North Carolina Institute of Medicine
Healthcare Safety Net Task Force
June 10, 2004
Meeting Summary
NC Hospital Center, Cary, NC

Members present: Thomas Bacon, Gillian Baker, George Bond, Sonya Bruton, Moses Carey, Mike Cinoman, Lawrence Cutchin, Leah Devlin, Richard Daugherty, Brian Ellerby, John Estes, Bob Fitzgerald, Olivia Fleming, John Graeter, Bobby Greer, Paul Harrison, Anita Holmes, Thomas Irons, Alan McKenzie, John Mills, Wanda Sandele, Adam Searing, Shirley Sims, Sherwood Smith, Steve Smith, and Jeff Spade.

Staff/Steering Committee present: Gordon DeFriese, Thalia Fuller, Dennis Harrington, Mark Holmes, Adrienne Parker, Jordan Parker, Andrea Radford, Tom Ricketts, Pam Silberman, Aimee Wall, Kristie Weisner, and Tom Wroth.

Others present: Pam Carpenter, Adam Froyum Roise, Paul Sherwood, and Rebecca Slotnik.

INTRODUCTIONS AND WELCOME

Sherwood Smith, JD

HEALTH DEPARTMENTS AS SAFETY NET ORGANIZATIONS

Leah Devlin, DDS, MPH
State Health Director

Historical Overview

Public health has been around 127 years. In 1877, the state created the first state board of health. Local boards of health were created in 1879, and the first local health department was established in Guilford County in 1911. By 1950, all 100 counties had health departments. In 1970, the NC General Assembly provided the authority to create district health departments. This year (2004), there are 85 local health departments, 79 single county, and six district health departments.

Nationally, the 10 greatest achievements of public health during the 20th century include: immunizations, infectious disease control, environmental sanitation and food safety, fluoridation of drinking water, injury prevention, healthier mothers and babies, reduced deaths from heart disease and stroke, family planning, tobacco control, and workplace safety.

Accountability

The health department is a unit of local government. It is accountable to locally elected officials and the citizens of the county. County commissioners appoint the boards of local health departments, according to certain statutory requirements. For example, local boards must have 11 members, nine of which are designated slots (a medical doctor, dentist, registered nurse (RN), optometrist, veterinarian, pharmacist, engineer, and County Commissioner) and three at large community members.

Local Health Department Staffing

Because of the breadth of health department responsibilities and services, local health departments can include many types of professional staff, including health professionals (doctors, nurses, nurse practitioners, physician assistants, dentists, and pharmacists), epidemiologists, social workers, engineers, veterinarians, professional administrators, etc. The North Carolina public health system currently has 10,300 full-time equivalent staff, including 2,270 RNs, 910 environmental health specialists, 575 social workers, and 410 nutritionists.

Funding

The total budget for state and local public health departments is $593 million. Of the $593 million, only 12% are state funds. Local government provides more than one-third of the funding (38%), federal grants comprise 40%, and other receipts (including Medicaid) equals approximately 10%.

Local government is a major contributor to public health; more than for mental health or child development. Only $23 million of state funds go to local health department, most of which is categorical (i.e., designated for a specific program/purpose). Only about $5 million of state funds go into general aid to counties (i.e., flexible funds to help support the existence of local health departments).

Services

Public health's essential services include: monitoring health status and identifying problems; investigating problems and hazards; informing and educating the public about health issues; mobilizing community partnerships for health improvement activities; developing plans and policies to support health; enforcing public health laws and regulations; striving to assure an adequate public health workforce; evaluating health services; and researching new solutions to health problems. Additionally, public health has a legal responsibility to help link individuals to, needed health services.

NC General Statutes 130A-1 *et. seq*. governs the NC public health system. Local health departments are required to provide quality healthcare services when not otherwise available. Essential services include: personal health services, child health, chronic disease control, communicable disease control, dental (oral) health, family planning, health promotion and risk reduction and maternal health. Health departments in the southeastern United States generally play a larger role in the delivery of personal health services than other health departments nationally. North Carolina is no exception, given the rural nature of the state and other barriers to care that many communities face with certain at risk populations.

Local health department safety net services include:

- *Preventive clinical services*. Many health departments provide family planning, prenatal care, child healthcare, nutrition, diagnosis and treatment of communicable diseases, dental services, and chronic disease and injury prevention services. For example, in 2003, health departments provided:

    - Family planning services to 142,802 clients (272,119 visits)
    - Prenatal/maternal to 35,592 women (214,079 visits)
    - Child health to 83,776 children (237,909 visits)

- Immunizations to 132,476 children
- Flu immunizations to 50,000 adults
- WIC services (Women, Infants and Children nutrition program) provided to 210,000 average monthly clients
- Tuberculosis (TB) services provided to 400 clients/contacts (average one outbreak/week)
- Dental health services provided to 48,474 clients
- Breast and cervical cancer control program provided services to 11,377 women (9,175 clinical breast exams, 9,055 mammograms, and 7,242 pap tests)
- Cardiovascular health risk factor screening for women (Wise Women program) provided to 2,671 women (the program is not yet statewide, and operates in 33 contract agencies)

- *Home based services*. Health departments often provide screening visits or case management services directly in the home. For example:

    - Child service coordination provided to 33,291 clients
    - Maternity care coordination provided to 33,950 clients
    - HIV case coordination: 5,634 counseling sessions
    - Maternal outreach worker support provided to 3,389 clients

- *Primary care*. Fifty health departments also provide comprehensive primary care, to either children (47 health departments) and/or adults (36 health departments); however, local health departments do not report the number of primary care visits, clients, or payment source for these visits because the state HSIS (information system) is not currently set up to gather this information.

Health departments have traditionally provided comprehensive "primary care" clinical services when there is a vacuum in the private sector. As the market and public policies have changed in certain counties, a number of traditional public health functions (such as childhood immunizations, well-child visits, and care for Medicaid recipients) are also delivered in the private sector. Health departments typically serve as providers of last resort; so the array of services will vary by community, depending on other available community resources. However, all 85 local health departments provide basic screening and preventive clinical services covering all 100 counties in NC.

In addition to clinical safety net services, the Division of Public Health is also a safety net provider providing comprehensive multi-disciplinary assessments and treatments for children with special health needs and by providing food to certain low-income individuals through the WIC (Women, Infants and Children Supplemental Foods and Nutrition Education Program) and adults and children in the CACFP (Child and Adult Congregate Feeding Program). The WIC Program has an average caseload of 110,000 clients at any given time.

In addition to these safety net responsibilities, health departments also provide additional clinical services, including:

- *Epidemiology*. State law requires health departments to collect data on approximately 65 reportable diseases and conditions. Last year, local health departments investigated ~6,500 cases of gonorrhea, 3,000 cases of food born illnesses, more than 1,000 cases of Hepatitis B, 125 cases of Hepatitis A (each case generates more than 1,000 contacts with individuals who may need immunoglobulin). Health departments are required to conduct

investigations and intervene when necessary to assure compliance with control measures, even if treatment and or coverage is provided in the private sector.

