2030



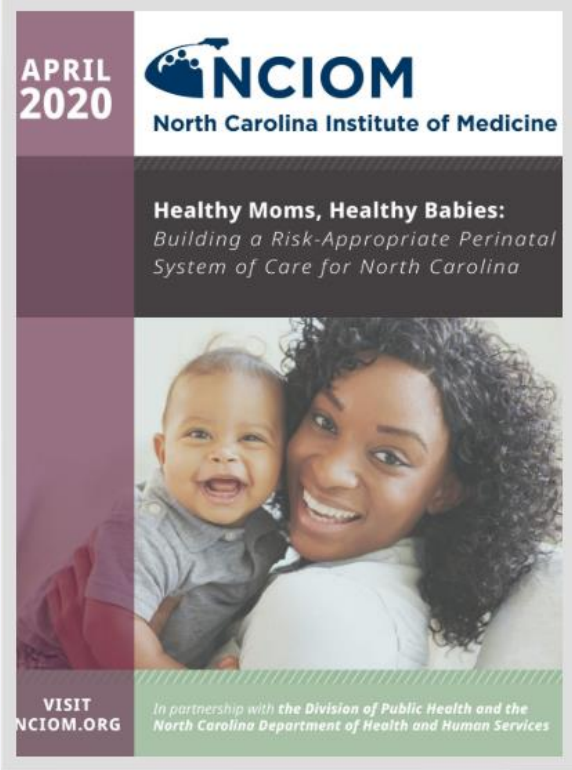
- Co-chairs: Dr. Ronny Bell, Mr. Jack Cecil, Dr. Laura Gerald, Dr. Betsey Tilson
- 4 working groups, 8 community meetings across NC
- Identified 20 indicators that will serve as springboard for the population health improvement plan for the North Carolina Division of Public Health. Focused on health equity and the overall drivers of health outcomes (health behaviors, clinical care, social and economic factors, and the physical environment)
- Funding: The Duke Endowment, Kate B. Reynolds, BCBS NC Foundation





Healthy Moms, Healthy Babies: Building a Risk-Appropriate Perinatal System of Care for North Carolina

- Response to SL 2018-93 proposed by Child Fatality Task Force
- This task force met a total of 11 times throughout 2018-2019 and developed actionable and evidence-based recommendations outlining a process for implementing a regionalized and risk-appropriate perinatal system of care in the state.
- Recommendations aim to use a regionalized and risk-appropriate perinatal system of care approach as a tool for decreasing the number of infant and maternal mortality and morbidity occurrences in the state, and the subsequent disparities that lie within them.
- Funded by North Carolina Department of Health and Human Services. Published July 2020



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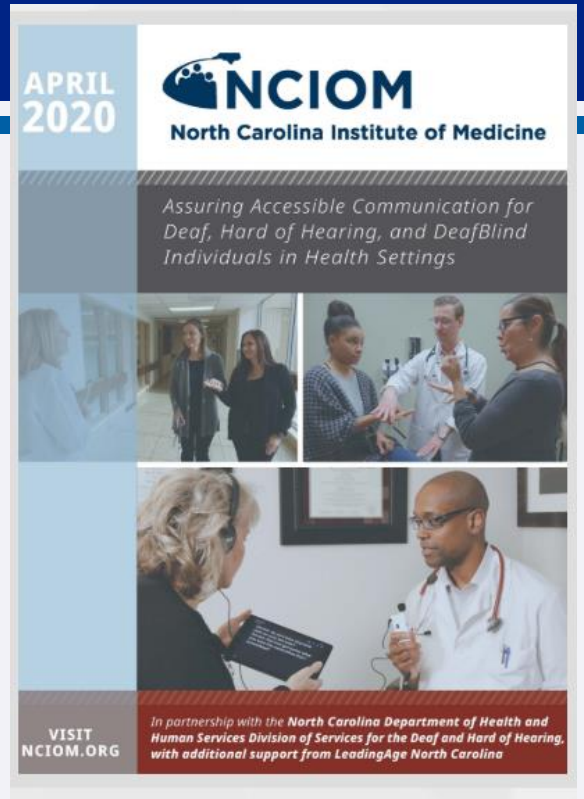
Access to Care for People that are Deaf and Hard of Hearing



- Convened to study the current state and limitations of health services for the deaf and hard of hearing population in North Carolina and the consequences of those limitations.
- The task force met a total of 7 times in 2019 and developed consensus-based recommendations focused on:
  - educating the health care workforce and Deaf and Hard of Hearing consumers through the development and dissemination of educational materials;
  - quality improvement and self-assessment of the policies, procedures, and system practices of health care systems and medical practices;
  - and quality improvement and self-assessment of the policies, procedures, and system practices of long-term care facilities.
- Funded by North Carolina Department of Health and Human Services. Report published June 2020.

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Task Force on Maternal Health

- Starting summer 2020, the NCIOM convened the Task Force on Maternal Health in partnership with the North Carolina Department of Health and Human Services Division of Public Health.
- The task force's goal is to identify evidence-based solutions to improve maternal health outcomes, reduce maternal health disparities, and promote maternal health equity in North Carolina.
- The task force will guide and develop a Maternal Health Strategic Plan for the state, which will include policy recommendations based upon the evidence-based solutions identified by the task force.
- The task force will also build upon the work of the NCIOM Perinatal Systems of Care Task Force and will align with the state's Perinatal Health Strategic Plan and Early Childhood Action Plan.

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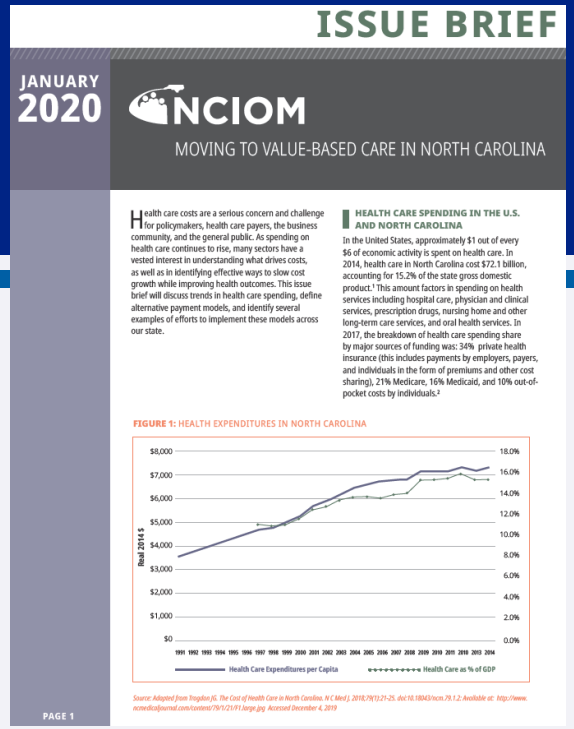
Legislative Health Policy Fellows

- Second cohort of Legislative Health Policy Fellows graduated in January 2020
- Special focus issue brief: Moving to Value-Based Care in North Carolina
- Additional health policy forums included one for legislative staff that included four two-hour sessions and another for AARP staff and key volunteers that included six two-hour sessions. Sessions covered a range of topics relevant to health care and health policy in North Carolina.


ISSUE BRIEF

JANUARY 2020

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MOVING TO VALUE-BASED CARE IN NORTH CAROLINA

Health care costs are a serious concern and challenge for policymakers, health care payers, the business community, and the general public. As spending on health care continues to rise, many sectors have a vested interest in understanding what drives costs, as well as in identifying effective ways to slow cost growth while improving health outcomes. This issue brief will discuss trends in health care spending, define alternative payment models, and identify several examples of efforts to implement these models across our state.

HEALTH CARE SPENDING IN THE U.S. AND NORTH CAROLINA

In the United States, approximately $1 out of every $6 of economic activity is spent on health care. In 2014, health care in North Carolina cost $72.1 billion, accounting for 15.2% of the state gross domestic product.[1] This amount factors in spending on health services including hospital care, physician and clinical services, prescription drugs, nursing home and other long-term care services, and oral health services. In 2017, the breakdown of health care spending share by major sources of funding was: 34% private health insurance (this includes payments by employers, payers, and individuals in the form of premiums and other cost sharing), 21% Medicare, 16% Medicaid, and 10% out-of-pocket costs by individuals.[2]

FIGURE 1: HEALTH EXPENDITURES IN NORTH CAROLINA

Source: Adapted from Yeaglue JG. The Cost of Health Care in North Carolina. N C Med J. 2018;79(1):21-25. doi:10.18043/ncm.79.1.2. Available at: http://www.ncmedicaljournal.com/content/79/1/21/F1.large.jpg. Accessed December 4, 2019

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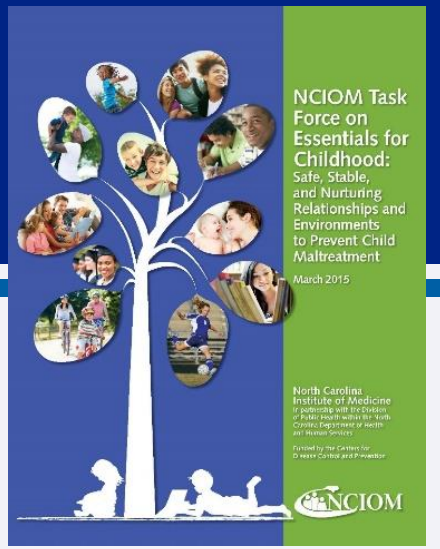
Essentials for Childhood



- Funded by NC DHHS with support from the Centers for Disease Control and Prevention
- Provides support for strategies to promote family-friendly workplace policies to strengthen families' economic stability and promote child and family well-being. NCIOM supports: MomsRising, Prevent Child Abuse North Carolina, North Carolina Early Childhood Foundation, and NC Child
- This funding also supports NCIOM's facilitation of the Stakeholder Workgroup on Strengthening the North Carolina Child Fatality Prevention System. This work-group builds upon recommendations from the Child Fatality Task Force to strengthen the statewide child fatality prevention system through consolidating teams that review child deaths and creating a centralized data and information system
- North Carolina Child Health Report Card – will be published in partnership with NC Child in March 2020. Special focus: Impact of COVID-19 on children and families

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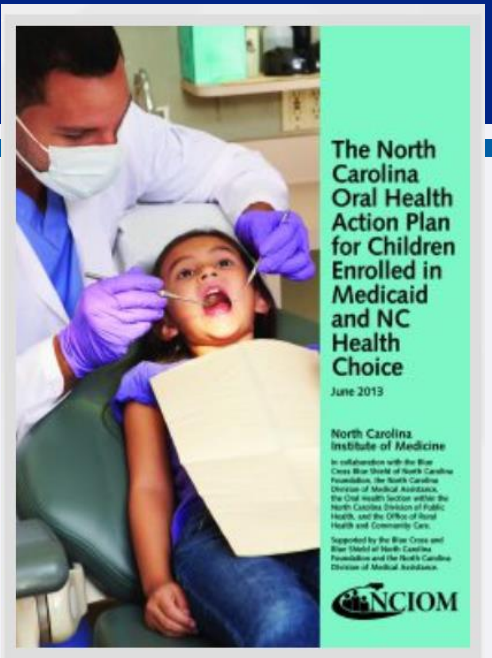
Updates on Task Force Recommendation Implementation



- Ten Years of the Affordable Care Act: Update on Implementation of Recommendations from the 2013 Report on the Impact of the ACA
  - 44 total recommendations
  - 10 fully implemented
  - 25 partially implemented
  - 9 not implemented
- 2013 Task Force on Children's Preventive Oral Health Services
  - 14 total recommendations
  - 2 fully implemented
  - 11 partially implemented
  - 1 not implemented

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COVID-19 Response: Convenings and Communication

- North Carolina COVID-19 Vaccine Advisory Committee: Convened in partnership with NC DHHS to synthesize feedback on NC COVID-19 Vaccination Plan. Includes public health experts, health care providers, advocacy organization leaders, and representatives of essential workers and at-risk populations. Committee provides expert guidance on the development of the plan, supports its successful operationalizing, and informs public awareness work, especially for prioritized and historically marginalized populations.
- Legislative issue briefs: Partnered with South Carolina Institute of Medicine & Public Health during the COVID-19 pandemic to monitor state and federal actions to address the health, economic, and social fallout of the crisis. Two issue briefs detailed federal legislation passed by Congress in March and discussed recommendations for phased reopening, state-specific actions, the status of funds allocated by previous federal actions, and a summary of the federal Paycheck Protection Program and Health Care Enhancement Act.
- Developed series of blog posts featuring data and analysis on the ways that key issues and recommendations identified by recent NCIOM task forces and stakeholder groups have been impacted by the pandemic, including telehealth access, advance care planning, paid leave policies, health insurance coverage, and financial impact on rural hospitals.
- In March-April 2020, NCIOM partnered with the NC Medical Society and the NC Healthcare Association to convene a Scarce Critical Care Resource Allocation Advisory Group to raise awareness and obtain community input on a draft revised protocol for allocating scarce inpatient critical care resources during the crisis stage of a pandemic.

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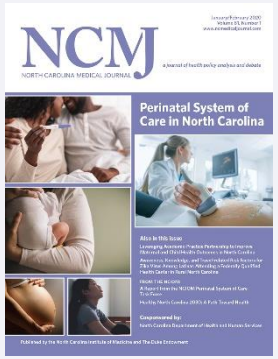
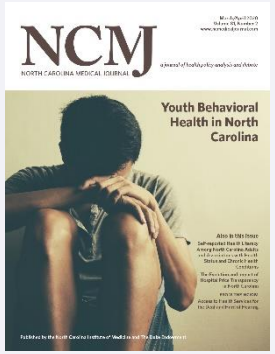
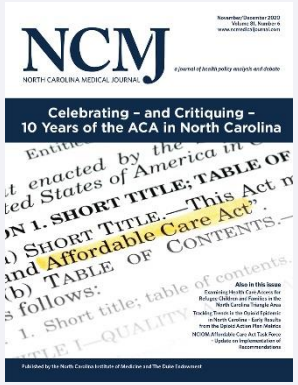
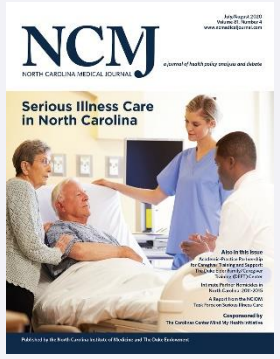
2019-2020 Issues

NCMJ continues to reach approximately 170,000 readers electronically and about 4,000 in print. In 2020 the NCMJ experienced a spike in interest from authors wishing to contribute scientific articles, with more than 50 submissions as of December 1, a new record.









Recent Issues:

Health of Incarcerated Populations

Perinatal System of Care

Youth Behavioral Health

Vital Directions for NC

Serious Illness Care

Health Impacts of a Changing Climate

Celebrating – and Critiquing - 10 Years of the ACA in NC

Upcoming Issues:

Covid-19 and Drivers of Health

Vaccination in North Carolina

North's Carolina's Public Health Accomplishments

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Today's Agenda

Keynote Speaker
Cynthia Cox, MPH
Vice President and Director for the Program on the ACA
Henry J. Kaiser Family Foundation

Clinical and Population Health Impacts:
Emmanuel Zervos, MD
Surgical Oncologist
Vidant Health

Ophelia Garmon-Brown, MD
Chief Community Wellness and Health Equity Executive
Novant Health

Payment and Financing Impacts:
Ish Bhalla, MD
Associate Medical Director of Behavioral Health Value Transformation
Blue Cross NC

Karen Smith, MD, FAAFP
Family Physician in Raeford, NC
2017 National Family Physician of the Year

Lisa Shock, DrPH, MHS, PA-C
Executive Director of Clinical Delivery, Global Operations,
and Integrated Care
Babylon Health

Impacts on Low-Value Care:
Corinna Sorenson, PhD, MHSA, MPH
Assistant Professor in Population Health Sciences and Public Policy, Duke University
Core Faculty Member, Duke-Margolis Center for Health Policy

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- And for those inclined, consider financial support to help advance our mission. This support will help us produce more issue briefs, additional analysis, and improved communication.

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- Attendees can post questions for panelists in the “Questions” section of the control panel. NCIOM staff will be reviewing questions and asking them during discussion time
- If you are having technical problems with GoToWebinar, please email nciom@nciom.org with questions
- Note: In GoToWebinar, attendees can not ask questions via audio

Keynote: A Check-Up of the Health System

Cynthia Cox, MPH

Vice President and Director for the Program on the ACA

Henry J. Kaiser Family Foundation

A Check-Up of the Health System:

How the Pandemic has Changed Health Costs, Quality, Access, and Outcomes

Cynthia Cox, MPH

December 8, 2020

KFF

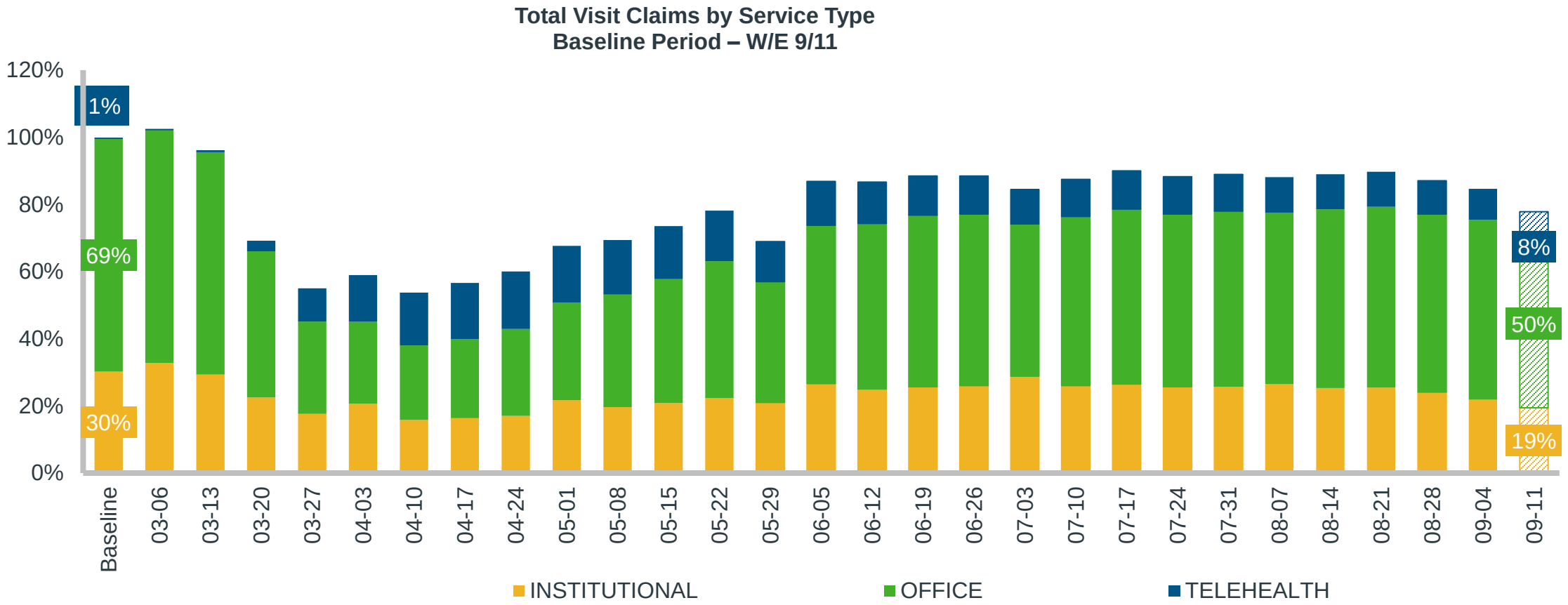
Filling the need for trusted information on national health issues.

