

**North Carolina Institute of Medicine
Safety Net Task Force
Meeting Summary
September 23, 2004
NC Hospital Center
Cary, NC**

ATTENDANCE

Members: Tom Bacon, Gillian Baker, George Bond, Mike Cinoman, Dick Daugherty, Leah Devlin, Brian Ellerby, Margaret Elliot, John Estes, Bob Fitzgerald, Olivia Fleming, John Graeter, Andy Hartsfield, Johanna Irving, Alan McKenzie, John Mills, Bill Pully, William Purcell, Wanda Sandele, Adam Searing, Shirley Sims, John Sullivan.

Steering Committee: Dennis Harrington, Mark Holmes, Andrea Radford, Tom Ricketts, Jeff Spade, Tom Wroth, Ben Money.

Staff: Gordon DeFriese, Kristen Dubay, Thalia Fuller, Adrienne Parker, Pam Silberman, Kristie Weisner Thompson.

Others: Linda Attarian and Pam Highsmith.

WELCOME AND OVERVIEW OF AGENDA

This meeting began with an update of the uninsured in North Carolina and an update on the Office of Research, Demonstrations, and Rural Health Development (ORDRHD) Advisory Committee Update. Then there was a brief summary of what has happened in our workgroups to this point. Work Group discussions concluded the meeting.

Among the handouts distributed on September 23 were the first three chapters of the Task Force Report. Changes that need to be made before the report chapters are finalized later this year. Please use the track changes feature on your computer if you make edits to the document.

COMMUNITY HEALTH GRANTS UPDATE

Pam Silberman, JD, DrPH

Vice President

North Carolina Institute of Medicine

The NC General Assembly appropriated seven million dollars to safety net organizations so they could expand care to the uninsured and “medically indigent.” Five million dollars was allocated for Federally Qualified Health Centers (FQHCs) or FQHC Look-Alikes. Two million dollars was allocated for public health and/or rural health clinics. The NC General Assembly appropriated these funds to the ORDRHD, with directions to establish an Advisory Committee that will develop objective criteria for distributing the funds.

ORDRHD asked the North Carolina Institute of Medicine (NC IOM) to help facilitate the Advisory Committee meeting. FQHC representatives: Sonya Bruton, Ben Money, and Michael Baker; Public Health representatives: Dennis Harrington, George Bond, and Leah Devlin; and ORDRHD representatives: Tork Wade and John Graeter were invited to attend the meeting.

The statute refers to the uninsured or “medically indigent,” but does not define the terms. The Advisory Committee defined “medically indigent” as individuals with family incomes equal to or less than 200% FPG who have inadequate health insurance coverage. For purposes of this legislation, individuals with Medicaid or NC Health Choice coverage are not considered medically indigent.

Comment: The definition for medically indigent should be changed. Many families above 200% FPG cannot afford health insurance.

The Committee defined Primary Care to include physicians, nurse practitioners, physician assistants, and certified nurse midwives. Primary care providers (PCPs) must provide medical care, including health promotion, identification of individuals at risk, early detection of serious disease, management of acute emergencies, render continuous care to chronically ill patients, and refer patients to another provider when necessary. They must also provide or arrange for coverage of services, consultation or referral, and treatment for emergency conditions 24 hours/day, 7 days/week. Automatic referral to the hospital emergency room does not satisfy this requirement.

In addition, PCPs must provide direct patient care a minimum of 30-office hours per week and establish and maintain hospital admitting privileges or a formal arrangement for the management of inpatient hospital admissions. The PCP’s affiliated hospital must be located no more than 30 miles or a 45-minute drive from the provider’s practice.

FQHCs are eligible for \$1.2 million (\$100,000 maximum per center) as long as the money will be used to increase access to preventive and primary care services. One million (\$250,000 maximum per center) will be used to create FQHC or FQHC-Look A-likes where no such services existed. Another \$1.75 million (\$250,000 maximum per center) will be used to create new services or augment existing services, including primary and preventive services, dental, pharmacy, and behavioral health. One million (\$175,000 maximum per center) will be used to enhance or replace technology, equipment, or facilities. No organization can receive more than \$500,000 in grant awards.