Services provided by local health departments vary, depending upon the needs in the local community and other available resources. All health departments provide adult influenza and child vaccines, HIV/AIDS testing and counseling, sexually transmitted disease (STD) testing and counseling, TB testing, family planning, and case management.

Services	Percent of Health Departments Providing Services
School health	68%
Home health	43%
Primary care	58%
Dental treatment	50%
Case management	100%
Prenatal care	92%
Family planning	100%
Nutrition	94%
HIV/AIDS testing and counseling	100%
STD testing and counseling	100%
Diabetes screening	87%
Well child care	93%
TB testing	100%
Adult influenza vaccines	100%
Childhood immunizations	100%

Clients served. Health departments provided clinical services to 626,000 unduplicated patients in FY 2003. Of these, 256,000 (41%) were uninsured. Thirty-two counties reported that they delivered more than $40 million in uncompensated care that year.

Local health departments provided prenatal care for nearly 25,000 live births in 2002 (approximately 21% of live births). Health departments served approximately 40% of the pregnant women enrolled in Medicaid and 40% of all pregnant Latinos in 2002. Local health departments receive Medicaid reimbursement (for Medicaid-eligible pregnant women), and can use Maternal and Child Health (MCH) block grant funds to help pay for prenatal care services. Nonetheless, health departments provided an estimated $10.3 million in uncompensated prenatal care in 2003 (which is an increase of 25% from 2001). In 2003, the average portion of the uncompensated local prenatal budget was 21%, with a high of 69%.

Health departments are trying to respond to the growing Latino population by adding bilingual staff (307), providing educational and informational materials in Spanish, and providing outreach services to the non-English speaking communities. Approximately three-fourths (74%) of health departments have staff designated interpreters.

Safety net services provided by the Division of Public Health

In addition to the safety net services provided by local health departments, the state Division of Public Health also provides additional safety net services (either in-house, through regional offices, or through contract services). This includes:

- *Clinical services*. The Division of Public Health has responsibility for the following programs

    - Child development services agencies (CDSAs), which provides early intervention programs to 10,420 infants and toddlers
    - Child and adult congregate feeding programs (CACFP). Approximately 130,500 people are fed on an average day, each person receiving 2 meals and a snack/day.
    - Summer food supplement program (SFSP) provides meals to 33,645 children in the summer to replace the free and reduced school lunch program.

- *State public health laboratory*. The state laboratory provides certain laboratory services including

    - Newborn screening tests provided for 132,827 newborns (4,547,828 results)
    - Thin prep pap tests (140,322 tests)
    - Rabies tests (4,671 tests, 769 positive)
    - Standard HIV testing (113,716 tests)
    - HIV/RNA pooled testing (2,157 tests)

- *Direct payment program*. The Division of Public Health also purchases medical care directly from local health providers. In FY 2003, this program covered the following services:

Program	Total expended	Number clients	Average/client
Children with Special Health Services	$2,519,156	2,126	$1,185
Assistive Technology	$423,444	305	$1,388
Cystic Fibrosis	$107,890	18	$5,994
Cancer Diagnosis	$718,968	1,171	$614
Cancer Treatment	$1,304,125	436	$2,991
Kidney	$307,239	1,848	$166
Sickle Cell	$521,019	202	$2,579
HIV-ADAP (AIDS Drug Assistance Program)	$20,584,596	2,899	$7,101

Data Collected to Support the Safety Net

In addition to the direct provision of services, public health collects and analyzes data that are used by safety net and other health providers, local communities, and state and local policy makers. These data sets include:

- Community diagnosis
- Behavioral Risk Factor Surveillance Survey (BRFSS), Youth Risk Behavior Survey (YRBS), Youth Tobacco Survey
- Prenatal Risk Assessment Monitoring System (PRAMS)
- Vital records (including birth, death, and medical examiners records). The state health department conducts 25,000 autopsies through the medical examiners office.
- Registries including birth defects, cancer, and immunizations.

The state also captures basic services information about clients and critical alerting and surveillance data in various systems:

- Health Alert Network (HAN)
- National Electronic Disease Surveillance System (NEDSS)
- Hospital Syndromic Surveillance
- Health Information System (HIS), which captures information on clients served and services provided by local health departments. The state is in the process of updating the HIS system, the first major update in 30 years.
- WIC information system
- State of the County's Health Reports
- Vital Records automation

Strategic Links

Healthy Carolinians are local planning efforts that bring stakeholders together to examine community health data, establish health priorities, and try to fill gaps. Healthy Carolinian efforts are active in 93 counties, and focus on the 2010 health objectives. Jeff Spade, Vice President of the NC Hospital Association, is the chair of the statewide Healthy Carolinians effort.

In 2004, the Secretary appointed a Public Health Task Force to examine the public health system. The Task Force identified $60 million in core service gaps, including needed funds for Prevnar® (immunization to prevent pneumococcal infections that can cause Meningitis or other blood infections) ADAP (AIDS Drug Assistance Program), school health nurses, and language/Title VI issues.

Schools as Safety Net Providers
There are almost 1.3 million children attending 2,171 public schools in North Carolina. The average NC school nurse/student ratio is 1:1,918, although national standards suggest that there be at least one school nurse for every 750 students. School nurses provide important services to children and adolescents including:

- Health counseling (35,828 children?)
- Known pregnancies in schools seen by school nurses (2,697)
- Known suicides attempts (431)
- Student injuries and acute illnesses originating at home (59,500)
- Chronic health conditions in the school (121,877 children including 44,971 with asthma, and 2,423 with diabetes)
- Healthcare procedures provided to 12,399 students
- Medications administered to: 82,147 (students)
- Care coordination: 8,149 home visits
- Emergency care provided for 445,552 minor injuries and 8,426 serious injuries

In addition, school nurses oversee the care provided to medically fragile children that require one-on-one supports: 85 professionals in 34 schools (i.e., catheters, oxygen, many medications).

More comprehensive primary care services are provided in school-based/school-linked health centers. In 2004-2005, 26 centers received $1.5 million through the NC Division of Public Health. These centers serve 28,290 students. Twenty-three of these centers are school based, two

are school linked. In addition, there are 25 other school-based or school-linked centers operating in North Carolina.

CRAVEN COUNTY HEALTH DEPARTMENT
Wanda Sandelé, MBA
Director

Craven County has a population of 91,000, of which 14.6% live in poverty, 28% are African American, and 5% are Latino. Latinos comprise a greater percent of the health department patients because many are uninsured, and not eligible for Medicaid. Many of the Latinos are non-English speaking. Craven County is predominantly rural with limited transportation.