The COVID-19 Pandemic has Affected All Aspect of The U.S. Health System, in 2020 and Beyond

- Costs/Spending
- Access/Affordability
- Quality of Care
- Health Outcomes

KFF

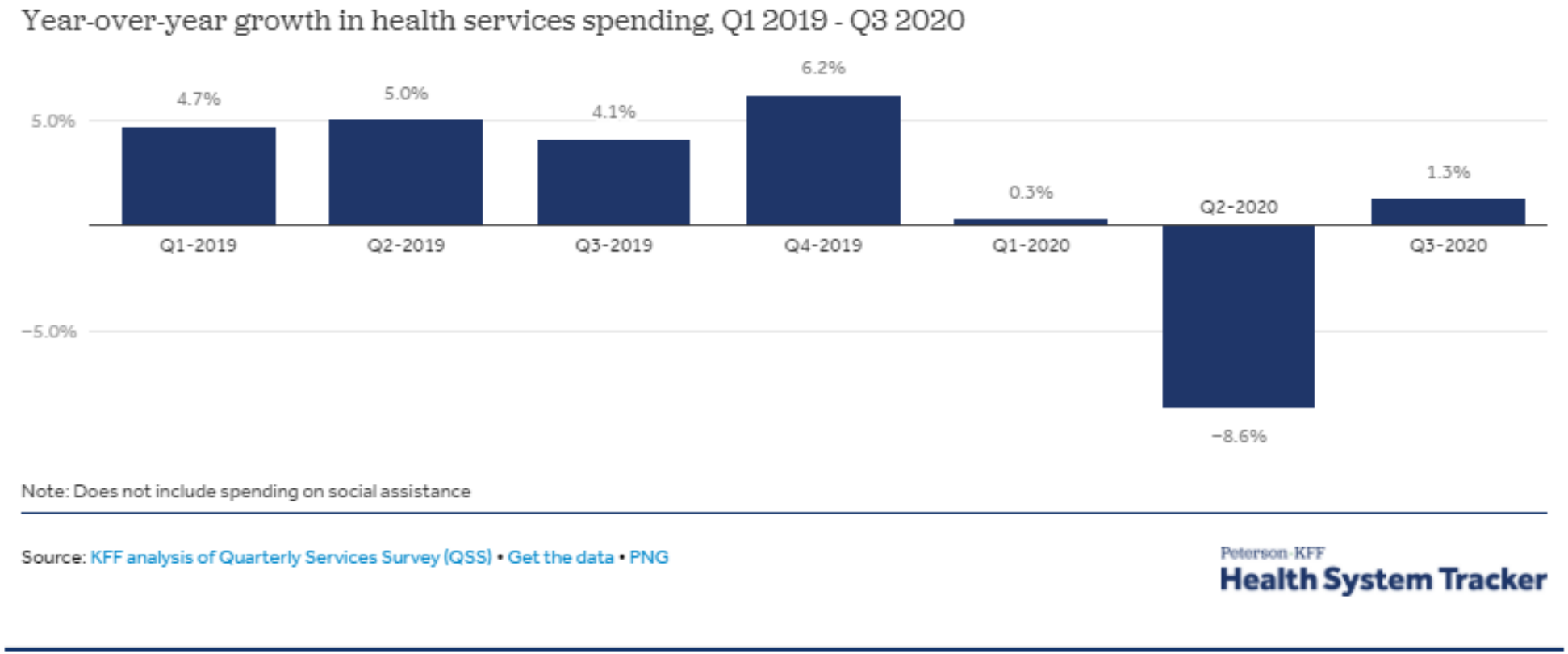
After falling in spring, claims have rebounded to a steady 80% of pre-COVID baseline with 8-10% from strongly adopted telehealth



Data for latest week date controlled against prior periods; estimates have been applied to reflect anticipated late-adjudicated claims based on historical rates

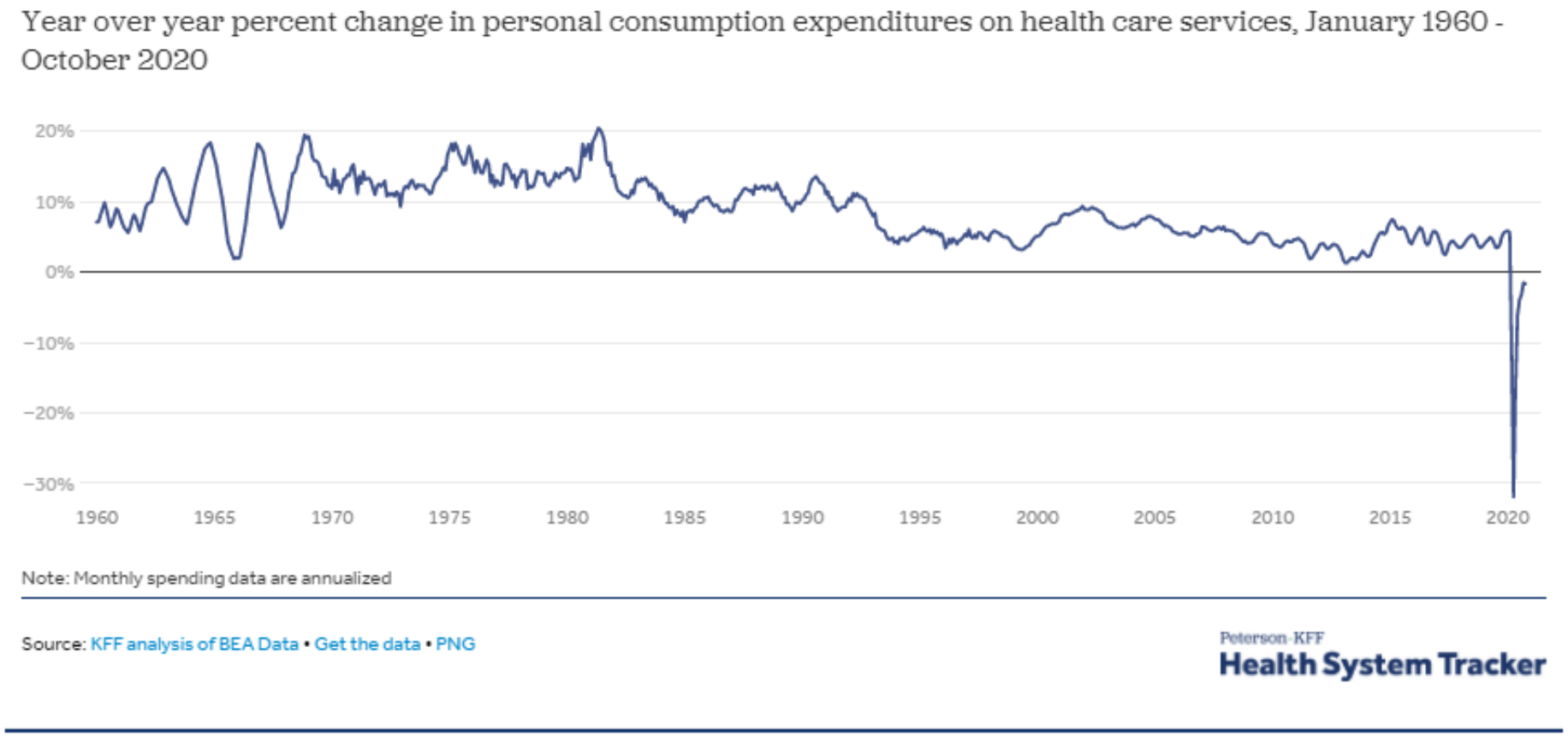
Source: IQVIA: Medical Claims Data Analysis, 2020; Baseline = Average of claims for period W/E 1/10/2020-2/28/2020,
Estimated amounts for latest weeks applied based on likely claims still to be received due to data latency or claim processing delays; See Appendix for further details

Health Services Revenue Plummeted in Spring 2020



KFF

This drop in spending was truly historic, but spending has since mostly rebounded



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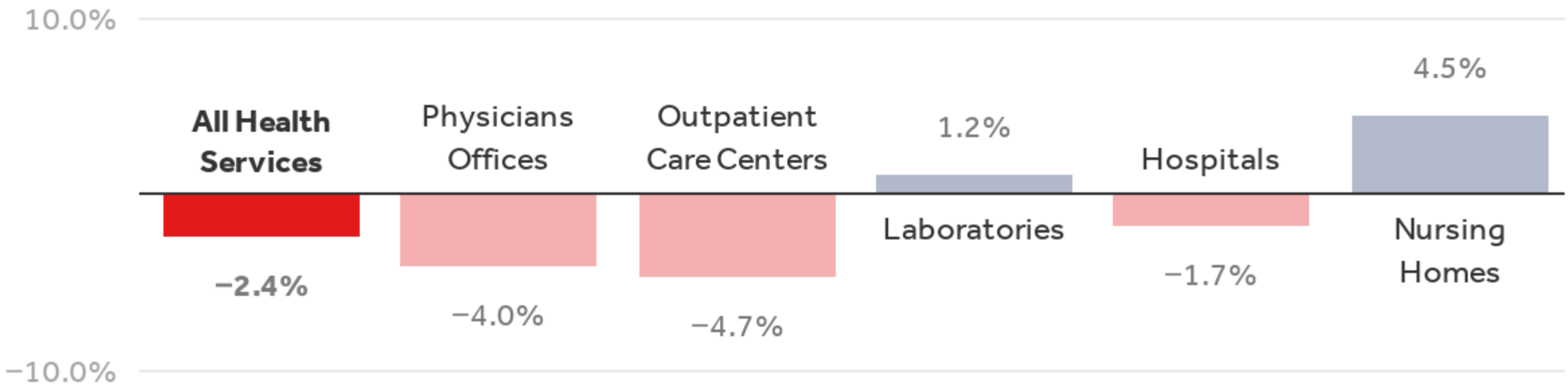
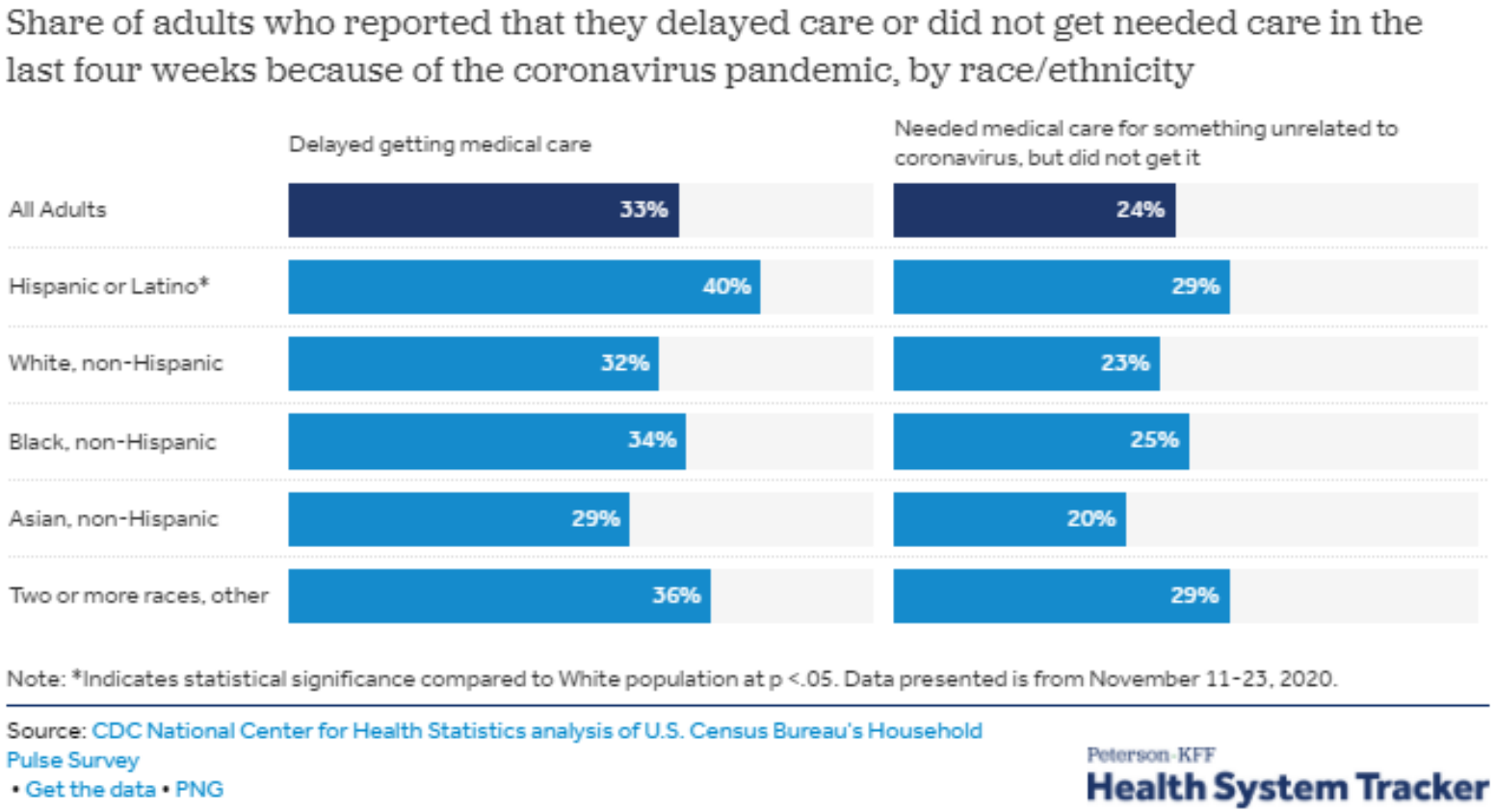
Year-to-date health spending has fallen most in physician and dentist offices and other outpatient settings



Source: Peterson-KFF Health System Tracker. KFF Analysis of Quarterly Services Survey Data

KFF

One third of adults report delaying medical care because of the coronavirus pandemic