Rural Health Clinics are eligible for \$1.0 million. A sum of \$300,000 (\$75,000 maximum per center) will be used for capital equipment or technology upgrades; \$500,000 (\$150,000 maximum per center) will be used for start-up funds for new organizations or new programs, including dental, pharmacy, mental health or nutrition; and \$200,000 (\$50,000 maximum per center) will be used to expand medical assistance program (MAP) funds to new organizations.

Public Health is eligible for \$1.0 million. Priority will be given to: (1) increasing access to preventive and primary care services in an existing primary care units; (2) creating new services or augmenting services, including primary care and preventive, dental services, pharmacy and

behavioral health services; (3) planning grants to enable local health departments that are not currently providing comprehensive primary care services to develop a business plan for offering such services in FY 2005-06 (\$20,000 maximum per local health department, maximum three planning grants); and (4) enhancing or replacing facilities, equipment or technologies. Priorities will be given to categories (1) and (2). The maximum amount per local health department is \$150,000.

Prospective grantees will be required to identify other organizations in their community that provide primary care services to uninsured and medically indigent. They must provide a narrative about efforts to collaborate and/or develop integrated delivery systems with other safety net groups. Letters of support from other safety net organizations would strengthen applications.

Applications for FQHC are due by September 27th, and Public Health and Rural Health applications are due by October 4th. Each association (or state agency) will make recommended funding decisions. The goal is to have funds distributed by Nov. 1, 2004.

Each successful applicant must provide information on the numbers of uninsured and medically indigent served. Baseline reporting will be required for the periods: November-December 2003, January-March 2004, and April-June 2004. Ongoing reporting responsibilities will be for the periods: November-December 2004, January-March 2005, and April-June 2005. Awardees will be required to supply the number of uninsured and medically indigent, number of patient encounters, number of services provided (if the grant is for new or augmented services), number of new patients seen in the clinic, and a narrative of how funds were used and the outcomes.

The Advisory Committee is responsible for reviewing grants, problems encountered in grant making process, and local collaborations. The Committee will develop recommendations to report to the NC General Assembly in the 2005 session. Potential recommendations include:

- Set aside funds to encourage collaboration among existing safety net organizations (e.g., state-funded HCAP program).
- Enhance technical assistance available to help low-wealth and high needs communities develop safety net capacity to offer primary care to uninsured and medically indigent
- Create opportunities to bring together safety net providers (on statewide or regional basis) to facilitate discussion, collaboration, and integration across organizations
- Create ongoing state-level Safety Net Advisory Council that can continue to encourage collaboration at state level after the NC IOM Task Force is completed. This group should be expanded to include other safety net organizations including free clinics, hospitals, Project Access models, etc.

The NC IOM Safety Net Task Force may want to consider similar types of recommendations.

Comments and Questions

Q: Where do we expect people to get the numbers of uninsured and medically indigent?

A: Clinics should gather this information when they treat patients.

Comment: The Advisory Committee is an ongoing committee. One of the things the legislation requires from ORDRHD is recommendations for the next session. Legislation requires they report back at the beginning of next session (January). If money is re-appropriated next year, should certain amounts be allocated to encourage collaboration? Some of the communities may not be ready to apply for funding because they lack technical support.

Q: Is the evaluation of collaboration for vertical or horizontal collaboration?

A: It is not that detailed yet.

Comment: Technical assistance to communities has always been a job of ORDRHD. Funding cuts have hurt their ability to provide technical support. We don't want to create another office for technical assistance. There is recognition that some of this work is going on, but how can we strengthen it?

Q: Is there a way to make sure the most needy areas know about these grants?

A: Yes, for public health, but the problem with rural health and community health centers is that if they exist, they know, but how do you grow those where they don't exist?

Comment: The health department in every county is responsible for assessing access to care. They are in a position to know who is in their community and what their access to care is. This is one of the 10 essential services. This avenue offers a clear-cut obvious mechanism for getting the word out. We should charge health departments with letting what ever powers in the community know.