Craven County has a regional medical center, and an adequate supply of primary care providers (although they are concentrated in n New Bern and Havelock). The Medicaid population is underserved for dental care (even though there are 34 dentists in the county). A free clinic operates two evenings/week and provides services to low-income, uninsured adults. The free clinic does not serve children as the health department provides primary care services to uninsured children.

Craven County health department (CCHD) has 146 employees, with an annual budget of approximately $8.0 million. Safety net services include: prenatal care, pediatric primary care, clinical dental care, and home health/hospice. Approximately 43% of the funding comes from Medicaid, 29% county, 15% state, 6% grant funds, 5% self-pay, and 2% insurance. Craven County safety net programs also serve clients in surrounding counties, including Jones (9,000 population) and Pamlico (11,000 population).

Self-pay patients are charged for services on a sliding-fee scale based on family size and income. A family with income at 200% of the federal poverty guidelines is considered a full-pay patient, however, no patient is refused care. Most patients pay 20% of the charges or less. Payment schedules may be set up for outstanding balances. A Spanish interpreter is always present, and no questions are asked about a client's immigration status.

Prenatal Care and Deliveries

The Regional Medical Center performs 1,200 deliveries per year; 66% are for women on Medicaid. For years, the health department was the only prenatal care provider for Medicaid-eligible pregnant women, carrying a case load of 400 women. Since the mid 1980s, Craven health department was one of three providers of prenatal care in Craven, Jones and Pamlico counties. The private practices started accepting Medicaid, thereby reducing the Craven caseload to 100 pregnant women. However, beginning in October 2003, the private practice decided to stop providing prenatal care to pregnant women until the 30th week of pregnancy. All new pregnant women are seen at the health department. Now, the health department sees all Craven and Pamlico Medicaid-eligible pregnant women until the 30th week of pregnancy; pregnant patients who have outstanding balances with the private practice; patients who choose to continue to receive care at the health department after the 30th week of pregnancy; Jones county pregnant women who are considered high-risk; low-income immigrant, pregnant women ineligible for Medicaid; self-pay, pregnant women unable to pay for prenatal services in full by the 5th day of the month; and women in need of wrap-around services. The funding for prenatal care is 27% state, and 73% from other earnings.

- In FY 2002-2003, Craven County health department provided maternity services to a caseload of 100 women (311 annually). Of these, 67% were Medicaid, 18% indigent care, 10% self-pay ($5-10/visit), and 5% with private insurance.
- In the third quarter of 2004 (after the changes in the private practice): CCHD has a caseload of 300 pregnant women (projected annual of 840). Of these, 87% are on Medicaid, 6% indigent, 5% self-pay, and 2% with private insurance.

Pediatric Primary Care

CCHD has a long-history providing child health services. Thirty to 35 years ago, CCHD was the only practice willing to accept Medicaid children. In the late 1980s, private practices started accepting Medicaid. CCHD used to be a pediatric teaching site for East Carolina University (ECU) medical school; however the program was withdrawn in the mid 1990s, as more private providers started taking Medicaid.

Currently, CCHD is the medical home for 2,200 children. It is the primary care provider for 1,300 Community Care of North Carolina (Medicaid Access II/III) patients. The services are provided by a pediatric nurse practitioner (PNP), under supervision of an ECU pediatrician. Inpatient coverage is provided through a local private practice. Of the 2,200 patients, 68% are Carolina Access, 12% are self-pay (most are $5/visit), 10% NC Health Choice, and 10% have private insurance.

CCHD plays a critical role in providing services to certain population groups. For example, individuals with incomes in excess of 200% of the federal poverty guidelines who are still low-income benefit from the sliding-fee scale. Most pay between 0-20% of the charges (unlike other health department services, the pediatric sliding-fee scale goes up to 300%—instead of 200%—for full charge). In addition, health departments work with families that are difficult to manage, including those who are no shows, non-compliant, or who need extra teaching and follow-up. The health department is also better able to handle Spanish speaking parents, and children who have babies.

Clinical Dental Care

In all of Craven, Jones, and Pamilico Counties, there is only one pediatric dentist. He will treat Medicaid children through age of three. General dentists rarely take Medicaid, and don't typically treat children until age six or seven. Children under age of six with NC Health Choice or Medicaid have difficulties finding a treating dentist. The CCHD receives an estimated 15 calls a day from parents, teachers, and school nurses seeking dental care for a child (typically for a child in acute pain).

CCHD received a grant from The Kate B. Reynolds Charitable Trust to purchase a mobile dental van. The Smile Mobile goes to 11 elementary schools and one middle school. It has three chairs, and is the dental home to 1,400 children in Craven, Jones, and Pamlico counties who lack a private dental provider. Providing dental services at the schools solves the no-show problem, because if "Bobby isn't there, Mary is." CCHD covered their operational costs in the first year. The dental van sees uninsured children on a sliding-fee scale basis, pregnant women, and adults with Medicaid or low-income (emergency only). Operational costs are supported from fees: 87% from Medicaid, 8% from NC Health Choice, and 5% from self-pay. If they expand the mobile dental program, they hope to provide services in other counties.

Home Health/Hospice

For many years, CCHD was the only provider of home health/hospice. Now, it is one of only two home health agencies, and is the only provider of free-care to low-income uninsured patients. CCHD was the only hospice in Craven until last year. CCHD started a foundation. They receive donations and pay for respite care, drugs and equipment for patients who are unable to afford these services. In addition, the foundation has fund for burial for indigent patients cared for by hospice. CCHD also provides personal care services from a grant from the Home and Community Care Block Grant.

BUNCOMBE COUNTY HEALTH DEPARTMENT
George Bond, Jr., MPH
Director

Buncombe County health department (BCHD) has a $16 million budget with 275 employees. BCHD employed the first female physician licensed in the United States. The health department provides traditional public health services, including: vital records, septic inspections, HIV/AIDs, Hepatitis/Menengitis, food protection (outbreak investigations), family life education, nursing visits to high-risk maternity patients, school nurses, school-based health centers, nutrition counseling, WIC, child service coordination, maternity care coordination, interpreter services, public health lab, regional Public Health Regional Surveillance Team (PHRST)[1] team host, lead investigations, and mosquito trapping. In addition to these traditional public health services, BCHD is the major provider of primary care to low-income uninsured patients.

Primary Care

In the 1970s, some of the local physicians got together through their church to start treating sick Baptist parishioners. Eventually, they hired someone to run this program, and then extended it to the rest of the community. It soon became a healthcare organization instead of a church, and eventually, the BCHD took over the Baptist Church clinic.

BCHD is the primary care home for 15,000-18,000 residents. Every day, the clinic sees 500 patients (60,000 active patients), fills 750 prescriptions, and performs 500 lab procedures. Over half of the staff provide clinical services. BCHD is the largest provider of clinical services to the un- and underinsured in Western NC. Seventy percent of the patients live in poverty. Buncombe County also has a Federally Qualified Health Center (FQHC) look-alike and a free clinic, but they only serve about 10% of the need. BCHD offers primary care services, but not specialty care. However, BCHD made 3,500 specialty referrals through Project Access.