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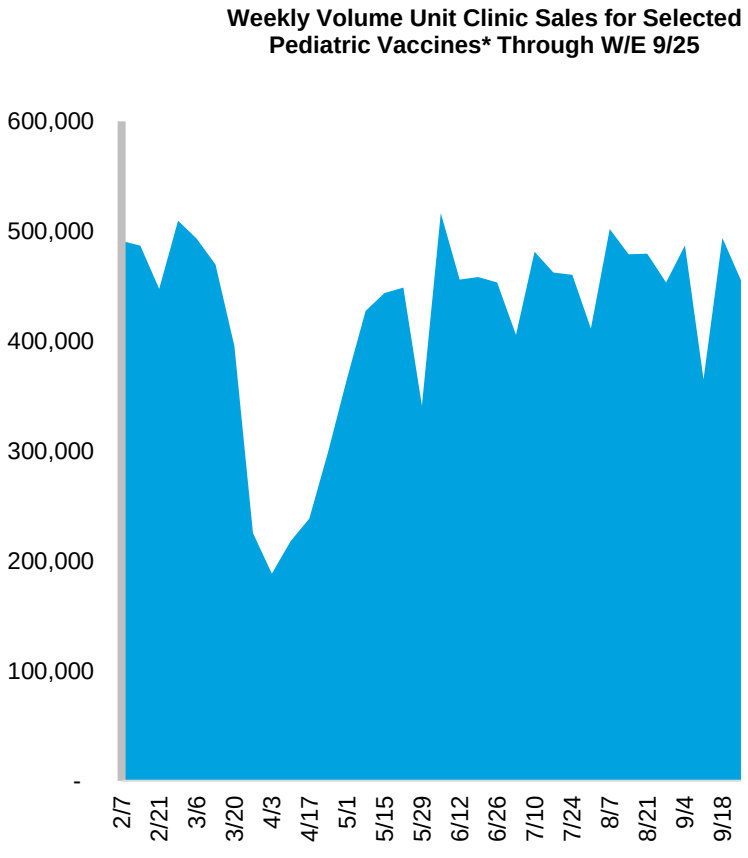
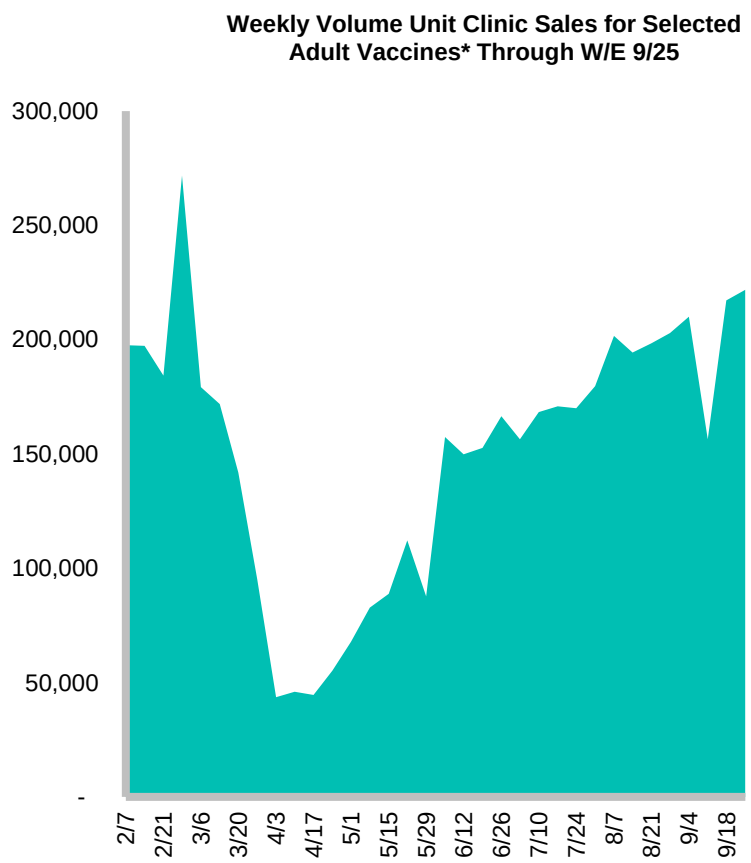
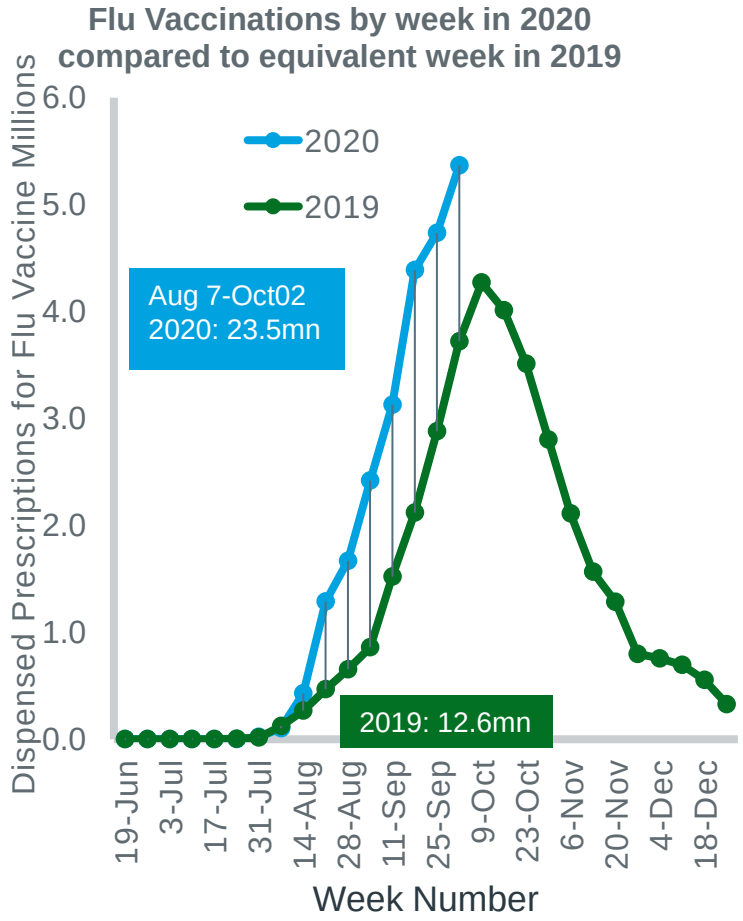
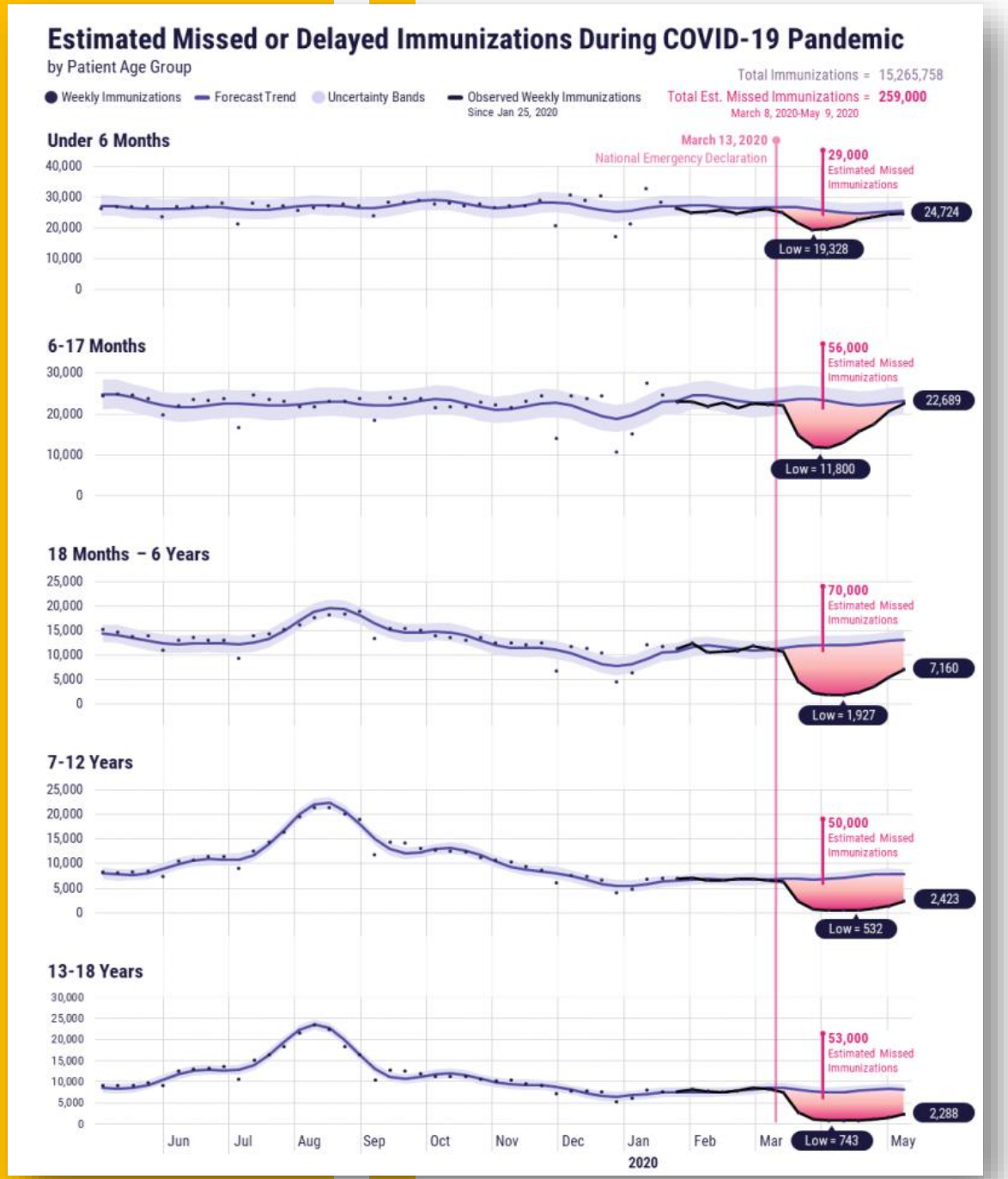
Pediatric and adult vaccinations were severely impacted early in COVID but have returned to more normal levels; Flu vaccinations a bright spot in 2020





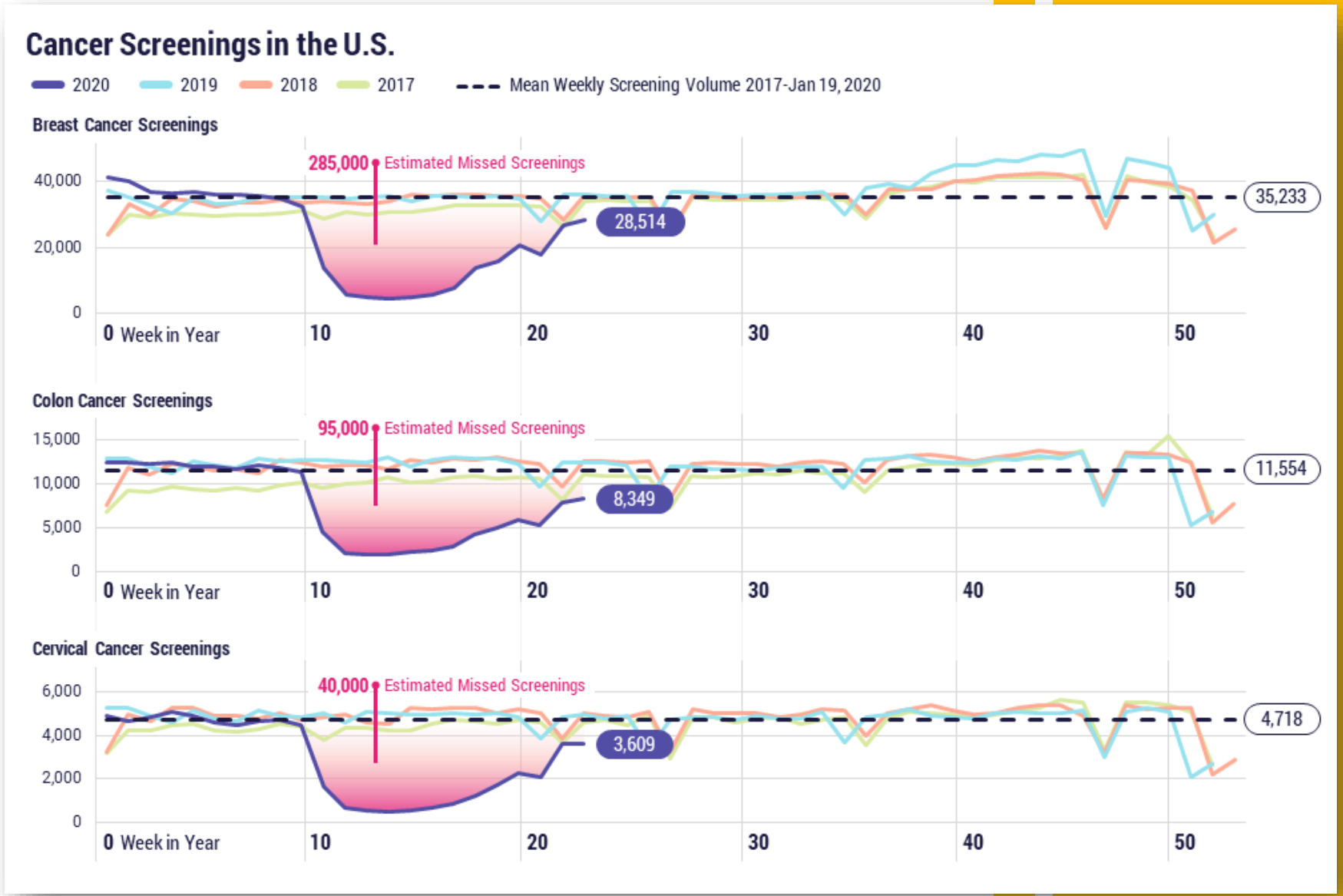


Source: IQVIA Weekly Sales Perspectives (WSP), February – June 2020; Note: **Data reflects sales to clinic channel as defined by IQVIA – No methodology has been applied to determine VACCINE USE BY AGE;** Source: IQVIA NPA Weekly, Week ending Oct 02, 2020



Pediatric Immunizations Drop in the Wake of COVID-19

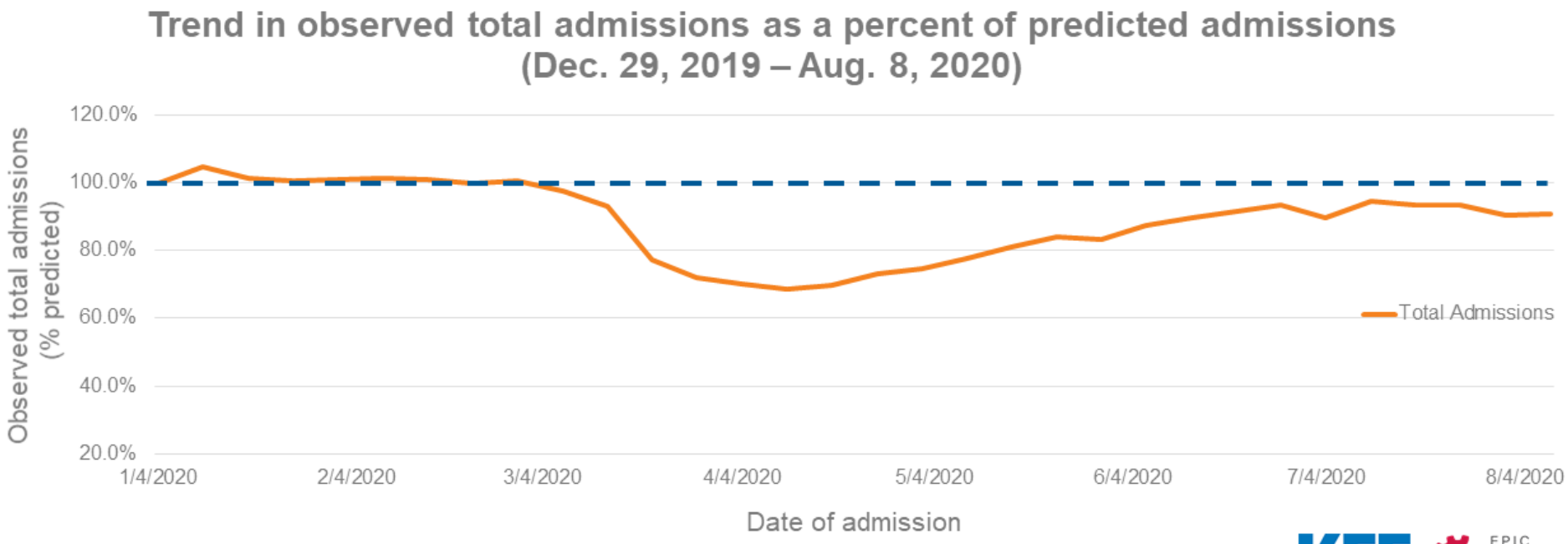
Delayed Cancer Screenings



Trends in Overall and Non-COVID-19 Hospital Admissions

Figure 1

Overall Admissions Decreased in March and April but Were Back at About 95% of Predicted Admissions by July 2020



SOURCE: Epic and KFF analysis of Epic Health Record System COVID-19 related data as of September 2020.

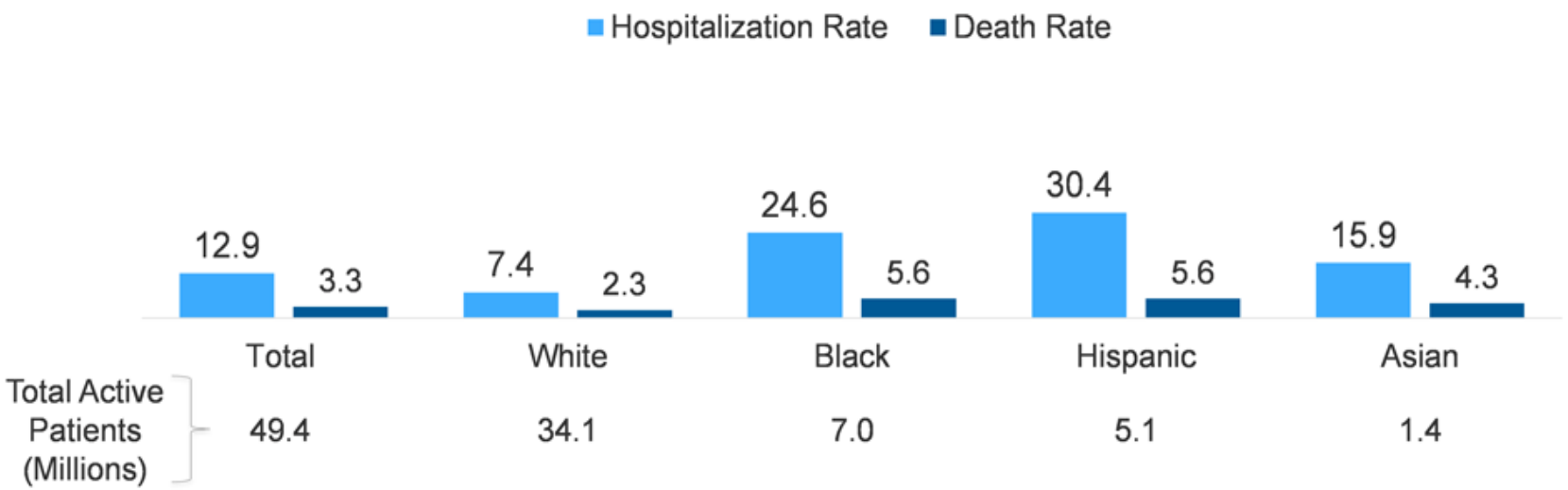
KFF HENRY J KAISER FAMILY FOUNDATION

EHRN EPIC HEALTH RESEARCH NETWORK

Figure 5

COVID-19 Hospitalization and Death Rates among Active Epic Patients by Race/Ethnicity, as of July 2020

Share of active Epic patients who were hospitalized and share who died, per 10,000:



NOTE: Rates for Black, Hispanic, and Asian patients are statistically significantly different from White patients at the p<0.05 level. Persons of Hispanic origin may be of any race but are categorized as Hispanic; other groups are non-Hispanic. Data for other racial groups not shown due to insufficient data.

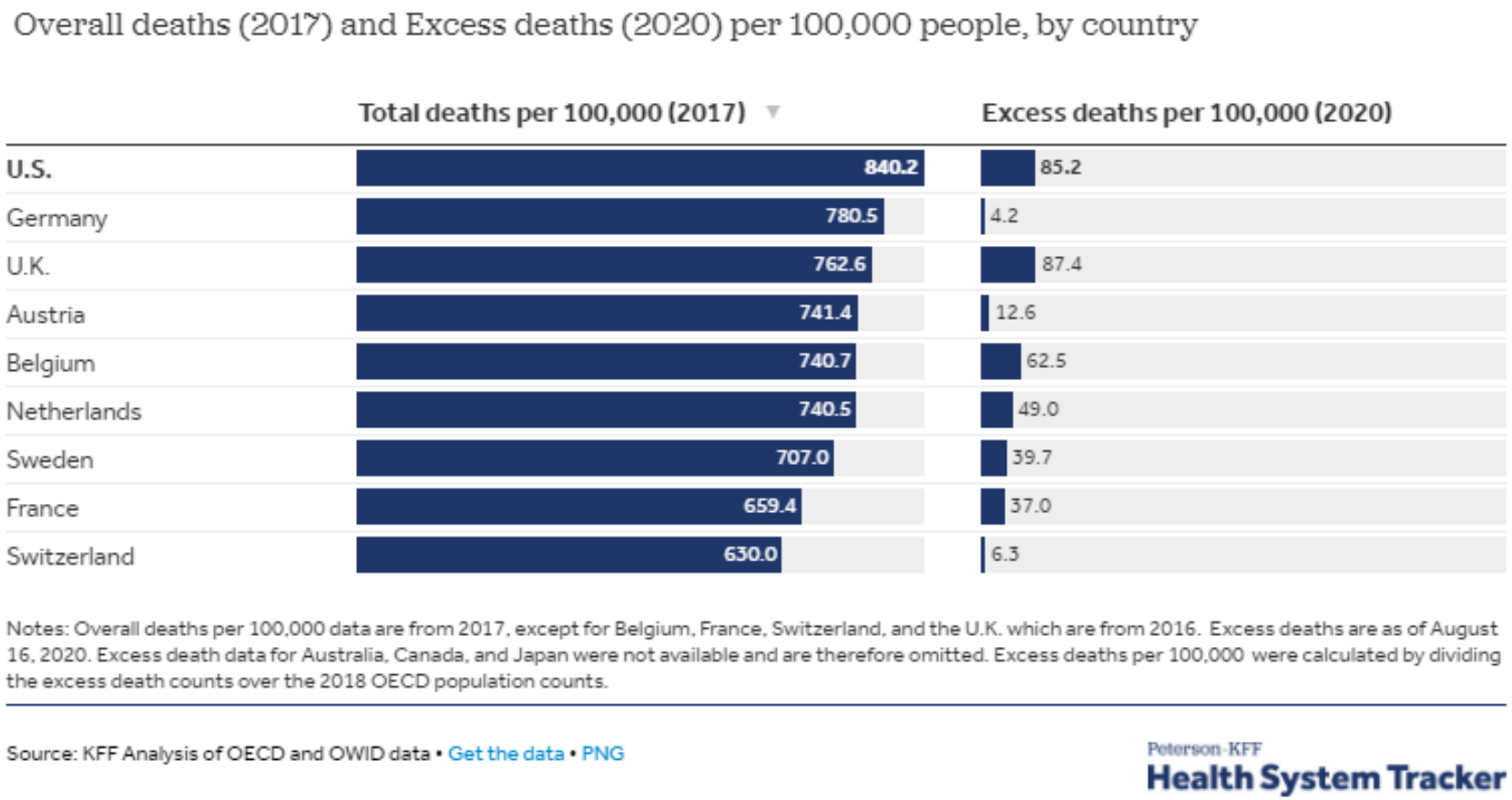
SOURCE: Epic and KFF analysis of Epic Health Record System COVID-19 related data as of July 2020.