OVERVIEW OF THE UNINSURED IN NORTH CAROLINA: 2004 UPDATE

Mark Holmes, PhD

Cecil G. Sheps Center for Health Services Research

University of North Carolina at Chapel Hill

We like to smooth the uninsured numbers over multiple years. This isn't all new data, its additional data added to what was already reported in the spring Task Force meeting.

The US Bureau of the Census's Current Population Survey (CPS) collects information from about 4000 North Carolina residents every March. A weighted average of 2003, 2002, and 2001 data is calculated with more weight put on the latest years. Insurance status is defined for the year *prior* to the survey. CPS 2004, for example, refers to the insurance status in 2003.

Respondents are asked, "At any time in 2003, was anyone in this household covered by Medicaid?" If so, "Who was that?" Respondents were also asked about numerous health insurance plans (Medicare, CHAMPUS, employer-based, etc.) If the respondent answered "no" to all, then they were asked a verification question. The interviewer would say, "I have recorded that (you) were not covered by a health plan at any time in 2003. Is that correct?" If the respondent agrees, then they were classified as uninsured. "*Uninsured*" is therefore defined as "*uninsured for the entire year.*" Most researchers, however, think these estimates are more indicative of "point-in-time" estimates.

In most of the results presented here, we combine the last three years and place more weight on the recent surveys. “One-year” estimates are less precise and “multi-year” estimates are less responsive to trends. Respondents age 65 or over were not included. People over age 65 only make up about 1% of the uninsured at this point.

The data reveal no significant changes in terms of risk factors for being uninsured. The uninsured rate of individuals below age 65 has grown over last three years. Those most at risk of being uninsured are between 20 and 30 years old, poor, living in an rural area, unemployed, a race other than white, Latino, not a US citizen, or employed at a small firm. Most uninsured, however, are connected to the workforce.

We define five types of coverage for those under age 65: (1) Medicare (disabled), (2) Medicaid and SCHIP (NC Health Choice), employer-based; (4) private, and (5) uninsured.

The Rate of Uninsured

In 2003 (the latest year available), approximately 19.4% of North Carolinians below the age of 65 were uninsured. Considering *all* individuals (including those age 65 and over), it yields an uninsured rate of 17.3%. This translates to 1.42 million individuals. After smoothing the data over three years, a slightly lower estimate of 18.9% is yielded.

There was a secular decline in employer-based coverage as well as an increase in the rate of Medicaid and uninsured. Those families in greater poverty are more likely to be uninsured and less likely to have employer-based coverage.

Table 1. Insurance Coverage by Poverty Status

Insurance Type (Percent of <65)	<100% FPL (15%)	100-200% FPL (20%)	200-300% FPL (17%)	300%+ FPL (48%)	Total
Employer	12.7%	30.5%	61.3%	80.8%	57.0%
Medicaid	36.6%	19.6%	8.2%	2.0%	11.9%
Medicare	6.6%	6.3%	3.4%	1.4%	3.5%
Private	8.5%	12.1%	10.8%	6.6%	8.7%
Uninsured	35.6%	31.6%	16.3%	9.2%	18.9%
Total	100%	100%	100%	100%	100%

Federal Poverty Limits (FPL) for a family of four in 2003 were \$18,400. Percentages in parentheses denote the proportion of North Carolinians in each poverty category. For example, 15% of North Carolinians live below the poverty guideline. Percentages add to 100 within the columns. For example, 12.7% of those below the poverty guidelines have employer-based coverage.

Nearly half of (46.2%) of the uninsured are unemployed, but nearly as many were employed—28% worked part-time, and 18% worked full-time. Twenty-three percent of the uninsured are not in the labor force. Children are excluded from this analysis. Full-time workers are the least

likely to be uninsured and the most likely to have employer-based coverage. Those not in the labor force can be covered by a spouse’s employer-based plan.