Laboratory Services

BCHD runs 40,000 laboratory tests, in addition to the 60,000 laboratory tests provided by Mission Hospital, and the 18,000 performed by the state laboratory. The BCHD lab will be established as a regional laboratory for the NC Division of Public Health to support bioterrorism response, real time disease and syndrome surveillance, and a regional Safe Worksite Action Team (SWAT) team.

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[1] **bioterrorism response team for 20 western counties**

Pharmacy

The BCHD pharmacy is the biggest pharmacy in Asheville, dispensing more than 750 prescriptions/day. The pharmacy provides prescription counseling in three languages.

Behavioral Health Integration.

BCHD received $1.5 million in grants from The Duke Endowment and the US Health Resources and Services Administration (HRSA) to develop a primary care/behavioral health integration program. The health department hired five licensed clinical social workers (LCSWs) to provide services on the primary care team. The BCHD administers depression tests for all of their primary care patients. After treatment over the course of a few clinic visits, the depression index has decreased and level of functioning has increased. This type of primary care/behavioral health integration effort is critically important with the state's reorganization of the area mental health, developmental disabilities, and substance abuse programs (MHDDSAS). People with severe and persistent mentally illness will use up most of the MHDDSAS resources; other people with less severe mental illness will seek care through primary care centers.

Electronic Medical Records (EMR)

Initially, BCHD developed an EMR system that was inadequate and didn't function well. They eliminated that system, and began work with Mission Hospital to create a new EMR system. This may be the only primary care program linked with a hospital in the same database. When the electronic medical record system is operational, Mr. Bond expects to experience a 20% improvement in productivity,[2] and improved quality of care.

Dental Clinic

BCHD also runs a dental clinic. They have 10 chairs, four dentists, three dental hygienists and an oral surgeon. This is the largest dental practice west of Charlotte. (Note: a private Medicaid clinic opened in Asheville, but this has not reduced the number of patients seen at the BCHD clinic, since the need is so great).

School Based Health Centers

BCHD also operates three school based health clinics. These clinics provide direct clinical services, preventive services, behavioral health, and medical nutrition therapy.

In summary, public health is generally perceived as a "sleeping giant," but they aren't in Buncombe county. The health department provides primary care as well as the traditional public health services. The health department provides over 50,000 outpatient visits/year, offers 24-hour/7-day-a-week coverage, has 28 exam rooms, seven physicians and 10 physician-extenders. They have a full laboratory and pharmacy, and incorporate behavioral mental health services.

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[2] **Mr. Bond has focused on increasing BCHD's productivity since he returned to the health department as director. Mr. Bond left public health for a number of years and worked for a for-profit business. When he came back to public health, he tried to incorporate some of the techniques he used in the for-profit world. Since returning and incorporating some of these techniques, the health department has increased the number of patients seen by 65% (with the same staff). Electronic medical records may improve efficiency by another 20%.**

Health departments across the state serve as the de-facto safety net. Last year, health departments provided $10.3 million in uncompensated prenatal care. In 2002, 32 counties reported $40.7 million in uncompensated care. They are often the provider of last resort, as county commissioners are sometimes willing to fund services for county residents.

Comments and Questions

Q: We have been asked to recruit obstetrician/gynecologists (OB/GYNs) into Wake county. Why did the private physicians stop doing prenatal care for Medicaid patients in Craven County?

A: The private providers did an analysis and found out that they made more money in GYN, not in OB. The practice also had some doctors that didn't provide OB, so that made it more difficult for the doctors that took OB. Also, there was some conflict in the practice; some of the physicians did not want to take any pregnant women (not even at 30 weeks). That would become a huge problem for the health department (as the health department would be "buried" with new clients if the private OB/GYNs refused to take the patients at 30 weeks). Also, malpractice rates are higher for OBs than for GYNs; the doctors can reduce the costs of liability coverage by eliminating deliveries.

Q: How did the Craven County health department convince them to continue to provide prenatal services?

A: The private practice approached the health department to see if they could handle the additional caseload. They have all agreed to this arrangement for the present, and can revisit this if it becomes a problem. The change has created an opportunity to create a model to better manage high-risk pregnancies. In addition, the health department is collecting data, looking at no-show rates, and focusing on avoiding repeat pregnancies.

Q: How is Buncombe County covering the costs of dental operation? Are you just seeing children (with a payment source) or are you also providing services to adults?

A: Medicaid pays enough to break even (or even make a little). These funds are used to support care for adults.

Q: How long does the dental van stay in one place in Craven County?

A: The dental van is staffed by one dentist. The van stays at one school until they are finished with the children, and then move to the next school.

Q: Around the country, partnerships between public health and community health centers (CHCs) have largely been failures. It seems like there is a clear opportunity for collaboration. Can it work?

A: No. The CHC rules have been created to make it impossible. In order to obtain CHC funding, a health center has to meet all these requirements [including board composition, located in a medically underserved area (MUA), etc.]. In Buncombe County, the health department has a statutorily required board that doesn't meet the federal requirements. Further, the location of the health department is not a MUA, although they serve lots of patients from MUAs. There is a pre-existing FQHC look-alike in Buncombe county; this center only serves 1,800 patients. To collaborate (i.e., to qualify for additional federal funds), the health department primary care clinic (which serves between 15,000-18,000 patients) would have to be subsumed under the FQHC look-alike. That didn't make any sense. The federal CHC rules need to be revisited.

Comment: There may be opportunities for collaboration in some counties. Several counties are working on ways to collaborate and create partnerships, even if they don't actually try to create a combined organization that receives federal funds. The Cleco Primary Care Network and Gaston County are examples where health departments have been able to successfully create collaborations that combine primary healthcare centers with health departments. The Division of Public Health and NC Community Health Center Association are trying to get their groups together to figure out partnerships and collaboratives.

Comment: A lot of what they have been able to do in Buncombe County to integrate services across organizations is because of the health department collaboration.

Comment: Doctors all over North Carolina want to "do the right thing." We need a physician or community leader to stir the pot, and direct their good will into action.

PROJECT ACCESS MODEL
Alan McKenzie
President of American Project Access Network

The Center for Studying Health Systems Change surveyed the uninsured regarding where they go for healthcare. Nearly two-thirds of the uninsured who receive care report that a physician is their usual source of care, and about half receive care in a private physician's office.[3] According to a 2000 study reported in the *Journal of the American Medical Association*, 77.9% of primary care visits for patients with Medicaid or no insurance occur in physicians' offices,[4] 11.5% occur in hospital outpatient departments, and 10.6% occur in community centers.[5]

However, few physicians feel comfortable being the only doctor volunteering to do serve the uninsured. To help spread the burden/risk of caring for the uninsured, Project Access organizes volunteer physicians and distributes the patient referrals among many volunteers. Organizing the volunteers, captures and channels a resource most communities.