KFF HENRY J KAISER FAMILY FOUNDATION

EHRN EPIC HEALTH RESEARCH NETWORK

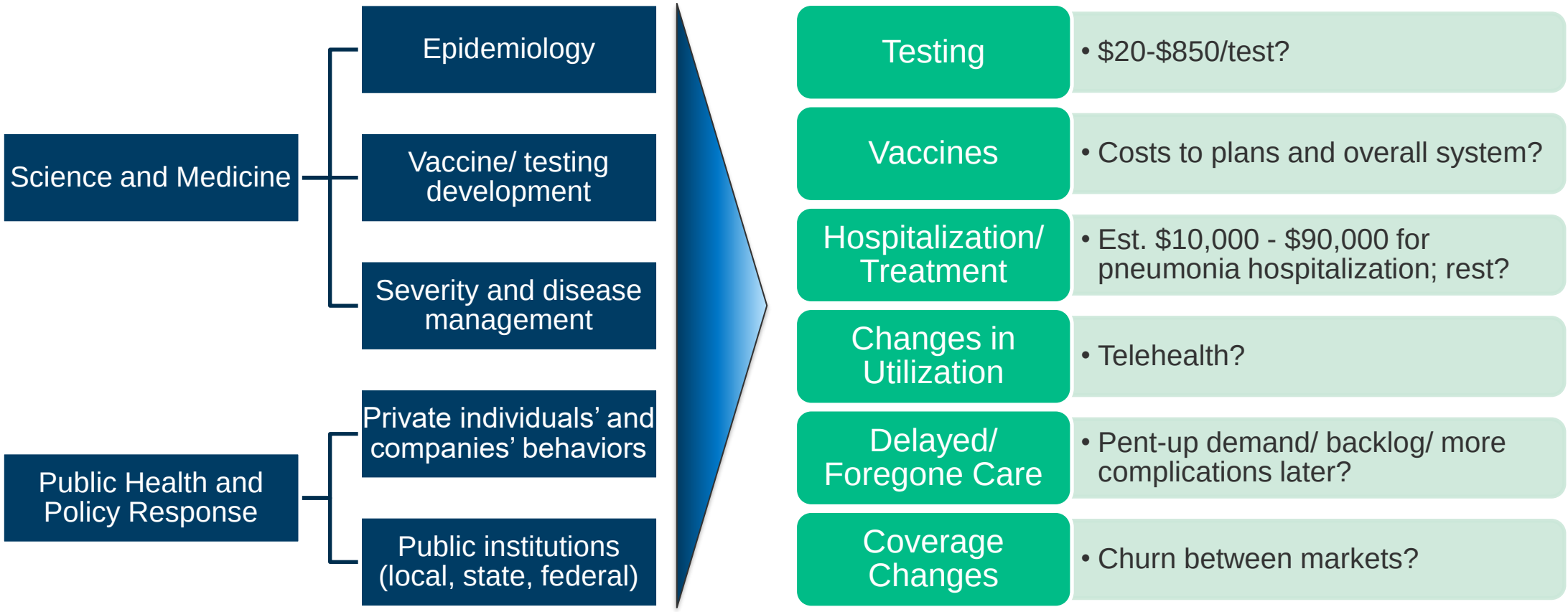
COVID-19 Racial Disparities in Testing, Infection, Hospitalization, and Death: Analysis of Epic Patient Data

The pandemic is worsening the mortality gap between the U.S. and peer countries



KFF

Uncertainty Due to COVID-19 Affects Various Drivers of Future Health Insurance Enrollment, Premiums, and Claims Costs



Sources: Peterson-KFF Briefs Available at: https://www.healthsystemtracker.org/brief/how-health-costs-might-change-with-covid-19/, https://www.healthsystemtracker.org/brief/covid-19-test-prices-and-payment-policy/

KFF

2021 Premium Changes in the ACA Marketplace

- Modest increase in overall rates: **1.1% (median)**
- So far in 2020, insurers have remained profitable and loss ratios have been low

Overall Rate Change and COVID-19 Load Among ACA Marketplace Plans		
	Overall Rate Increase	**Impact of COVID-19 on Rates** (among insurers with unredacted justifications)
25th Percentile	-3.5%	0.0%
Median	**1.1%**	**0.0%**
75th Percentile	4.6%	2.0%

Sources:
2021 Premium Changes on ACA Exchanges and the Impact of COVID-19 on Rates. https://www.kff.org/private-insurance/issue-brief/2021-premium-changes-on-aca-exchanges-and-the-impact-of-covid-19-on-rates/

KFF

The State of the U.S. Health System in 2020

- **Spending** is falling, but driven by drops in utilization
  - Recent rebound in spending -> pent up demand?
  - Health employment coming back
- **Access** is suffering
  - Some of this care may have been “nice to have”
  - Other, high value, care is being delayed
- **Mortality** rate gap is growing between U.S. and peers
  - Disparities may also be worsening
- **Uncertainty** ahead in 2021 and beyond

KFF

Clinical Impacts of Foregone Care

Emmanuel Zervos, MD, MBA

Executive Director, Vidant Cancer Care

Raab Distinguished Professor of Adult Oncology, East Carolina University

Ophelia Garmon-Brown, MD, M.Div

Senior Vice President and Chief Community Wellness and Health Equity Executive

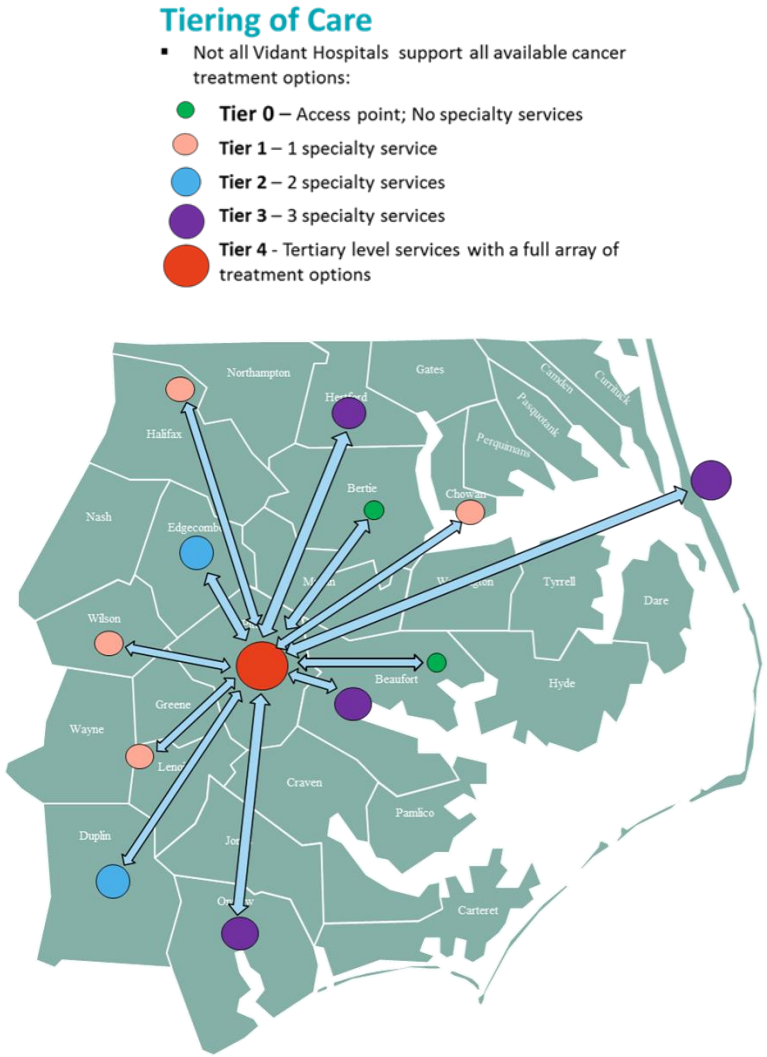
Novant Health

COVID-19
Impact and consequences on a rural cancer care delivery model

Emmanuel Zervos, MD, MBA
Executive Director, Vidant Cancer Care
Raab Distinguished Professor of Adult Oncology
East Carolina University

Vidant Cancer Care

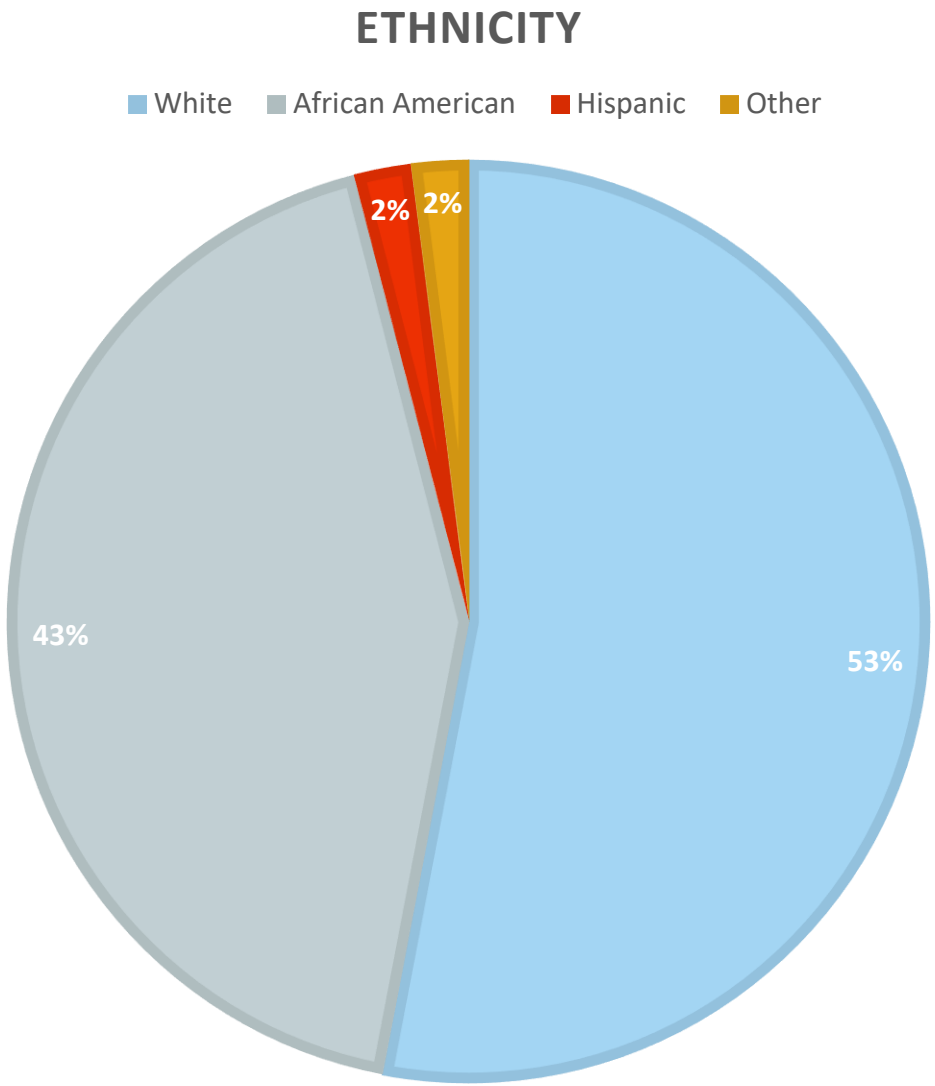
- System Service Line
  - Hub and spoke model
  - 8 regional hospitals
  - 4 ACS-COC accredited
  - Serves eastern NC
    - 29 counties
    - 1.5 million people



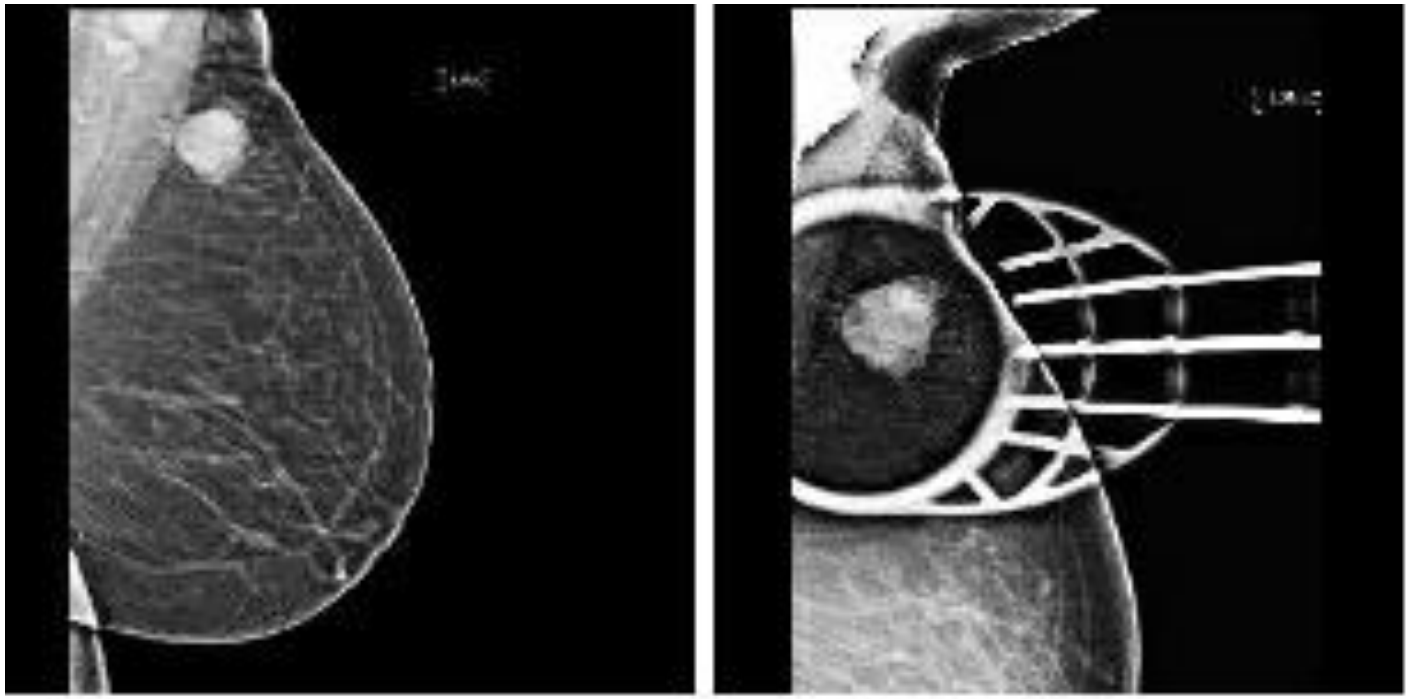
Vidant Cancer Center

- By the numbers (FY 2019)
  - 2,523 new cancer diagnoses
  - 703 oncologic directed surgeries
  - 18,594 infusion visits
  - 21,574 radiation doses delivered
  - 26,468 outpatient visits
  - 3,496 inpatient admissions

A skewed ethnic profile



A patient story



Unanticipated effects…

4/17/20
I spoke with patient today by phone. She has not received chemotherapy since 3/11/20. At first her concern was the side effects she was experiencing from the chemotherapy. spoke with patient twice by phone to address these concerns and husband also participated in the phone discussed of the 2nd call. plan was to resume chemotherapy with Taxol alone. Patient was then scheduled to resume chemotherapy on 4/8/20. This was cancelled by patient. It was then rescheduled for 4/17/20, but patient called again to cancelled. I was notified patient was not willing to come in for chemotherapy unless her husband could come with her. Current policy due to COVID-19 pandemic prohibits visitors. I talked with , RN nurse manager for Infusion and Cancer Service Line Administrator. They were unable to make an except for husband to be present at her oncology appointments or chemotherapy infusions. However they would be willing to provide patient with an IPAD during her chemotherapy infusion if her husband would like to be in video communication with her. I also checked with Vidant Home Health regarding possibility of giving chemotherapy at home. Vidant Home Health felt she needed closer monitoring and did not feel comfortable giving at home and was not aware of an infusion company that would administer chemotherapy at home.

I discussed with patient the importance of moving forward with chemotherapy or surgery for treatment of her breast cancer. Patient very fearful of begin exposed to COVID-19. She is also upset with the current conditions which prohibit her husband from accompanying her to her appointments. I allowed her to express her feeling and provided emotional support. At this point she was not willing to move forward with surgery. She said she discuss the situation and option of IPAD usage so she can communicate with her husband during her infusions with her husband and pray about it over the weekend. She will call me back on Monday to let me know her decision.

The impact of the COVID-19 pandemic on cancer care

The COVID-19 pandemic has disrupted the spectrum of cancer care, including delaying diagnoses and treatment and halting clinical trials. In response, healthcare systems are rapidly reorganizing cancer services to ensure that patients continue to receive essential care while minimizing exposure to SARS-CoV-2 infection.