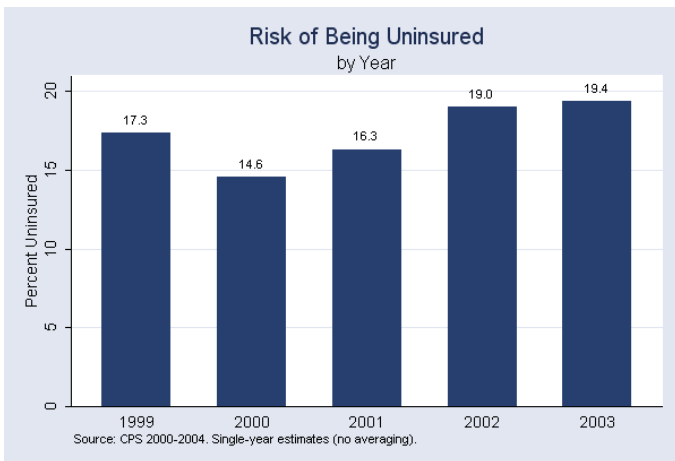
Most families that were uninsured had at least one family member with a full-time job—19.8% of uninsured families have one family member that works full-time and 11.5% have two family members who work full-time. Nearly one-third of the uninsured families (30.2%) have families members that only work part-time. The rest (25%) have no family members in the workforce. Families with full-time workers tend to have employer-based coverage. The distribution of insurance type is similar for families with no workers and families with only part time workers.

Q: Is Cobra considered to be employer-based or private-pay insurance?

A: It is considered to be employer-based even though the individual pays most of it.

The rate of uninsured has increased over the last four years (See Figure 1). The poor economy is likely a large cause of this increase. Figure 2 shows estimates of the uninsured in both the US and North Carolina for 1994-2003. Note that in 2002 and 2003 North Carolina exceeded the US average.

Figure 1. Risk of Being Uninsured



The age groups most likely to be uninsured are 20-29 year olds, although nearly all ages have a more than ten percent risk of being uninsured.

The unemployed are the most at-risk of being uninsured, with an uninsured rate of over 45% (46.2%) (See Figure 1). Thus, the “risk” of being uninsured is highest for unemployed workers, but most uninsured adults are not unemployed. Most work either full-time (47.2%) or part-time (16.5%) employees (See Figure 3).

Figure 2. Percent Uninsured in US and NC

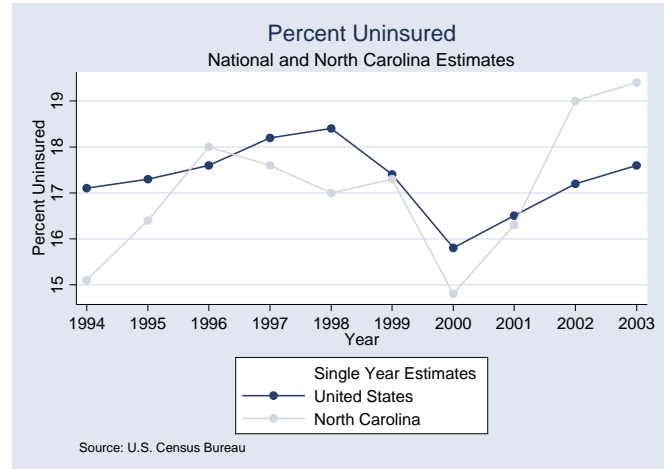
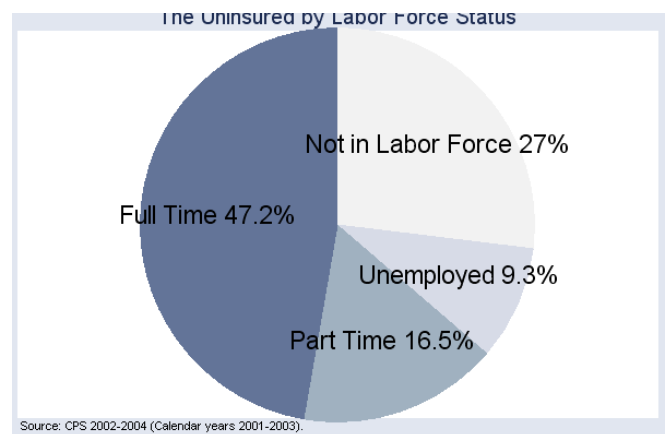