The Asheville/Buncombe County Project Access story is a celebration of partnerships. Project Access began in Asheville with an emotional commitment from the physician community. According to Dr. Jim Powell, an Asheville physician, "We acted to do something simple: provide increased support for safety net clinics and specialty care to uninsured patients. It was the right thing to do. As a result, we saw good things happen. We did not set out to achieve 100% access or fix the delivery system."

Project Access in Buncombe County partners with physicians, practice managers, hospitals (acute care, rehabilitation, laboratory testing), neighborhood and community clinics (primary care), the faith community, and pharmacies. Funding may come from city, county, and/or federal grants and allocations; hospitals; and local, state, and national foundations and charity organizations. Administration is provided by managed care organizations (claims forms), area health education

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[3] Reed, MR, Cunningham, PJ, Stoddard, J. HSC's Community Tracking Study. Physician Survey Center for Studying Health System Change. Issue Brief No. 42, August 2001. Available at http://www.hschange.org/CONTENT/356/
[4] Includes locally funded health departments.
[5] Forrest, CB. Primary Care Safety-Net Delivery Sites in the United States: A Comparison of Community Health Centers, Hospital Outpatient Departments, and Physicians' Offices. JAMA. 2000; 284:2079.

centers (evaluations), department of social services (Medicaid), medical societies, hospitals, and coalitions. Planning is enhanced by the Health Carolinians Task Forces.

The Project Access Model is a system of healthcare for low-income, uninsured patients that uses a better organized physician-donated care component to help leverage alignment of existing healthcare and related resources to improve access to quality care in the community.

To begin a program like Project Access, a community must first be able to assess the unmet healthcare need in their area. How many low-income, uninsured people reside in the community? How many physician offices exist in the community and what is the capacity of these offices, the health department, the hospital and other sources of care?
It is surprising how many communities with significant safety net providers cannot answer data questions about unmet healthcare needs in their community.

In order for physicians to have hospital admitting privileges, they have to participate in unassigned emergency department coverage. During the shifts they cover the emergency department, physicians pick up uninsured patients. This is a type of mandatory volunteerism. Other partners are needed to make this system work (e.g., residency programs, local DSS, healthy Carolinians task forces).

In the Project Access Model, patients receive a card that serves as an insurance card and helps brings dignity to the patients. Patients receive primary care from federally qualified community health centers (FQHCs), free clinics, health departments, and private doctors. The Project Access CARES (centralized applications, referrals, and enrollment status) System refers patients to free specialty and hospital care as of they have private insurance. Specialty care is provided by a network of physicians in their offices or free clinics. Project Access also provides medication assistance cards, which are honored by participating pharmacies.

Before agreeing to participate, the physicians wanted assurance that patients would be able to get needed medications. Project Access supporters negotiate for medications with county commissioners by leveraging all of the free care provided in exchange for medications. They also negotiated with drug companies to get lower prices. All 44 pharmacies in Buncombe County participate.

The physician community has been reinvigorated by Project Access. Physician participation has grown from less than 20% to nearly 100%. The physicians provide a higher percentage of the value of donated care than the hospital does (about $8,000 per doctor per year) and the uninsured are now less likely to use emergency department.

There has been a jump in the productivity of the primary care safety net (i.e., seeing more patients with the same staffing, budget, etc.). From 1995 to 2003 the average number of visits per patient per year in community health clinics dropped from 5.0 to 2.5. The average length of each visit decreased from 45 minutes to 20 minutes. The number of nurses needed to refer patient to specialty care decrease from eight full-time equivalents to one. Physician time spent finding specialty care for patients also decreased.

The health of the uninsured in the community has improved. According to a population health survey, the uninsured and insured now report similar health status and emergency department use.[67]

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[6] 2000 Community Health Survey, Professional Research Consultants

With Project Access, a restructuring occurs that increases access. In 1995 the uninsured population at income levels less than or equal to 200% FPL was 15,000 (8% of the population) compared to 23,000 (11% of the population). In that same time frame, the uninsured with access to a medical home and specialty care, treatment, testing, and hospital services increased from 7,300 to 21,500. The percent of uninsured with increased access to care increased from 50% to 90%.

Another study measured the employment of Project Access patients. Of the patients surveyed, 14% reported gaining employment since enrolling in Project Access, 25% reported that the services helped them return to work or do a better job, 46% reported obtaining a job that provided health insurance, 98% reported having a routine check-up within the last two years, and 80% reported their health is better or much better.

Hospitals were also able to report a $2-3 million reduction from projected charity care expenses.

WAKE COUNTY PROJECT ACCESS
Paul Harrison
Director of Medical Society in wake County

Project Access of Wake County is very similar to Project Access in Buncombe County,. Like the Project Access model in Buncombe County, Project Access in Wake County is also physician driven (460 physicians participate).
Partners include Wake Health Service Clinics, Inc., WakeMed faculty physician clinics, health department clinics, Urban Ministries-Open Door Clinic, Alliance Medical Ministry, Raleigh Rescue Mission, The Healing Place, and Wake County School nurses and hospitals. School health nurses are a major source of referrals. Olivia Flemming at the Open Door Clinic is a major partner in making this work. There is a tremendous amount of donated care.

Over eight million dollars worth of inpatient and outpatient care has been donated equally between hospitals and private practice physicians to the uninsured through Project Access. Medical services have been delivered to 3,889 residents. Project Access has increased volunteerism by 460 physicians, established a network of primary care clinics as a successful medial referral service, leveraged donated care on a ratio of $1:$21, and identified 2% of Project Access patients as Medicaid eligible, allowing hospitals and physicians to bill for services.

Project Access has less than two full-time equivalent employees—half the budget goes to those employees and half to pay for medications. Everything else is donated.

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[7] MAHEC. October 1998. Sample 276 Project Access patients (51% no longer enrolled).

Wake County Project Access Cost-Benefit Ratios

Activity	2001	2002	2003
Patients	757	1210	1387
Appointments	1797	4262	6448
Donated Care	$3,388,842.00	$5,726,809.00	$8,205,159.00
Program Cost	**2001**	**2002**	**2003**
Administrative Cost	$ 160,029.00	$ 160,110.00	$181,842.00
Pharmacy Cost	$ 44,335.00	$ 198,136.00	$ 87,595.00
Total	$ 204,364.00	$ 358,246.00	$ 269,437.00
Cost Ratio	**$1:$16.58**	**$1:$15.98**	**$1:$30.45**

Wake County Project Access is able to track claims internally. Using CPT® coding, Project Access is able to report the types of medical problems presented and services rendered. They also benefit from having a CARES system and an on-line database physician volunteer pool.