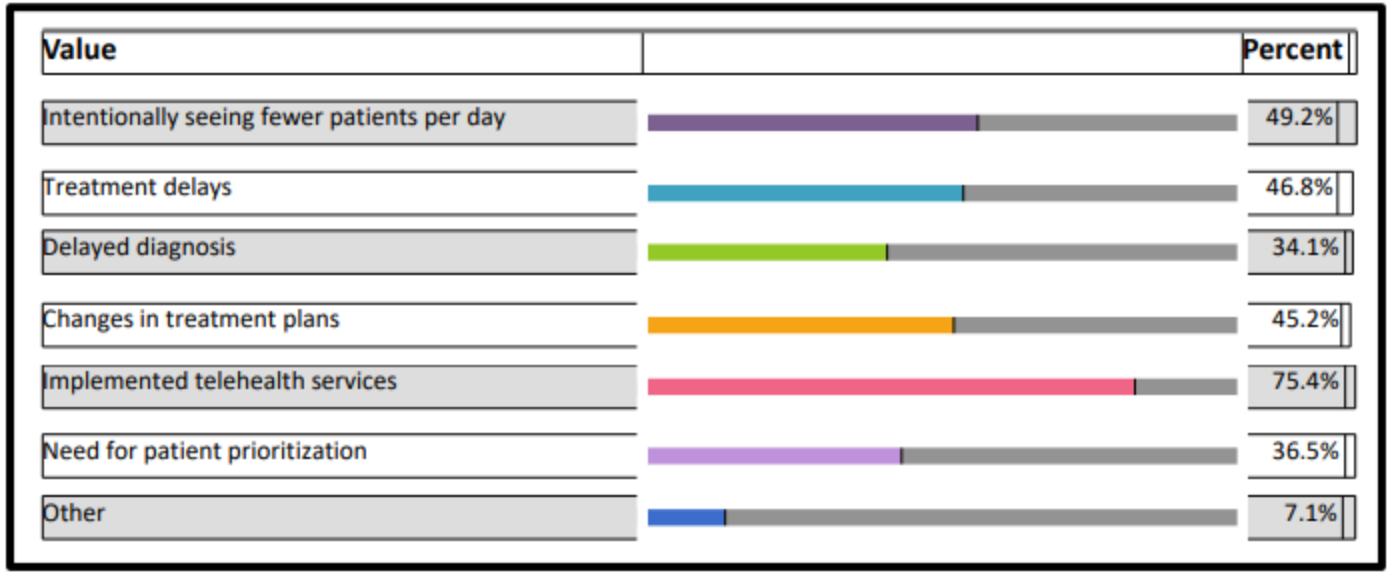
Mike Richards, Michael Anderson, Paul Carter, Benjamin L. Ebert and Elias Mossialos

- Worse outcomes in patients with cancer
- Delay in diagnosis (decreased screening)
- Treatment pathways modified or altered
- Delayed care due to resource prioritization
- Clinical trials suspended

Nationwide Survey – 300 Oncology Providers

VIDANT™ Cancer Care

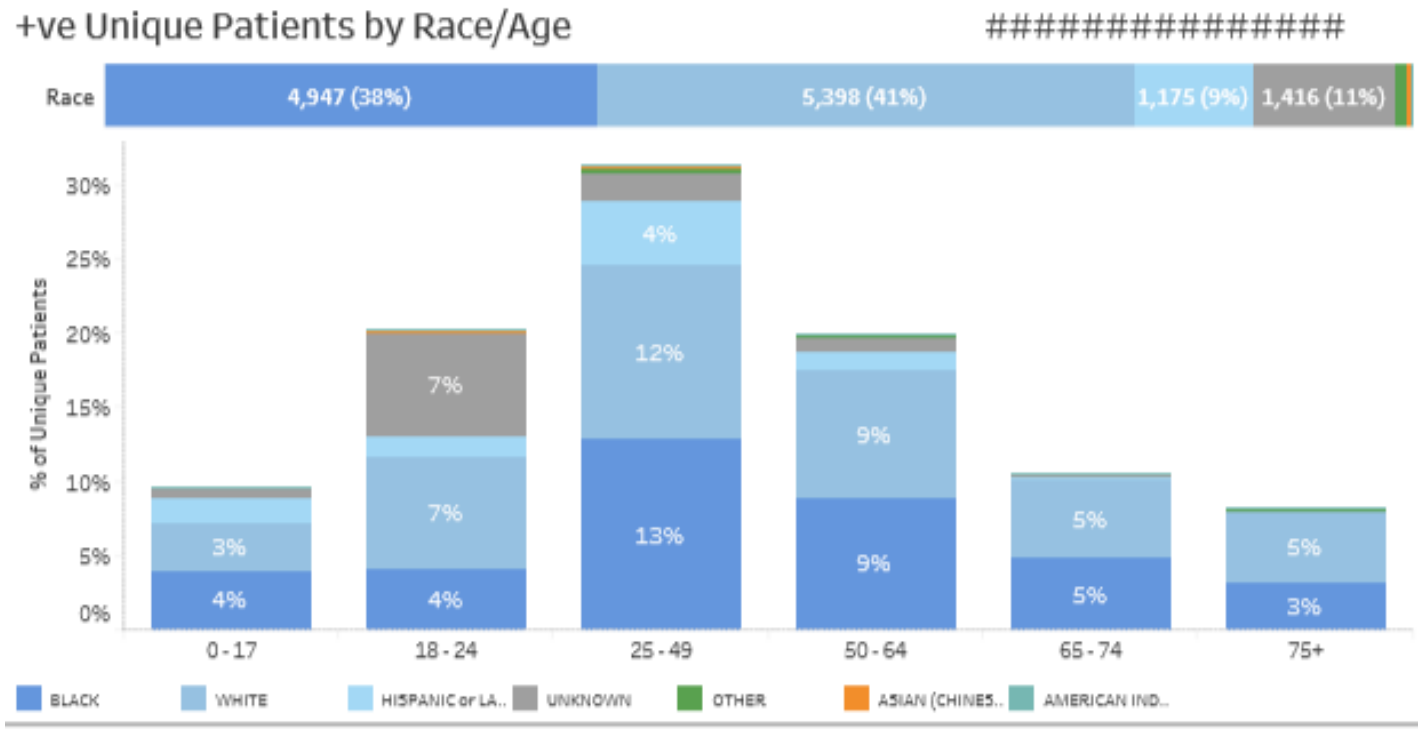
Survey Results – How has COVID-19 impacted your practice?



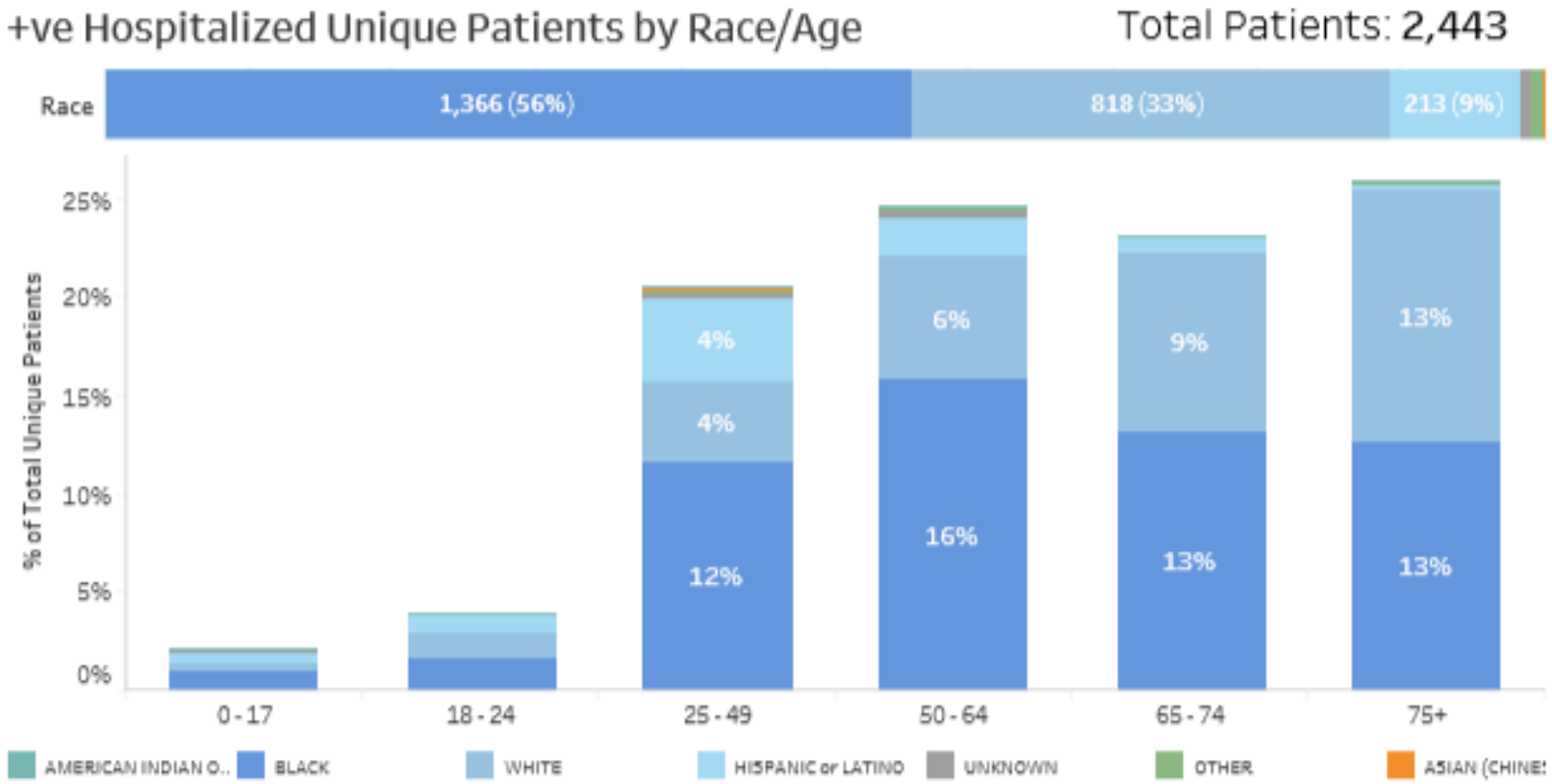
Value	Percent
Intentionally seeing fewer patients per day	49.2%
Treatment delays	46.8%
Delayed diagnosis	34.1%
Changes in treatment plans	45.2%
Implemented telehealth services	75.4%
Need for patient prioritization	36.5%
Other	7.1%

- COVID has changed very little in our practice. Patients don't socially distance and no screening done. Marks are enforced …..
- Less collaboration w/colleagues; limited on site support as ancillary services all work remotely; decreased patient support as family are mostly not allowed to accompany patients to visits

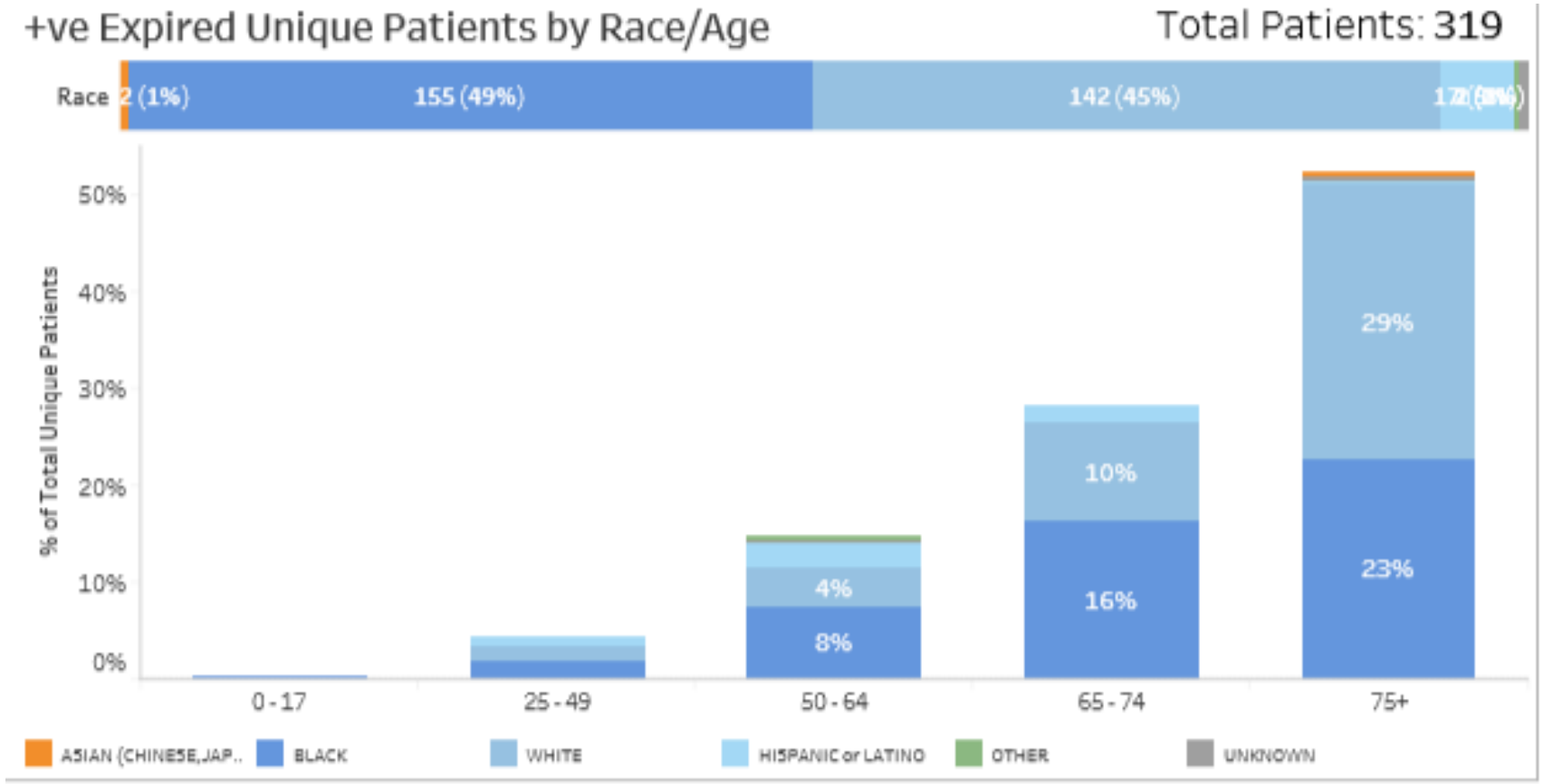
Ethnicity of COVID19 Test Positive



Ethnicity of COVID19 Hospitalized



Ethnicity of COVID19 Died



COVID and Cancer

VIDANT™ Cancer Care

Mortality for select subgroups

Subgroup	Number/Total	Percentage
ECOG PS 0, no comorbidities	0/86	0%
Global statistics[1]	343k/5.35M	6%
Overall for CCC19 cohort	121/928	13%
Male sex	78/468	17%
Age 75+	70/279	25%
Cancer present, progressing	25/102	25%
ECOG PS 2+	42/118	36%
Age 75+ with intubation	26/44	59%
ECOG PS 2+ with intubation	11/13	85%

[1]Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU) (accessed 5/24/2020 13:50 CT)

Cancer Screening Data

* All VH data for:

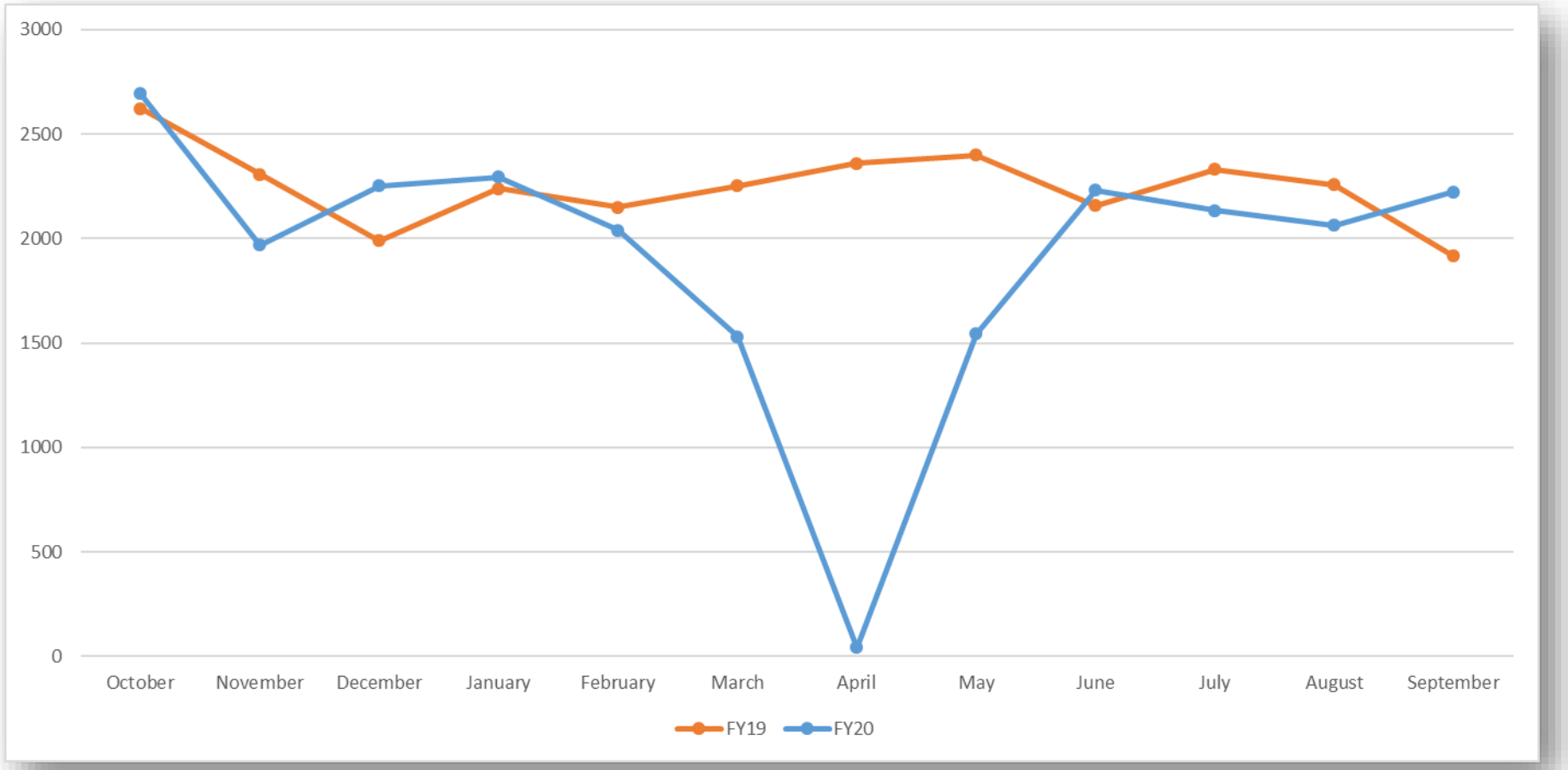
Screening mammography, Low Dose Lung CT, Screening Colonoscopy and Cervical Pap