Figure 3. Uninsured by Labor Force Status



Individuals in a family with no full-time workers are more likely to be uninsured. One quarter (25.1%) of the families with no one in the work force were uninsured; 30.2% of the families with only part-time workers are uninsured; and 11.5% of families with two or more full-time employees are uninsured. The difference between the percentage of uninsured among families with no workers in the work force and those with only part-time workers is partly due to Medicare being more common form of insurance coverage for the families with no workers.

Most of the uninsured are in families with some connection to the workforce. Families with two or more full-time workers comprise 17.9% of all uninsured, and families with one full-time worker comprise over half (50.2%) of all uninsured. Together, over two-thirds of uninsured are in a family with at least one full time worker (See figure 4).

Figure 4. Uninsured by Family Labor Force Status

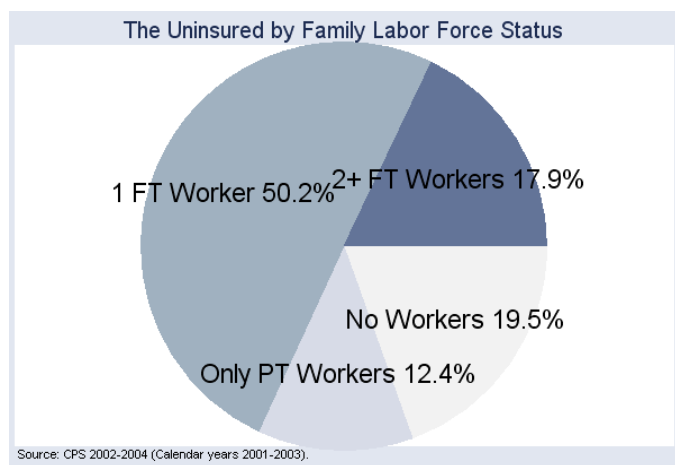
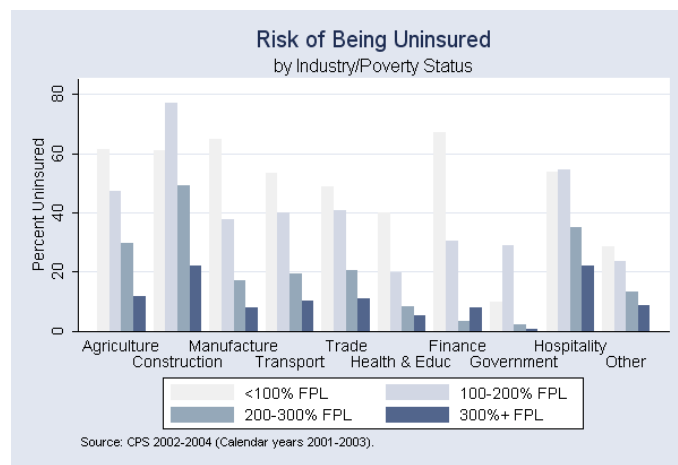


Figure 5. Risk of Being Uninsured by Industry/Poverty Status



The industry of the worker (or the industry in which the individual most recently worked) also relates to the rate of uninsured. Agriculture, construction, and hospitality tend to have higher rates of uninsured. Note that poverty status is related to the rate of uninsured even within industry (See figure 5).

The rate of uninsured varies by race and ethnicity. Non-Latinos of races other than white have higher rates of uninsured (20%) than non-Latino Whites (14%). Latinos have an even higher rate of uninsured (55.7%).

The rate of uninsured varies by nation of birth and citizenship, especially for Latinos. Although the rate of uninsured is similar for non-Latinos regardless of their nation of birth and citizenship (16.2 of those born in the US were uninsured and 17.8% of those born outside the US were uninsured), more than 45% of Latino citizens born outside the US are uninsured. Almost 70% of Latino non-citizens are uninsured. One quarter of Latinos born in the US is uninsured.