Project Access has developed integrated relationships with most providers in Wake County. We have been able to expand on the platform of Project Access and create some child-oriented programs (e.g., immunizations, early identification of children with developmental disabilities, community pharmacy program with 340D discounts on drugs.

APPALACHIAN HEALTHCARE PROJECT
Gillian Baker, MHA
Director

The Appalachian Healthcare Project was generated from a study of the healthcare delivery system in the High Country region of northwest North Carolina. Watauga Medical Center is the lead agency. The Project was the first rural Project Access program and serves Watauga and Avery Counties.

Watauga County has a population of 42,857 people with 25 primary care providers and 60 specialists. Avery County has a population of 17,610 with 17 primary care providers and two specialists.

In the spring of 2000, there was no healthcare service other than the emergency department for low-income people in the two counties. There were no free clinics in Avery or Watauga County. Forty-two percent of Watauga County patients receive primary care from the local health department and 58% receive it from private primary care physicians.

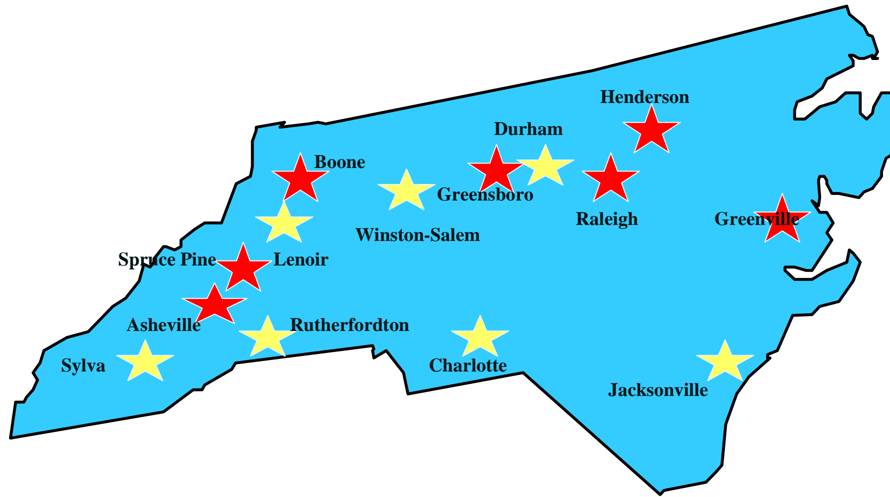
Since implementation in April 2001, 586 patients have been served by the project. On average, there are about 200 active patients at any given time. In 2003, the value of care provided to Appalachian Healthcare Project patients was more than $2 million.

The success in Watauga and Avery County is proof that the Project Access model can work in small rural areas. There is flexibility in the model.

PROJECT ACCESS SITES IN NORTH CAROLINA

The Project Access model has been implemented in seven North Carolina communities—Buncombe County, Watauga-Avery County, Mitchell-Yancey County, Guilford County, Wake County, Vance-Warren County, and Pitt County—with more than 1,900 private sector physician volunteers. Six other communities (i.e., Sylva, Rutherforton, Charlotte, Winston-Salem, Durham, and Jacksonville) are in the process of implementing Project Access models. Project Access models are also operating in other states.

Project Access Operational and Implementing Sites in NC



There are a variety of funding sources used to plan, implement, and operate the model in each county. For example, Buncombe County receives funding from the Robert Wood Johnson Foundation and Buncombe County government. Pitt County received funds from the **NC Office** of Research, Demonstrations, and Rural Health Development, The Duke Endowment, and from the Healthy Communities Access Program (HCAP) grants. Wake County received funding from the NC Division of Rural Health, Wake County government, and the John Rex Endowment. Watauga received funding from the hospital, the Appalachian Regional Commission via the Office of Rural Health, The Duke Endowment and The Kate B. Reynolds Charitable Trust. Guilford County received funding from the Moses Cone-Wesley Long Community Health Foundation. Vance-Warren County received funding from the Managed Care Health Network. Mitchell-Yancey County received funding from The Kate B. Reynolds Charitable Trust and Spruce Pine Community Hospital.

The American Project Access Network was formed to create better organized, more accessible safety net access provider systems in every community. The group supports 100% access and a goal to eliminate healthcare disparity. The mission also includes invigorating physician leadership in communities and fostering statewide initiatives and platforms.

The matrix on the next page has gotten fairly sophisticated with what it takes to implement Project Access in a community. There are10 activity streams that need to be addressed and six phases.

Matrix for Forming Safety Net Access Provider Systems

		Î. Investigate	II. Staging	III. Implement	IV. Operations	V. Sustainability	VI. Expansion
	Physician Engagement	ID Physician champion	Recruit super seven	Secure MD pledges	Monitor MD satisfaction	MD pledge renewal process	Recruit new MD champions
	Community Partnerships	Identify needed partners	Recruit partners	Partnership deals	Keep commitments	Demonstrate value to partners	New venture partners
	Communication, Media	Generate media interest	Media on planning events	Media: Launch	Secure regular media coverage	Celebration, awards	Community interest, demand
	Resource Development	Organize asset mapping	Secure start up funding	Make business plans	Make deals with PA asset	Secure sustained local support	Secure funding
	Pacing Events	Presentation by PA leaders	Visit operational Project Access	Event "first patient" seen	Celebrate milestone events	Secure awards & give recognition	Convene Task Force for new project
Operating System Activities	**Operational Infrastructure**	Create physician owned vehicle	Implementation Manager.	Network Manager	Manage MD patient flow	Produce service	Restructure management
	Evaluation Of Performance	Declare PA purpose	Evaluation team, measurements	Baseline assessment	Track performance	Performance reporting	Evaluation plan for new ventures
	Technology Integration	Examine models that work	Select approach, system, funding	Acquire technology	Training and integration	Demonstrate integration	Integration of new projects
	Case Mgt	Examine models that work	Form clinical steering team	Organize case mgr function	Coordinate organizations	Track impact on revenue, costs	Add new areas
	Pharmacy Programs	Examine models that work	Identify programs, need	Formulary team, secure funding	Organize "patient in need"	Track cost and impact	Adjust to align new ventures

Policy Implications of the Project Access Model

Physician capacity for donating care is being squeezed out of existence due to increasing costs and reducing reimbursement. They are still one of the single largest sources of care for the uninsured. There has been a recent drop in physicians providing charity care from 76% to 72%.[8]

Fewer physicians are providing charity care because of increasing medical liability, administrative, technology investment, labor, and overhead costs. Lower payments per unit of service are another barrier to the provision of charity care by private physicians.