VIDANT™ Cancer Care

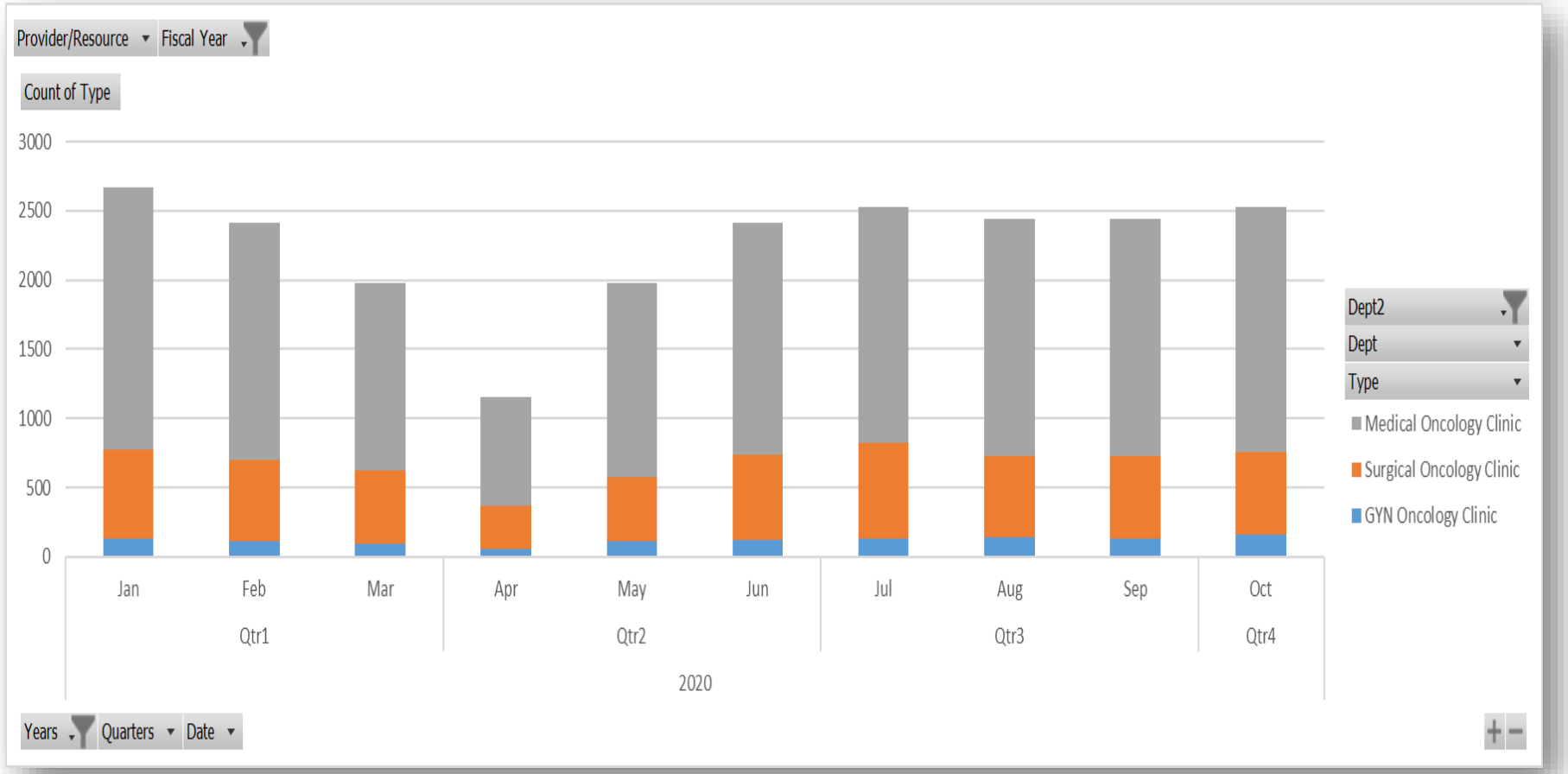
15% decline FY19/FY20

FY19 = 26,980

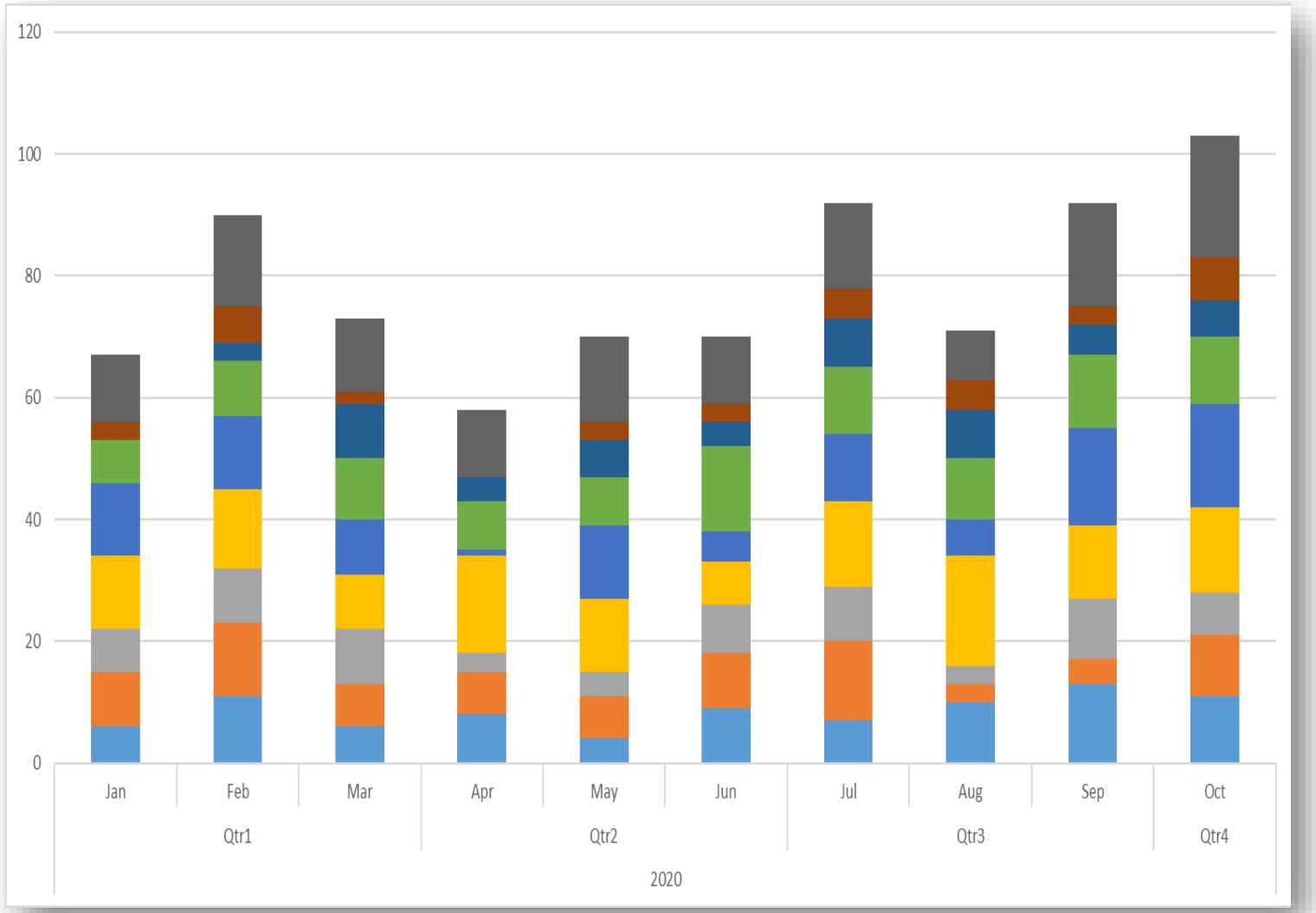
FY20 = 23,008



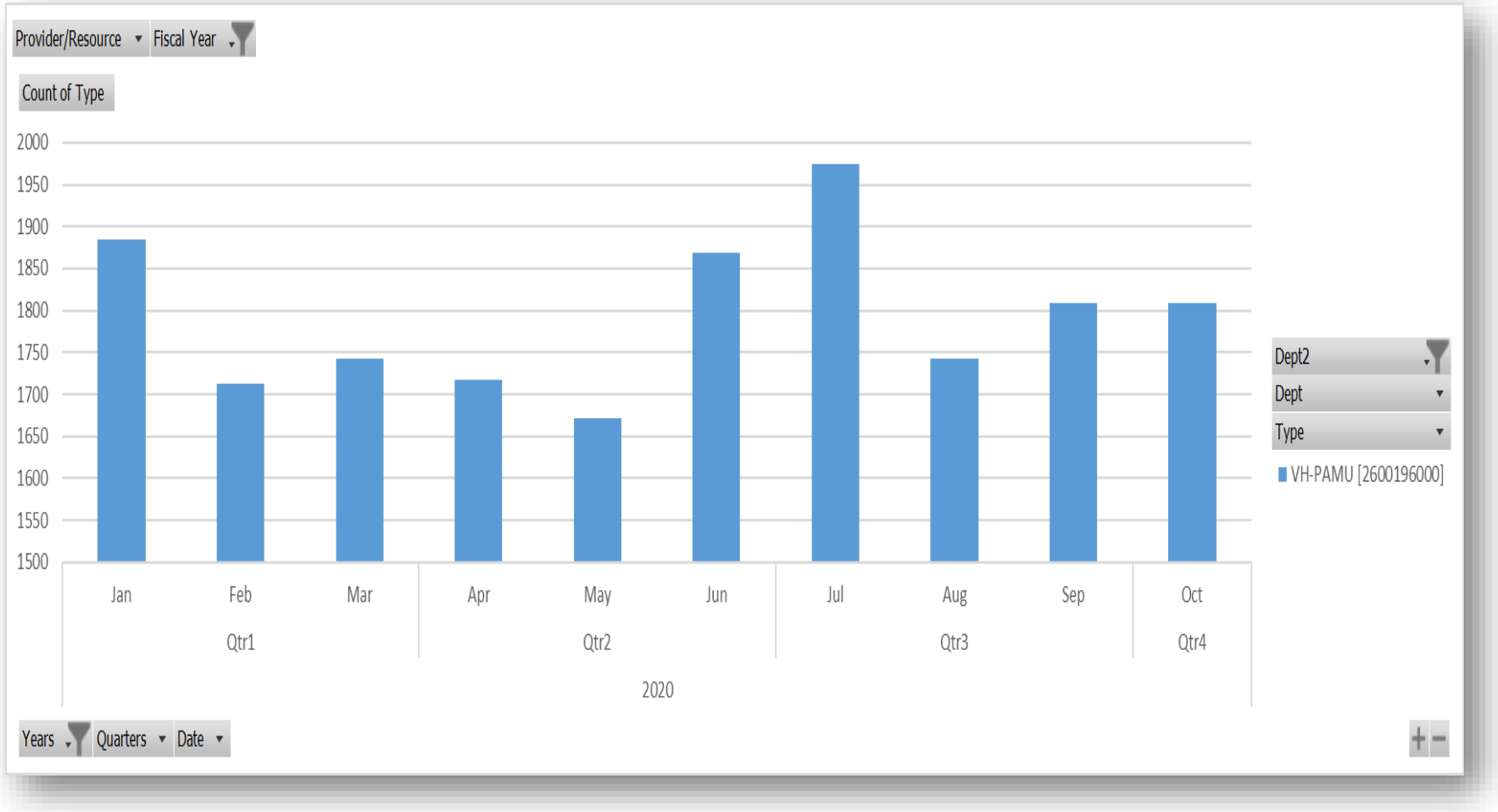
Outpatient Clinic Volumes
2020 Calendar Year



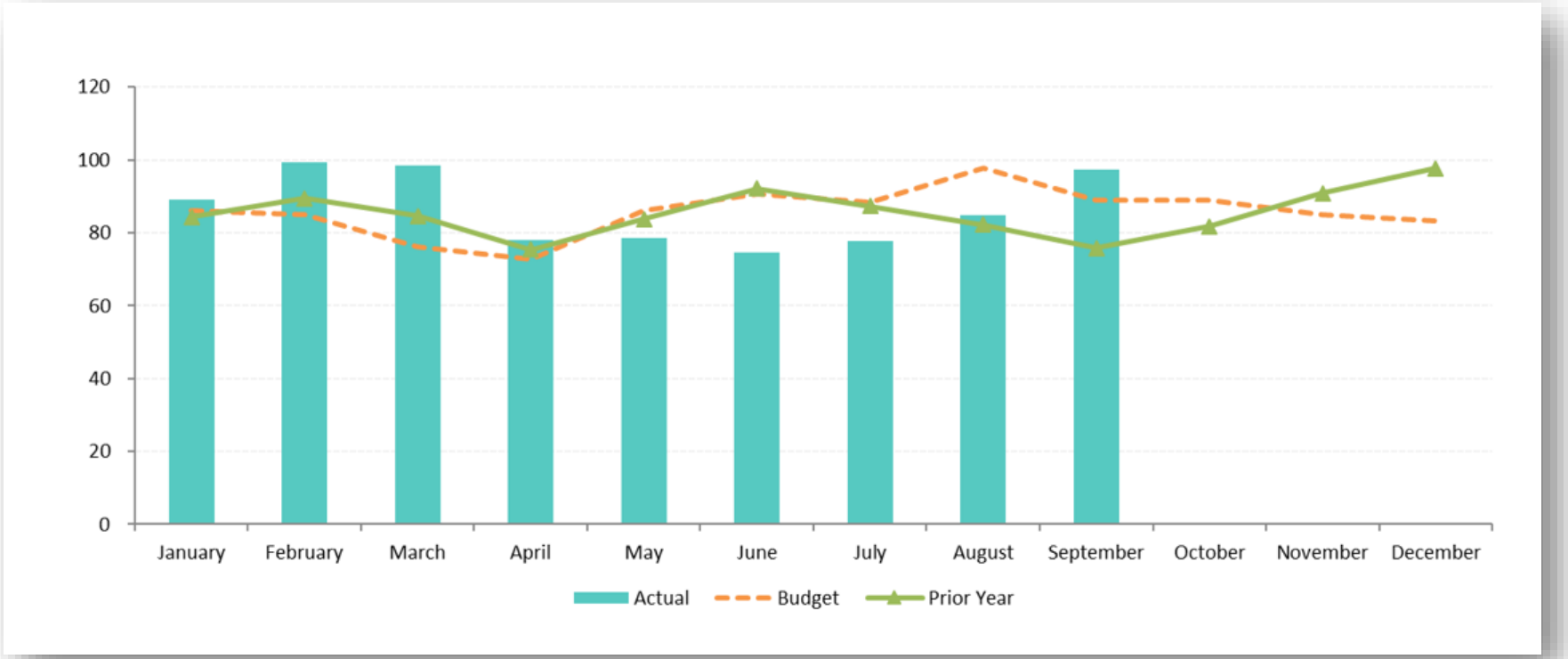
Surgical Oncology Cases 2020
* Surgery and GYN Oncology



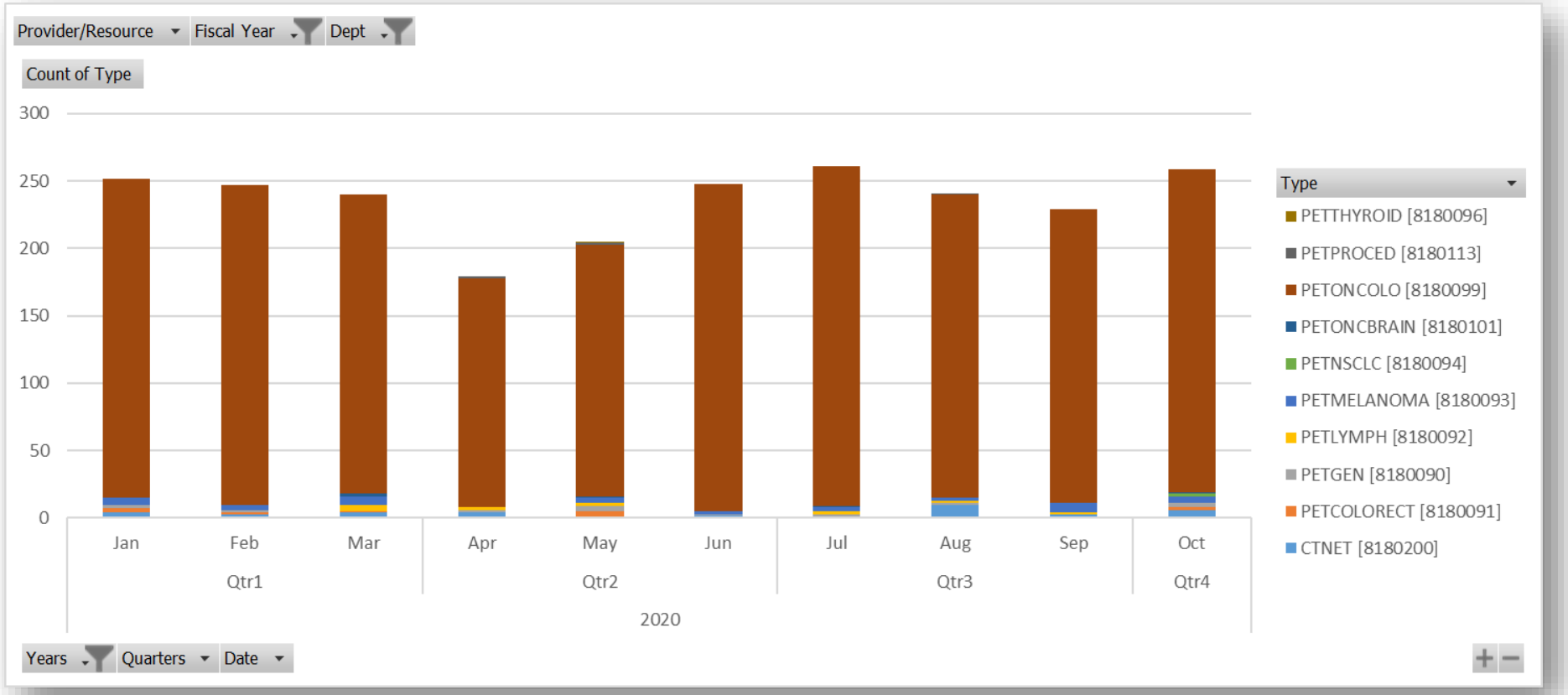
Infusion Volumes
*2020 All Visit Types, VMC Infusion



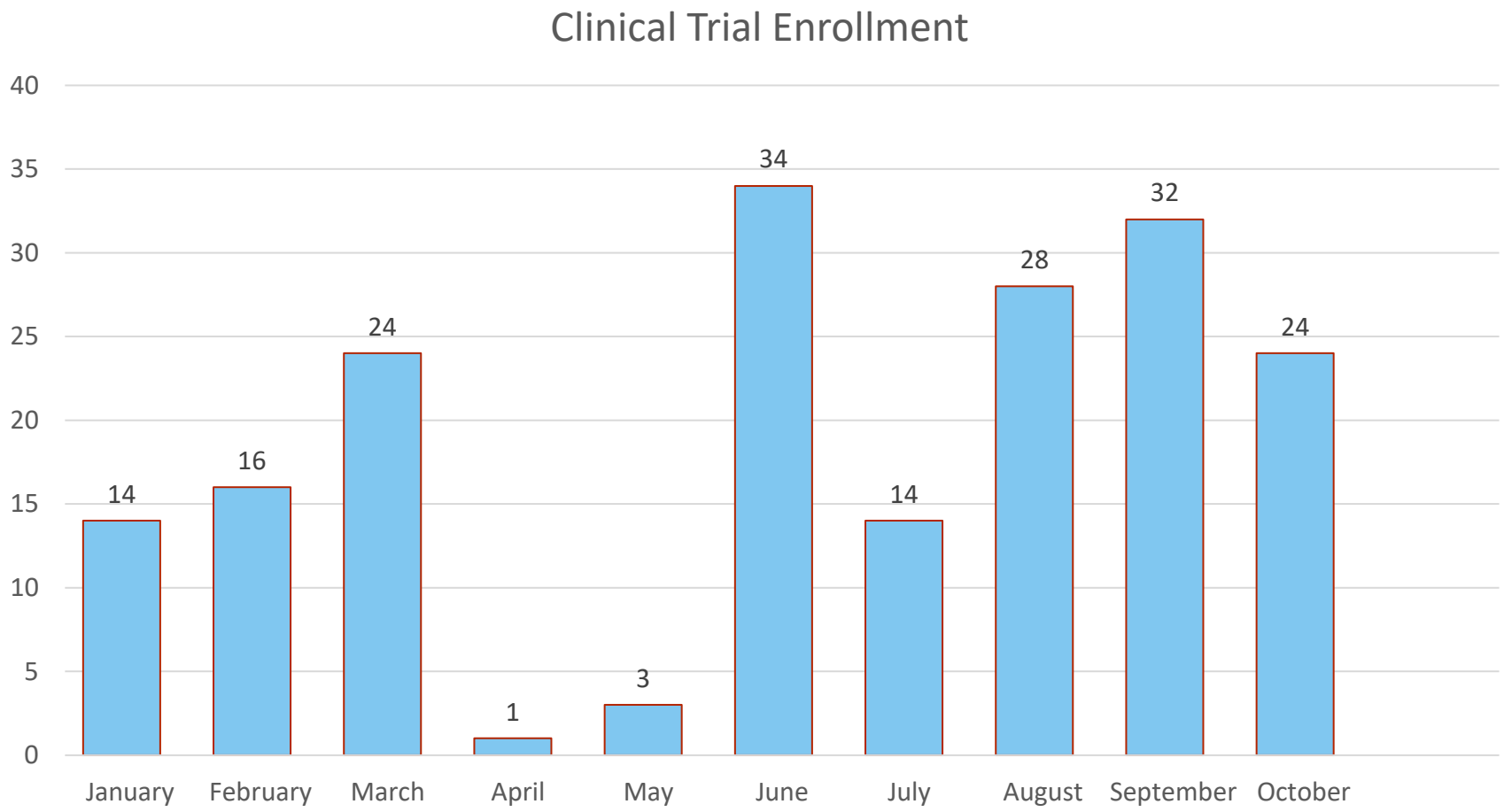
Vidant Radiation Oncology
Average Treatments Per Day - 2020