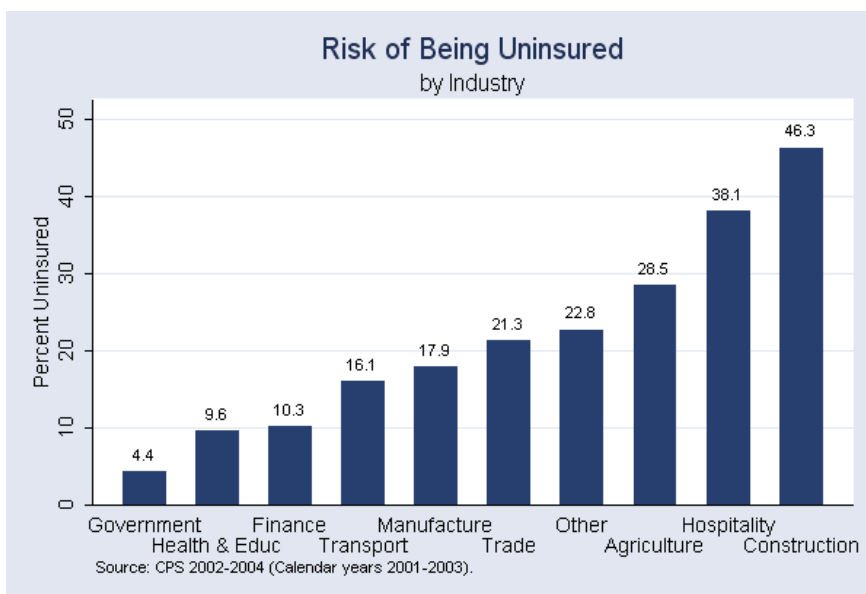
The risk of being uninsured also varies by the size of the company by which workers are employed. The smaller the firm, the more likely a worker is to be uninsured. Nearly 35% of people who work for firms with less than 25 people are uninsured, and 24% of people who work

for firms with 25-99 people are uninsured. This likely reflects higher health insurance premiums for smaller firms. Over half (51.1%) of uninsured workers are employed at a business employing fewer than 25 employees.

Rural residents are more likely to be uninsured (24% versus 17%), but there are more urban uninsured (67.3%) than rural uninsured (32.7%).

Uninsured rates by industry vary widely, from 4.4% in government to nearly 50% in construction. Figure 6 represents part- and full-time workers (full-time results similar).