Physician perceptions may also be barriers to buy-in to charity care. Physicians and feel the distribution of charity care is inequitable among other physicians and other community providers. Every physician thinks they are the only one helping to provide care to the uninsured. Physicians also believe others in community are being paid to provide care to the uninsured (i.e., community health centers). Another barrier to physician buy-in is the perception that these patients are irresponsible. Project Access representatives are educating physicians about patient barriers and increasing sensitivity to patient's challenges. Physicians may also feel their efforts are futile if the patients have no access to prescription drugs. Assurance that patients will be able to get the prescription drugs they need will help attract physicians to the model. In addition to these

[8] **www.hschange.org/CONTENT/356**

barriers, a lack of appreciation, recognition, and executive and administrative support may prevent physicians from providing charity care.

Nationwide, an estimated $38.1 billion of uncompensated care was provided in 2003. The federal, state and local governments provided reimbursements to hospitals, clinics, and service programs through the Disproportionate Share Hospital Fund (DSH) and state local taxes for $30.6 billion. This leaves a net of $7.5 billion in unreimbursed, uncompensated care ($2.3 billion for hospitals and $5.1 billion for private sector physicians).[9] Theses estimates may be underrepresented by a factor of four based on the Asheville data. This data was self reported.

Some possible solutions that might encourage physician to continue treating patients without insurance might include a Disproportionate Share Physician (DSP) Fund based on the DSH fund. The fund would provide reimbursement to physicians providing care to the uninsured if physicians were able to organize them selves and document the care provided.

Other policy implications involve prescription drug programs for the uninsured (Virginia and Kentucky are examples of state's that have programs.), medical liability reform (e.g., expansion of good Samaritan Act for physicians in their practice), and financing to communities for Project Access planning and implementation (possibly from Healthy Carolinians Task Forces).

Comments and Questions

Q: If you were going to go into a community and try to ask if it was practical to start a Project Access system, what would you be need to know?

A: You should know the ratio of providers to patients and the number of low-income people in community. This data should be compared to an established Project Access model. You need to find at least one doctor to champion the idea.

Comment: Dr. Herman Godwin, a practicing oncologist in Watauga helped champion the Project Access model in Watauga and Avery Counties. He was well-known and had the time to talk with other physicians in the community. He started the ball rolling by getting a core group of doctors together, and they took the message to their peers. Some physicians in New Bern could be found to do this. There is a large regional hospital there, which would help. Does New Bern have any military support?

Q: With regard to incentives for volunteers, do you feel like DHS funds or something like them would be key to statewide implementation or should we continue to depend on locally grown Project Access Models?

A: The Project Access principles are universally applicable, but we think these incentives would help lower the barriers to volunteer participation.

Comment: Buncombe County is doing a great job because it has resources in people and places. Realistically, it works better in partnership with another community organization. It is tougher for Watauga, for example.

Q: In communities that don't have the resources (like one with no tertiary care system) or that have too many uninsured low-income people, how would these networks work?

[9] A Shared Destiny: Community Effects of Uninsurance. National Institute of Medicine, 2003.

A: Henderson-Vance County is an example of a county that had more uninsured than they new what to do with. Their Project Access encompasses Duke and Wake County hospitals (which have agreed to take referrals, because that is where their private paying patients going for care). So, they are able to build off of the private pay referral networks.

Q: How many of those kinds of networks can Duke support?
A: They are getting these referrals anyway because this is the referral pattern. The Project Access plan is to make this more effective and efficient. Project Access does not create new demands on an existing patient referral system. It should reduce the demand by improving health of patient.

Q: Has anyone ever done research on a state tax credit for volunteerism in physician community? That might be a policy option that can be explored. It would benefit both free clinics and doctors volunteering.
A: There are some models out there. Virginia has one, but North Carolina not pursued this so far partly because we want doctors to be perceived as compassionate.

Q: Buncombe County has been successful in funding medications. Have other communities been able to replicate pharmacy programs?
A: Many communities have found recurring financial support from government officials, hospital foundations, and other sources. They have been able to attract and sustain programs using measurable outcomes and demonstrated partnerships/support. The mutual support among the community of providers drives and sustains the programs. However, no North Carolina County east of I-95 provides medication assistance to their local community.

Comment: There are a significant number of retired doctors who would be willing to volunteer, but may be concerned about their malpractice insurance.

A: Medical Mutual will write a policy for $100/year for retired physicians to use only for volunteer efforts. The Good Samaritan Act also protects doctors who provide charity care, but falls short of providing coverage for patients seen for free in their own practice. We need to address this as a policy issue.
Comment: Physicians are being told that exposure to certain populations will cause their insurance to go up. Medical Mutual must know actuarially that this is not true or they would not provide the policy. So far there are no law suits against any of these clinics. The Good Samaritan Act helps by paying for the defense coverage that may be needed to get a malpractice case dismissed. We should distinguish between a policy that covers every thing and a policy that covers the defense. We should clearly define what the malpractice-related problems are.

PRIVATE PHYSICIAN INVOLVEMENT IN SERVING THE UNINSURED
John Estes
NC Medical Society Foundation

There is not much data about private physicians and the uninsured. There are a few national studies, but little state data. Formal systems where private physicians provide care to the uninsured include: hospitals/emergency rooms, Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), community health centers (CHCs), health departments, free clinics, and Project Access models.

Nationally, $5.1 billion in documented charity care is provided. Hospitals provide 65% of this care, clinics and direct care programs provide 20%, and physicians provide 15%.

Private physicians often volunteer to provide charity care through informal systems. Their provision of charity care is voluntary. Although the American Medical Association encourages volunteerism, there are no standard guidelines to document amount of charity care they provide.

The Health Systems Change survey shows 71% of physicians provide charity care, Medical Group Management Association documented 73%, and NC Medical Society documented 61% in their survey.

The number of physicians providing 10 or more hours/month is also trending down. (76% in 1996-1997 and 72% in 1998-1999).[3] The numbers of physicians NOT accepting new uninsured patients is rising. This may be due to less cross subsidization available to help pay for indigent care.

External forces are pushing physicians out of the indigent care market. The practice of medicine is changing (i.e., physicians more likely to be employed by systems such as managed care plan, and employed physicians are less likely to provide charity care). There are financial constraints and lower reimbursement rates for care provided (i.e., Medicaid, Medicare, and commercial), increasing costs of doing business (malpractice, staff costs), and time constraints (increased regulation from Clinical Laboratory Improvement Amendments (CLIA), Health Insurance Portability And Accountability Act (HIPAA), managed care oversight, and physicians are wanting more time off for family).

When Medical Group Management Association did a survey in 2003, they found that 29% of practices have a written or formal process to identify and treat the financial component of indigent care patients. In more than half (53%) of practices the decision on how to classify the patient encounter is made by the physician. In 25% of practices this decision is made by the practice administrator and the remainder by billing clerks, collection clerks, or other staff. Collection staff are more likely to write off costs than physicians.

Most practices (95%) record indigent encounters in their billing system. Three-fourths of the practices record these encounters in full and then adjust downward to $0. Seventeen percent report the encounter as "no charge"—which means that the $5.1 billion reported in previous studies is conservative if only 75% are capturing the full charge. The average practice writes off 1.5-2% of total charges to indigent care.