PET Scans
*2020 By Scan Type

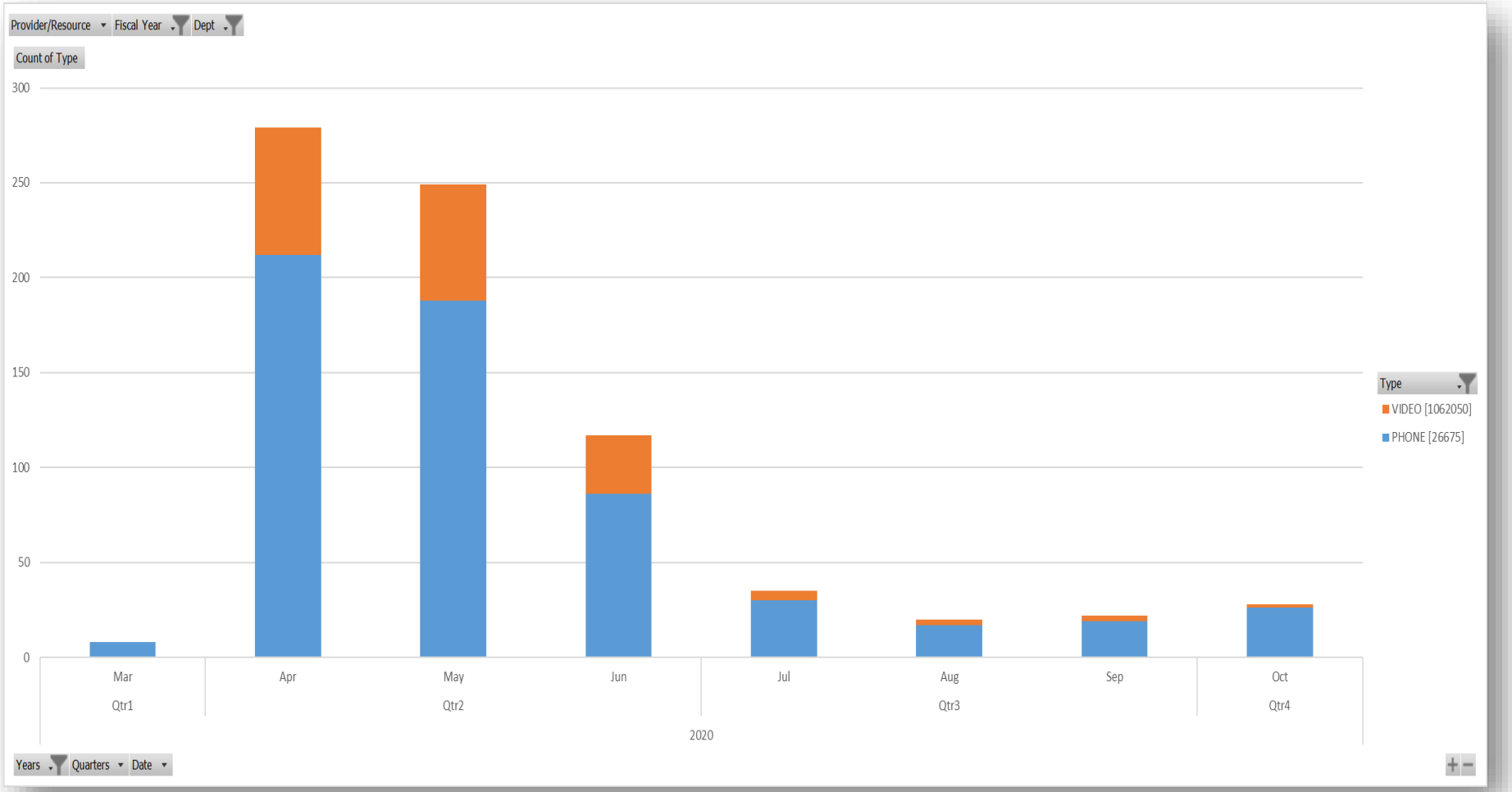


Vidant Cancer Care
Clinical Trial Enrollment



Telehealth Visits

*2020 – Medical, Surgical and GYN Oncology

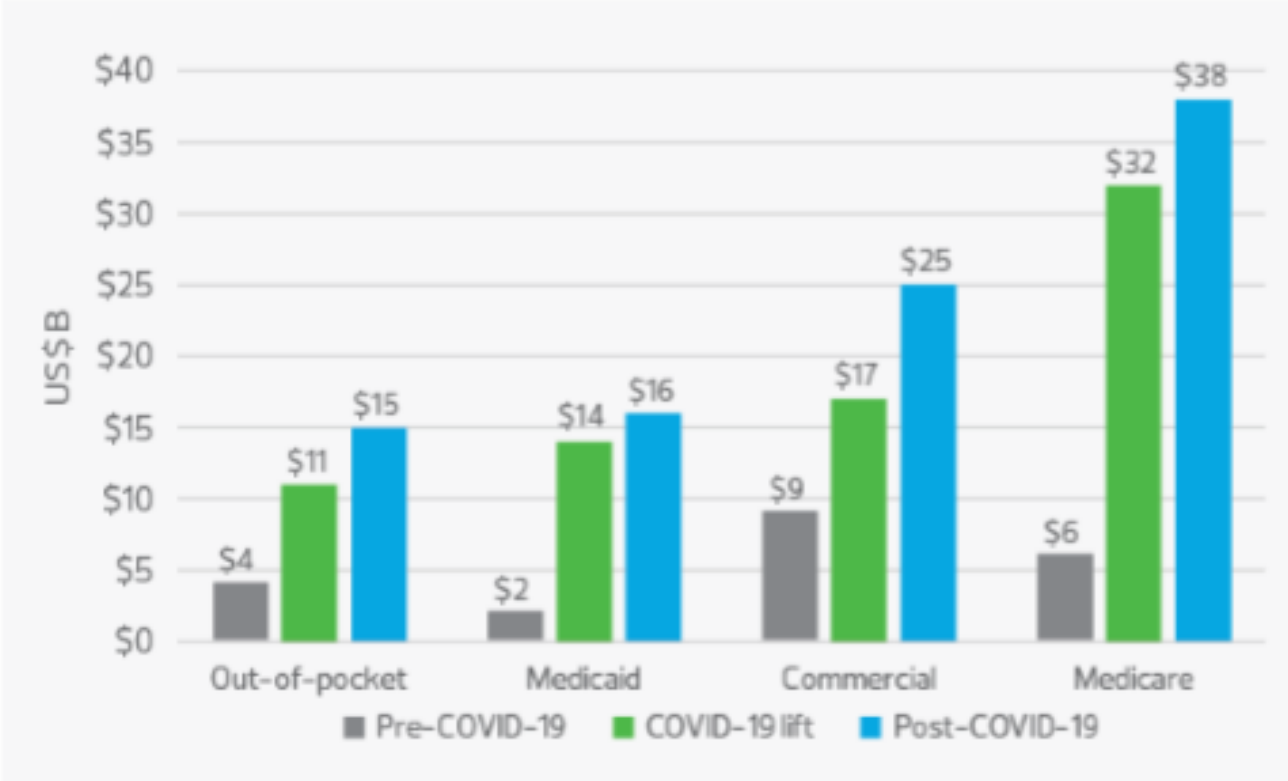


Summary

- Pandemic has negatively impacted cancer care in our rural population
- Disproportionate impact on African Americans
- All indices have since rebounded to pre-pandemic levels
- Long term implications will not be fully understood for years

COVID Silver Linings

Telehealth estimated market 2020



Source: CMS, Centers for Disease Control and Prevention and PSC estimates

Hope…

Cranberries not just for sauce
LIFE, B4

Black firefighters allege racism
STATE, A5

ESTABLISHED 1882 • GREENVILLE, NC

The Daily Reflector

WEDNESDAY, December 2, 2020 | reflector.com | Home delivery price 50¢ | $1.50

State to get 85,000 COVID vaccine doses

The federal government is anticipated to provide the first allotment as early as Dec. 15. with additional doses being distributed to states on a weekly basis.

News, wire reports

RALEIGH — North Carolina Gov. Roy Cooper announced on Tuesday that the state soon will receive about 85,000 doses of Pfizer's COVID-19 vaccine from the federal government.

His health secretary, Dr. Mandy Cohen, said she anticipates the federal government will provide the first allotment as early as Dec. 15 with additional doses being distributed to states on a weekly basis.

Hospital workers will be the first to receive the vaccine in North Carolina, according to Cooper and Cohen. Other healthcare workers and nursing home residents will be next in line. Residents who self-report at least two serious underlying health issues will be prioritized next.

"Healthcare workers, people in long-term care and those at risk for severe illness will come first," Cooper said in a news conference. "But when it's my turn to get this vaccine, I'll be ready to roll up my sleeve."

Farmville mayor

The news came on the same day that Farmville Mayor John Moore announced he had contracted the virus.

Moore said he was tested for the virus on Saturday and received confirmation on Monday. He is self isolating at home, but said things continue to runs as usual with Farmville's government.

Moore is fairing well, but noted he has lost his senses of taste and smell.

He encouraged everyone to continue safe COVID-19 practices.

"We have been very vigilant in protecting employees and people coming into town hall with requiring

See VIRUS, A3

Clinical Impacts of Foregone care

Dr. Ophelia Garmon-Brown, MD, M.Div

Senior vice president and chief community health and wellness officer at Novant Health

The state of a pandemic: A view from the top

COVID-19 Overview

Data during the COVID-19 pandemic

Data as of Dec. 1, 2020

United States	192,776,284 Number of COVID-19 tests performed in the United States	13,653,957 Number of COVID-19 positive cases in the United States	7% Percent of COVID-19 positives per tested in the United States	1.9% Percent of COVID-19 deaths per positive cases in the United States
North Carolina	5,322,548 Number of COVID-19 tests performed in North Carolina	367,395 Number of COVID-19 positive cases in North Carolina	7% Percent of COVID-19 positives per tested in North Carolina	1.4% Percent of COVID-19 deaths per positive cases in North Carolina

United States data source: https://covidtracking.com/data

North Carolina data source: https://covid19.ncdhhs.gov/dashboard/cases

NOVANT HEALTH

North Carolina COVID-19 Demographics

		Percent of COVID-19 positives	Percent of COVID-19 deaths	Percent of COVID-19 hospitalizations	North Carolina population
Age	0-18	10%	0%	1%	22%
	18-49	55%	4%	22%	42%
	50-64	20%	14%	29%	19%
	65+	15%	82%	48%	17%
Sex	Female	53%	48%	49%	51%
	Male	47%	52%	51%	49%
Race/Ethnicity	White	50%	58%	52%	62%
	Black	18%	26%	34%	22%
	Hispanic	18%	7%	5%	10%
	Asian	2%	1%	1%	3%
	American Indian	1%	1%	5%	2%
	Other	11%	6%	3%	2%

North Carolina data source: https://covid19.ncdhhs.gov/dashboard/cases
North Carolina population data source: www.census.gov

THE STATE OF A PANDEMIC

Every demographic is impacted

NOVANT HEALTH

Why are more People of Color being hospitalized and dying due to COVID-19?

More People of Color have conditions like hypertension, heart disease, diabetes and obesity, that make COVID-19 more severe and deadly.

Many People of Color work in essential jobs that make social distancing more difficult.

There are long standing gaps in access to health care and other resources among People of Color communities.

THE STATE OF A PANDEMIC

WHY ARE OUR BROWN & BLACK COMMUNITIES ALWAYS HIT THE HARDEST?

Key determinants: Access to care

More than **120,000 residents** in Mecklenburg County are **uninsured**.

230,000 adults in Mecklenburg County **do not have a primary care provider**.

Even with health insurance coverage, **over 160,000** adults in the county reported **not being able to see a doctor due to cost**.

Over 210,000 residents report **not being able to see a dentist** due to cost.

Chronic conditions can diminish quality of life due to dependence on medication, disability and high costs of medical care. Locally, chronic diseases such as cancer, diabetes and heart disease are the leading causes of disability and premature deaths. **More than half of all deaths in Mecklenburg County are due to chronic conditions**.

NOVANT HEALTH

Key determinants: Food security

North Carolina ranks in the **top 10 of hungriest states** in the U.S.

130,000 people in Mecklenburg County live in poverty, **and 1 in 5 children** in Mecklenburg County live in poverty.

16.4% of Mecklenburg County households **are considered food insecure**. (The U.S. national average is 13%).

"Just for people to get food – using public transportation – can require hours-long trips, with perishable items." – local food access stakeholder

NOVANT HEALTH

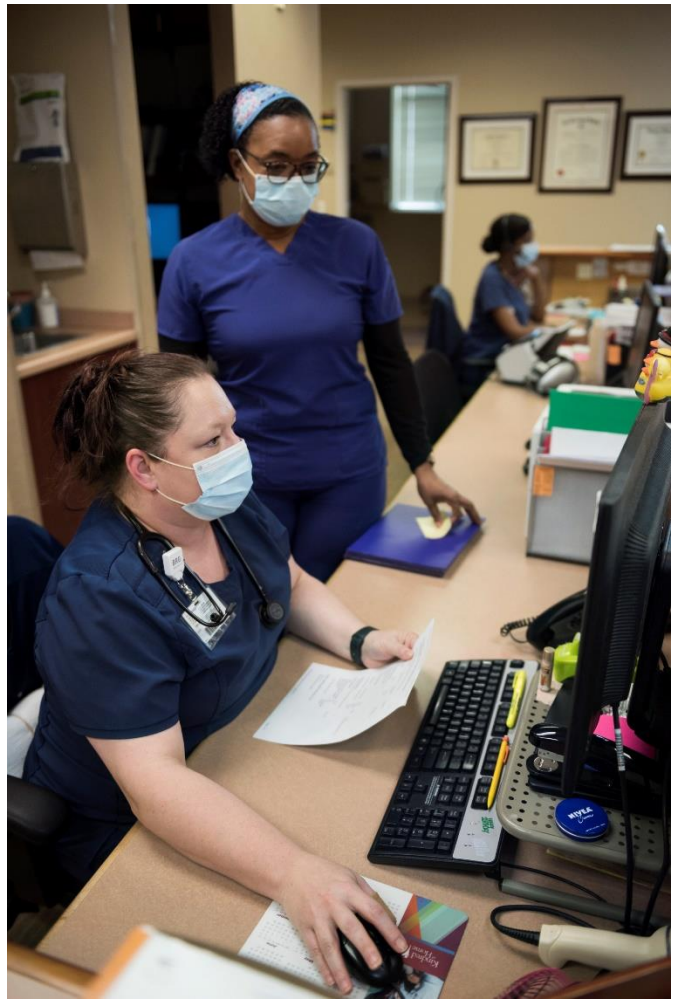
Key determinants: workforce

Concentrated areas of poverty are a key indicator of low community economic mobility. **The south Charlotte *wedge***, makes up less than 25% of the geographic area of the city, **yet contains over 75% of the city's wealth**.

11.5% of the workforce in Mecklenburg County **is unemployed**.

In Mecklenburg County, **women, young adults and communities of color are disproportionately unemployed**.

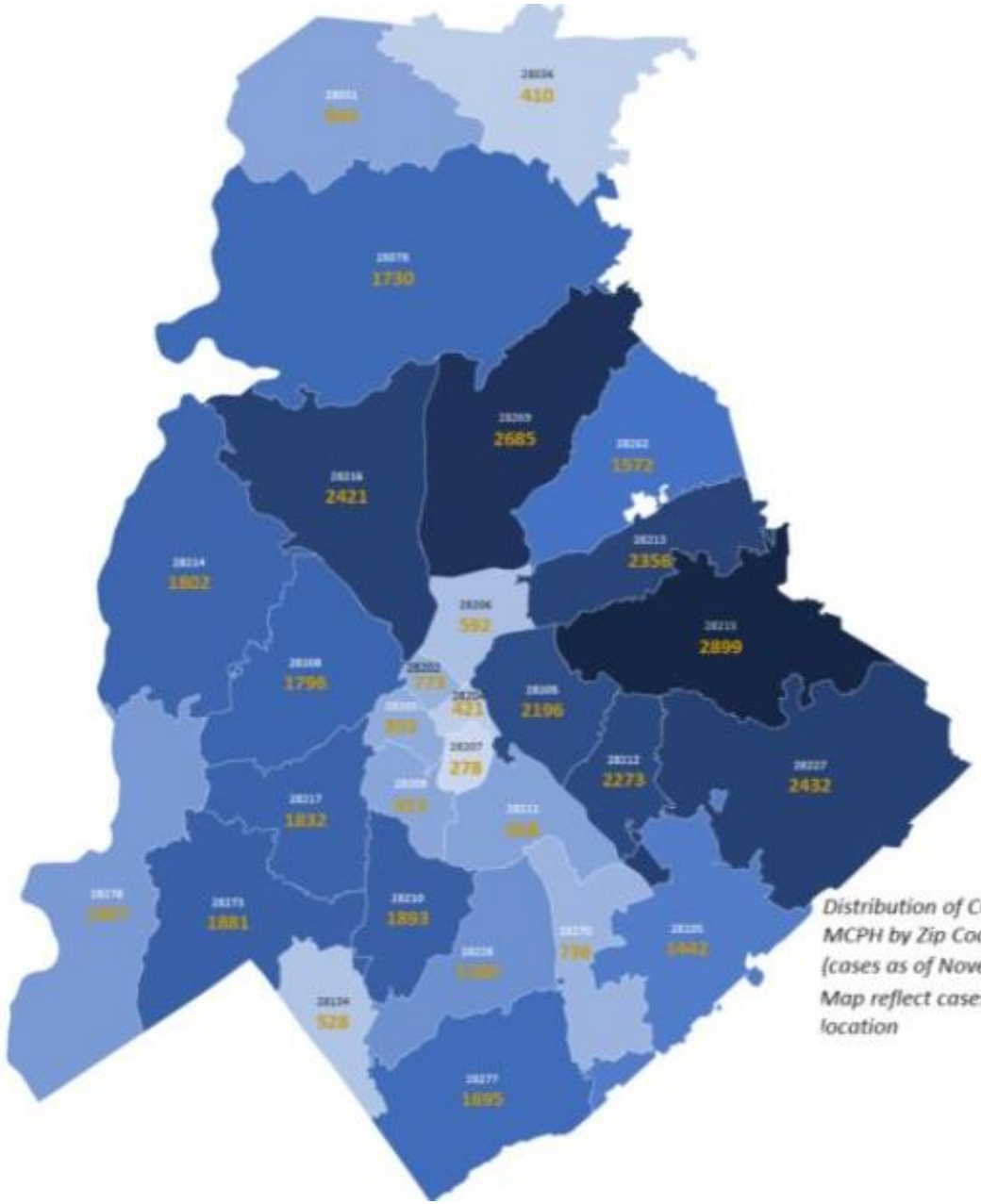
There is a critical need for technology and healthcare careers. Specifically in healthcare, there is a significant need for nurses, and a growing need for CMAs and community health workers across the U.S. North Carolina is slated to have one of the worst nurse shortages in the country, with **nearly 13,000 nurses needed by 2025**.