Figure 6. Risk of Being Uninsured by Industry



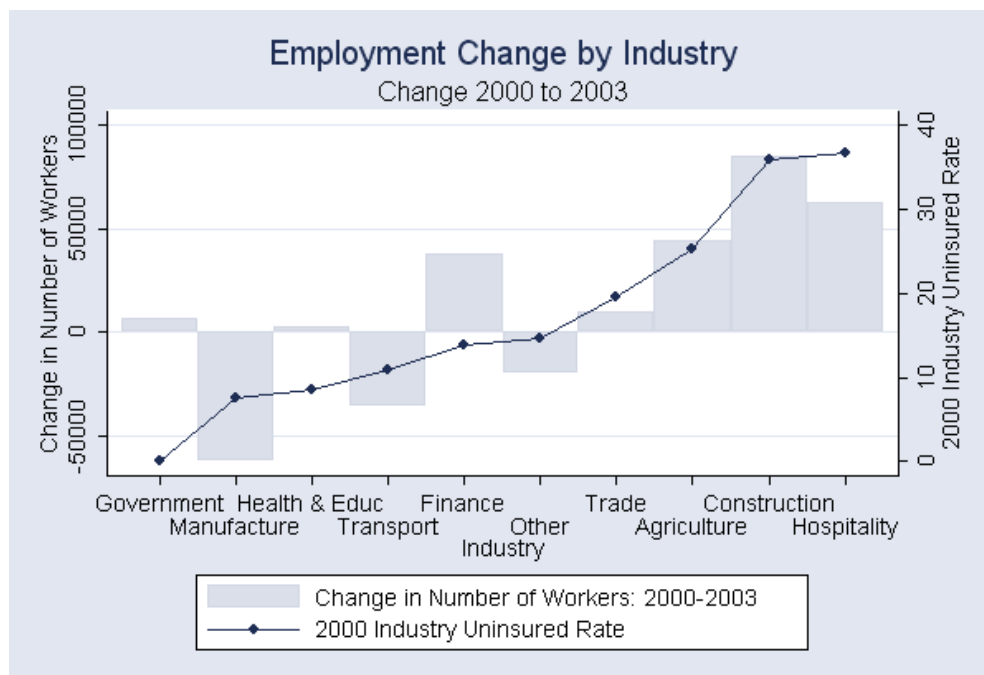
Dynamics

We can separate two ideas: (1) Changes in the statewide uninsured rate are due to differing demographic characteristics, from (2) Changes in the statewide uninsured rate are due to differing uninsured rates for each characteristic. This may help us understand the dynamics of the statewide uninsured rate

Conventional wisdom says the changing North Carolina economy is responsible for a large portion of the 2000-2003 increase in uninsured. However, what if NC workers in 2003 had the same distribution across industries as North Carolina workers in 2000?

Figure 7 contains two pieces of information. The left axis, represented by bars, indicates the change in the number of full-time and part-time NC workers from 2000 to 2003. For example, there are over 500,000 fewer manufacturing workers in 2003 than in 2000. The right axis, represented by the line, indicates the percent of full-time and part-time workers in that industry in 2000 who were uninsured. Note that the three highest uninsured industries—agriculture, construction, and hospitality—had the largest increases in numbers of workers.

Figure 7. Employment Change by Industry



Zero percent of government employees were uninsured in 2000. The three industries that have gained the most jobs (agriculture, construction, and hospitality) also have the highest percent of uninsured.

Notwithstanding the evidence presented in the Figure 7, changes in the economy between 2000 and 2003—such as a decrease in the number of manufacturing jobs and an increase in the number of hospitality and construction jobs—account for only a 1% point increase in the percent of NC adults who are uninsured. However, the changing rates of uninsured within industries are responsible for a 4.7% point increase between 2000 and 2003. This suggests that more employers are dropping coverage.

Although workers in some fields experienced a slight decline in the uninsured rate, the transportation, manufacturing, construction, and ‘other’ industries experienced an increase in the rate of uninsured of over five percentage points.

Changes in the uninsured rate within poverty are more responsible for the increase than changes in the poverty rate. The bulk of the change was felt in the 100-200 % FPL group: the uninsured rate increased from 16.2 to 19.9%.

Changes in the uninsured rate within firm size are more responsible for the statewide increase than changes in the poverty rate. The largest change was felt in the 25-99 employee group: the uninsured rate increased from 14 to 24%.

Approximately 18-19% of North Carolinians between the ages of 0 and 64 had no health insurance for the entirety of 2003. Considering the *risk* of being uninsured for a given characteristic may yield different policy conclusions than considering the *characteristics* of the uninsured. For example, the unemployed are more likely to be uninsured, but relatively few uninsured are unemployed. The increases in the statewide uninsured rate is due somewhat to changes in demographic structure, but more due to changes in the uninsured rates within the demographic.

For more information contact the Sheps Center for Health Services Research web site (<http://www.shepscenter.unc.edu>). Click <What's New> for county-level estimates. The 2003 estimates not posted yet, but will be soon. The Kaiser Family Foundation also has an analysis of national trends (<http://www.kff.org>). The US Census Bureau web site posts results of national surveys (<http://www.census.gov/hhes/www/hlthins.html>).

Comments and Questions

Q: What is the essence of all this?

A: There are two things to think about: the groups that with the highest percent of uninsured people and the surprising fact that two-thirds of the uninsured are connected to the workforce in some way.