In summary, physicians provide approximately 15% of the indigent care, which amounts to at least $5 billion annually. However, the number of physicians providing charity care is decreasing, the number providing the most hours (10+ per month) of charity care is decreasing,

and the number refusing to accept new patients is increasing. These changes are largely due to external forces, which are pushing physicians out of the charity care market. Physicians are committed to providing their share of charity care.

Comment: Physicians don't want to report costs of charity care, because in many systems it is listed as accounts receivable and would require additional work to zero out the bill.

UPDATE ON COUNTY-LEVEL ESTIMATES OF THE UNINSURED

Mark Holmes, PhD
Research Fellow
Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill

Dr. Holmes presented two North Carolina maps that illustrated county estimates of the uninsured in 2002. The maps are estimates from the US Census Bureau Current Population Survey (CPS) that were produced by the North Carolina Rural Health Research and Policy Analysis Program at the Cecil G. Sheps Center for Health Services Research.

The percent of uninsured ranges from 15.9% in Wake County to 26.1% in Duplin County. The counties with the highest percentages of people ages 0 to 64 without health insurance are in the eastern part of the state (east of Interstate 95). There are a few counties in western North Carolina that also have more than 20% uninsured. Most of these areas are rural areas.

If you look at number instead of percent you get a different story. Higher numbers of uninsured are concentrated in more populated areas. The counties with highest number of uninsured people ages 0 to 64 are in more urban areas (Mecklenburg, Forsythe, Guilford, Alamance, Orange, Durham, Wake, Cumberland, and New Hanover Counties).

There is considerable interest in small area estimates of the uninsured (i.e., county level). Everyone has different numbers—that's why they are estimates. There are two methods that are feasible to make small county estimates. One is a direct estimate—to administer a survey directly to the people in the county. The second survey method is to take an indirect measure from a super population. This method is used when it's not feasible to do a direct survey of all of the counties.

The direct method is preferred, but expensive, because it would require an adequate survey for each of the 100 counties. The indirect method combines state data with other information to develop county level estimates. The idea is to model the probability of being uninsured by age, gender, race/ethnicity, employment status, industry, poverty status, and education; and then identify the number of people in the county who fit those characteristics to estimate numbers of uninsured. The estimates presented here were calculated using the indirect method.

Comments and Questions

Q: The data presented represents uninsured people age 0 to 64. Is the Hispanic population young (less than 65), so we don't have to worry about them?
A: Conventional wisdom says that the number of people over age 65 and uninsured is not high enough to model. In the past it was only 0.1%. This assumption is becoming more questionable. Until recently, we haven't had to look at people over age 65 because most of them are covered by Medicare, but will start looking at them.

Q: Are these people that are uninsured for the entire year?
A: In theory, yes, but in practice you should think of it as snapshot data. The question asks, "Have you had insurance coverage anytime in the last year," but if you look at other surveys where they are asking about insurance status based on coverage for a three-month basis, it looks similar. There are three different ways of looking at the data: (1) entire year, (2) one day (point-in-time) data, and (3) anytime during the year. CPS is considered a point-in-time estimate, Families USA is anytime. This confuses policy makers.

Comments: Maps are good at telling us where and how many, but they don't tell us why people are uninsured (i.e., rural, type of industry). What are the possible regional correlations with this data? Small businesses are locating in some of the rural areas and not providing insurance. Maybe this is an area we could address.
A: Poverty and education are driving a lot of this, but we should look at numbers more carefully.

Comment: National data 2000 says the reason people don't have coverage is because: it is too expensive (50%), people have jobs that don't offer coverage (15%), people are between jobs (15%), people are denied coverage (5%), people don't think they need it (3%), and miscellaneous other reasons (15%). Most of the uninsured are males, ages 24-30, who are working in the construction industry with low household incomes. Living in a rural is a component, but not as strong as some of these others.

Q: Some say we are losing employer provided health insurance at 0.5% a year. Is this true?
A: We gained employer coverage in the 1990s during boom, and lost during the recession. Whether or not coverage is provided depends on characteristics of the employer (service industry) and the wage level. Employers haven't stopped offering it, but employees can no longer afford it. Surveys have shown drops in the number of people accepting employer-based insurance versus employers dropping programs.

Q: Is employer-sponsored insurance (ESI) going down?
A: Yes, recently (but there was an increase in ESI for the early 2000). In last two years, there has been a decrease in ESI. Surveys show that employers are not dropping coverage, but that employees can't afford the coverage, or their hours are being reduced so they are not eligible for coverage, or they may change to a job that don't offer coverage.

Q: In my county, we have an estimated 10,000 uninsured, but we only see 200 for care. Where are the others going? Are they healthy?
A: There are a lot of healthy uninsured who don't need much care. We would like to identify numbers of high-risk uninsured.

Comment: The question is not just whether trends are increasing for the numbers of uninsured, but also whether we will be increasing the numbers of underinsured through high-deductible plans. How will the safety net respond to those with high-deductibles, who are effectively uninsured until they meet the deductible.

Q: Can you create a map that shows how many uninsured people facilities say they are seeing and overlap the map of the uninsured to see where need is?
A: Pam is working on this.

Q: Have the numbers of the uninsured ages 0 to 17 gone down since NC Health Choice increased enrollment capacity?
A: Yes it has been reflected in number and percent. Nationally 25% of the uninsured are children. However, not all eligible children are in NC Health Choice.

Comment: Most people are healthy most of the time so these people aren't seeking regular care, but may go to the emergency department for a problem. Concentrated problems are probably in children and people ages 45 to 65 (i.e., people who have chronic diseases

Q: Health insurance carriers at one point were moving away from the small group market. Is that trend continuing?
A: We need to have a presentation on the trends of employer-based coverage. However, this task force is not set up to discuss the uninsured, its about the safety net. This Task Force is not properly constituted to focus on the uninsured. Even so, seeing these trends might help safety net providers see where their future may be. We are probably going to start seeing more underinsured because of higher deductibles, etc.

Comment: There are cafeteria plans that give consumer choice.
Comment: These are programs that shift the costs to the consumer and leave them exposed.
Comment: As healthcare costs increase, it's a way for employers to still provide insurance.
There was disagreement over the terms of the cafeteria plans.

SITE VISITS

Mark Holmes, Kristie Weisner, Gordon DeFriese, and Pam Silberman gave brief overviews of the groups' site visits to Greenville, Winston-Salem, Greensboro, and Concord.

NEXT MEETING JULY 23

At the July 23 meeting, we will be talking about hospitals, AHEC clinics, DSH payments, and about prescription drug programs.

In August we will meet in workgroups. Some possible workgroup themes include: how do you support community collaboration/integration, where are the areas of greatest unmet need, prescription drug programs, etc. We will discuss how we can meet the need, financing mechanisms to care for the uninsured, the consumer's role, etc.