NOVANT HEALTH

THE STATE OF A PANDEMIC

THE NUMBERS OF CASES BY ZIP CODE

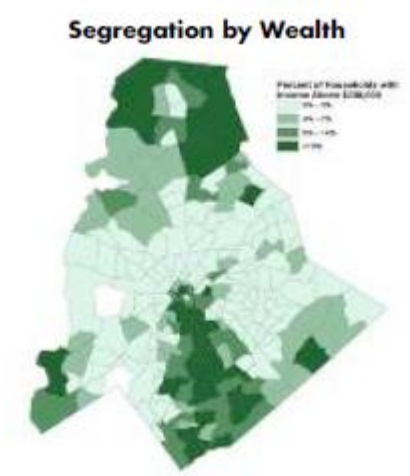


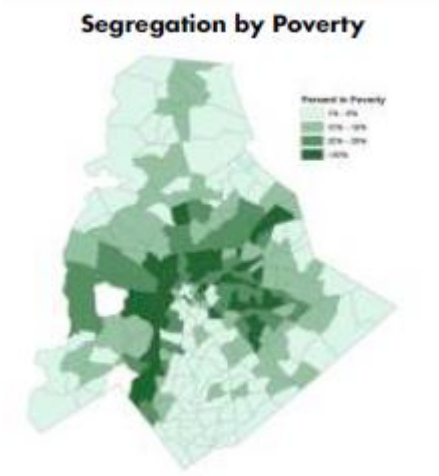
Distribution of COVID-19 Cases Reported to MCPH by Zip Code of Patient's Residence (cases as of November 29, 2020)

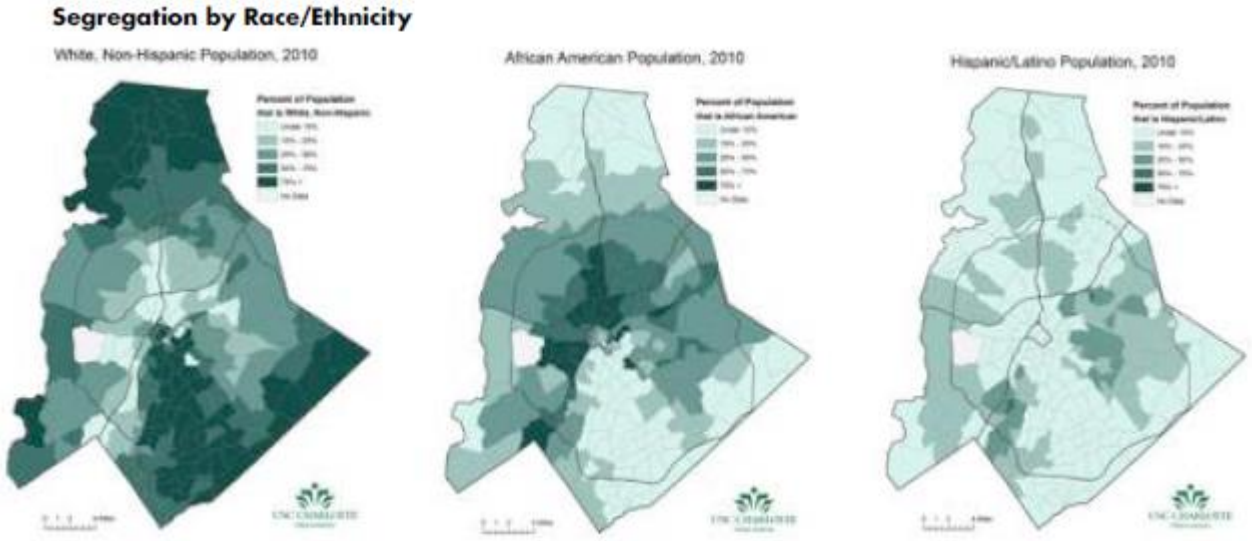
Map reflect cases with reported geographic location

NOVANT HEALTH

Cross-cutting factors







THE STATE OF A PANDEMIC

The longer we permit our current systems, policies and institutions to remain unchanged and implicit bias to play a role, the more lasting these trends will become – only exacerbating the divide in our community.

NOVANT HEALTH

Payment Impacts Panel

Ish Bhalla, MD
Associate Medical Director of Behavioral Health Value Transformation
Blue Cross NC

Karen Smith, MD, FAAFP
Family Physician in Raeford, NC
2017 National Family Physician of the Year

Lisa Shock, DrPH, MHS, PA-C
Executive Director, Clinical Delivery
Babylon Health

Low-Value Care

Corinna Sorenson, PhD, MHSA, MPH

Assistant Professor in Population Health Sciences and Public Policy

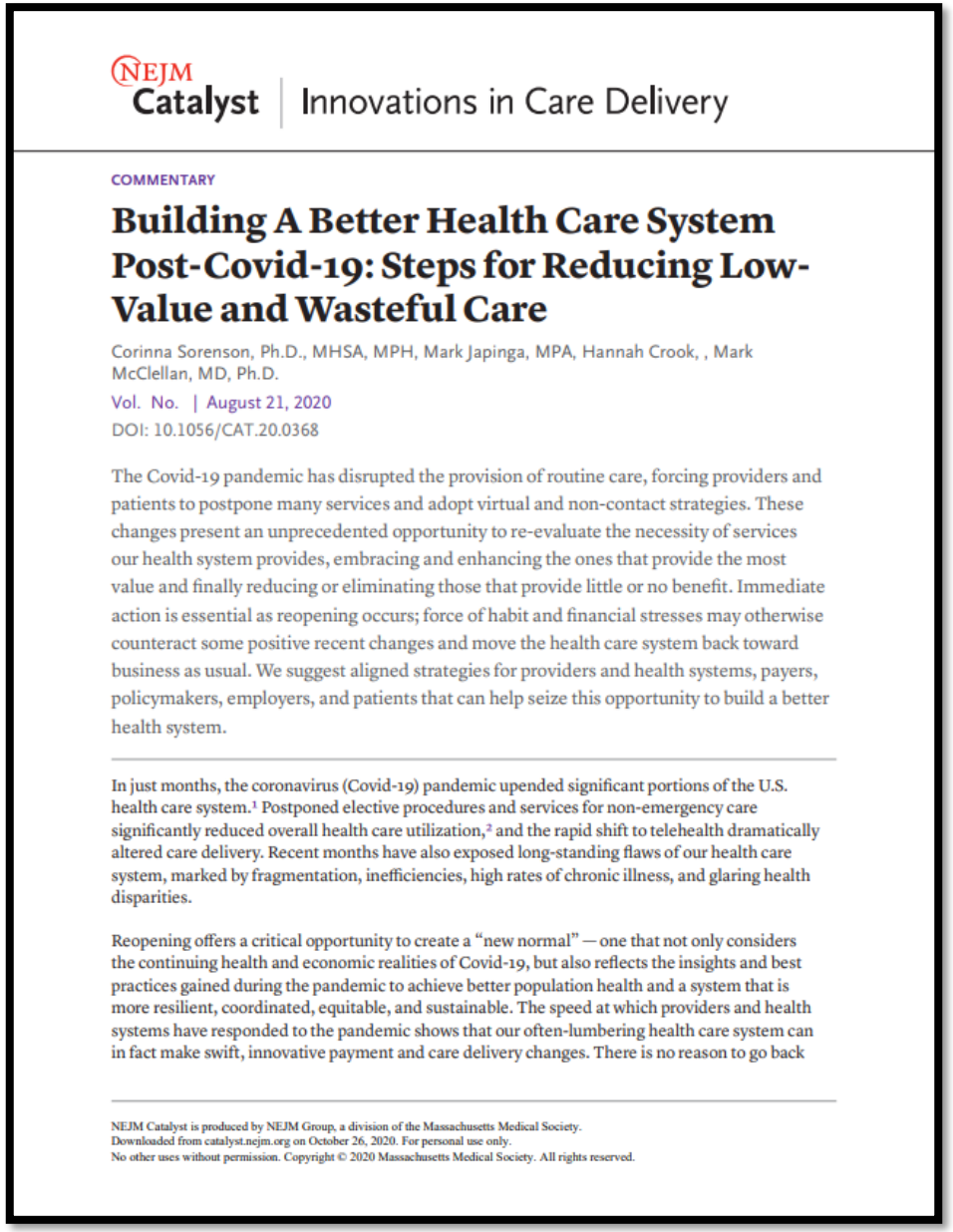
Core Faculty Member, Duke-Margolis Center for Health Policy

Duke University

Building a Better Health Care System Post COVID-19: Reducing Low-Value and Wasteful Care

Corinna Sorenson, PhD MHSA MPH
Assistant Professor in Population Health Sciences and Public Policy
Duke University

NCIOM 2020 Annual Meeting | December 8, 2020



NEJM Catalyst | Innovations in Care Delivery

COMMENTARY

Building A Better Health Care System Post-Covid-19: Steps for Reducing Low-Value and Wasteful Care

Corinna Sorenson, Ph.D., MHSA, MPH, Mark Japinga, MPA, Hannah Crook, , Mark McClellan, MD, Ph.D.

Vol. No. | August 21, 2020
DOI: 10.1056/CAT.20.0368

The Covid-19 pandemic has disrupted the provision of routine care, forcing providers and patients to postpone many services and adopt virtual and non-contact strategies. These changes present an unprecedented opportunity to re-evaluate the necessity of services our health system provides, embracing and enhancing the ones that provide the most value and finally reducing or eliminating those that provide little or no benefit. Immediate action is essential as reopening occurs; force of habit and financial stresses may otherwise counteract some positive recent changes and move the health care system back toward business as usual. We suggest aligned strategies for providers and health systems, payers, policymakers, employers, and patients that can help seize this opportunity to build a better health system.

In just months, the coronavirus (Covid-19) pandemic upended significant portions of the U.S. health care system.[1] Postponed elective procedures and services for non-emergency care significantly reduced overall health care utilization,[2] and the rapid shift to telehealth dramatically altered care delivery. Recent months have also exposed long-standing flaws of our health care system, marked by fragmentation, inefficiencies, high rates of chronic illness, and glaring health disparities.

Reopening offers a critical opportunity to create a "new normal" — one that not only considers the continuing health and economic realities of Covid-19, but also reflects the insights and best practices gained during the pandemic to achieve better population health and a system that is more resilient, coordinated, equitable, and sustainable. The speed at which providers and health systems have responded to the pandemic shows that our often-lumbering health care system can in fact make swift, innovative payment and care delivery changes. There is no reason to go back

Building a Better Health Care System Post-COVID-19: Steps for Reducing Low-Value and Wasteful Care

Corinna Sorenson, PhD, MHSA, MPH; Mark Japinga, MPA; Hannah Crook; Mark McClellan, MD, PhD

Some care shouldn't be restarted, because we can't afford to go "back to normal" in health care…

**This research is supported by a three-year partnership between the Duke-Margolis Center and West Health to accelerate value-based care.*

https://catalyst.nejm.org/doi/pdf/10.1056/CAT.20.0368

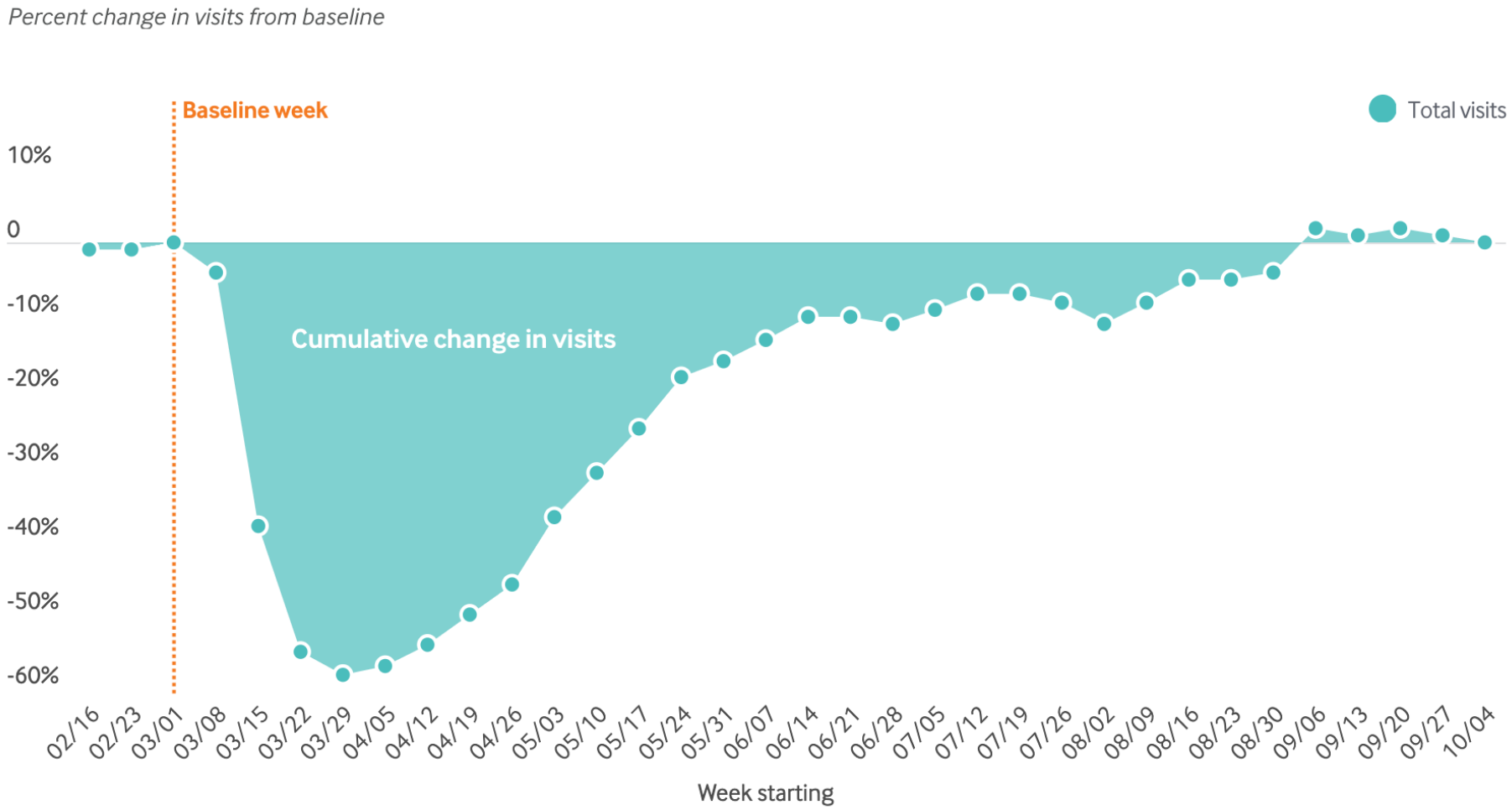
The Pervasive and Protracted Nature of Low-Value Care Pre-Pandemic

- Use of low-value care in the system is pervasive, amounting to ~$106 billion in wasted spending annually
- Low-value care services are medically unnecessary and provide little or no benefit to patients
  - Examples include lab tests for low-risk patients before a low-risk surgery or procedure, head CT scans for simple dizziness, Vit D screening, and inappropriate use of antibiotics
- Many pitfalls – potential patient harm, unnecessary costs to patients, waste of limited health care resources
- Proven extremely difficult to reduce or eliminate

COVID-19 Presents an Opportunity to Move the Needle

- Pandemic resulted in a dramatic decline in utilization of all health care services – both low- *and* high-value care
  - Large decreases in outpatient and elective care – up to 60% lower than normal in March and April
  - More than 40% of American adults report avoiding or delaying medical care
- System-wide disruption from COVID-19 provides an impetus for rethinking how to deliver care
- This is particularly true for low-value care, thanks to increased focus on patient safety, expanded opportunities to engage patients digitally, and the implementation of alternative care models in some cases
- Health and economic impacts of the pandemic also showcases need to spend limited resources more effectively

But There's High Risk of Returning to Business as Usual



Source: Source: Ateev Mehrotra et al., *The Impact of the COVID-19 Pandemic on Outpatient Care: Visits Return to Prepandemic Levels, but Not for All Providers and Patients* (Commonwealth Fund, Oct. 2020).

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Strategies for Different Stakeholders to Reduce Low-Value Care

Stakeholder	Recommendations
Providers & Health Systems	• Develop & disseminate ”Do Not Restart” lists • Leverage clinical decision supports, such as EHR alerts • Measure, track, and report provider use of LVC with peer comparisons • Expand telehealth platforms and home- and community-based services
Payers	• Cease or reduce payment for low-value care services • Support practice redesign and accelerate development of value-based payment models • Increase patient cost-sharing for low-value care services (while decreasing cost-sharing for high-value services)
Policymakers	• Direct additional COVID-19 relief funding to systems who agree to pilot new models of health care • Work with payers and providers to determine which telehealth flexibilities should stay in place • Encourage states to address social drivers of health and integrate clinical and social care
Employers	• Accelerate the adoption of value-based tools, such as Centers of Excellence • Utilize benefit design to encourage use of high-value provider networks
Patients	• Maximize the use of appropriate telehealth services • Participate in shared-decision making and other patient engagement strategies

Pathway for a Better Future

- **More research**: Evidence of impacts of reduced use during pandemic; studies on organizations that have been successful in their efforts to reduce low-value care, affording opportunities for sharing learning
- **More supports**: Providers, health systems, and other stakeholders need tools to guide low-value care reduction and make it the right and easy decision
- **More reform**: Further COVID-19 relief and related reforms should be linked to "new normal" goals
- **More implementation**: Don't wait, harness this opportunity to experiment and pilot
- **More political will and collective action**: Pandemic highlighted their power to drive rapid changes – leadership, culture, and collaboration key to tackling low-value care

Thank you for attending the 2020 NCIOM Annual Meeting!

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