Comment: The other take home message may be that things are getting worse and that North Carolina is worse than the rest of the country. We have seen this in our clinics and it's nice to have data to confirm that.

Comment: Many people work in smaller firms are underinsured with only catastrophic coverage, so this is just the tip of the ice burg.

Q: How might immigration be driving the uninsured rate in certain industries?

A: Latinos make up 6-7% of our state population so they are not large enough to affect these numbers yet. We can bring more statistics about this to the next meeting.

Q: How many people are voluntarily uninsured?

A: The term voluntarily is a little misleading. If we are seeing individuals who make over \$100,000 and still uninsured, they are probably not uninsured do to cost.

Q: Do the industries with a high number of uninsured offer choice?

A: According to national data, only 3-4% of the uninsured say they chose not to have insurance. We don't know if someone who makes \$75,000 a year, but has very poor health may not have health insurance by "choice".

Comment: The numbers are hard to visualize, but if you say 1.4 million equals the combined population of 53 NC counties, then that makes a more compelling visual.

Comment: Is there any evidence that some of the trends of employers reducing coverage may be reversed? Employers are not going to go back and add insurance options unless there is

enormous prosperity. Even when we had the best economy in 1999-2000, there was a only a slight dip in number of uninsured.

Comment: The time frame for which this data was collected does not include data that would reflect the most recent job losses in North Carolina. The CPS numbers are slightly behind the changing state demography. The baby boomers are being over taken by a rising median age in the population (partly as a result of immigration). The trend toward higher deductible health insurance policies is going to have a cut into this. The market for medical savings accounts is expanding. The problem of the future isn't going to be one of absolute uninsurance, but one of increasing underinsurance

AUGUST 10 WORK GROUP UPDATES

Pam Silberman, JD, DrPH, gave a brief update of the the August 10th Areas of Greatest Unmet Need Work Group discussion, and Gordon H. DeFriese, PhD, gave a brief update of the August 10th Integration and Collaboration Work Group discussion. For more information, please see the meeting Summary for the August 10, 2004 Healthcare Safety Net Task Force meeting, which can be found at: <http://www.nciom.org/projects/SafetyNet/safetynet.html>.

MEETING SUMMARY FROM THE WORK GROUP ON AREAS OF GREATEST UNMET NEEDS

Dr. Silberman reviewed the data sheet she provided, which lists safety net providers and data on the number of uninsured patients they served in 2003. She noted that AHEC providers and data from Moore County were added to the data sheet. In addition, ORDRHD identified a list of other potential safety net providers, who are being contacted for more information. Jeff Spade is working to collect information from hospital outpatient clinics, which will be included in the data sheet.

The other new aspect of the document is the addition of primary care provider information. It was determined that some understanding of the number of primary care providers in a county is valuable because they may provide some free care, which may serve some of the safety net need.

Primary care providers see, on average, two uninsured patients per month. However, this cannot be built in because that would assume that every primary care provider sees the same number of uninsured patients per month and there may be a large variation in this number. Plus, that statistic may include primary care providers that are providing services outside of their practices, in clinics that are already included in the data. Instead, NC IOM included the number of primary care providers in a separate column to capture a community's potential to serve uninsured patients.

Q: Which specialties are included in the primary care numbers?

A: It includes OB/Gyn.

Q: Are you just looking at those in poverty?

A: No, we are including all of the uninsured. Some safety net providers use different poverty guidelines and county level data on the uninsured with family incomes below 200% of the federal poverty guidelines are not available.

Next, the work group reviewed the safety net report card Dr. Silberman developed, which evaluates the safety care network available in each North Carolina County. Dr. Silberman asked if the Consumer Reports model of using symbols was effective in illustrating the level of safety net services each county provides to the uninsured.

Q: The report card doesn't indicate the magnitude of care. What is the range of services? Perhaps you could provide a quartile range.

A: A quartile range would be fine, but it could not be specific to each county because the data aren't that precise. Therefore, we can add the quartile range for each column.

Q: Could you also put the county rankings so that it would be easier to compare?

A: No, there is too much variation in the data and the data are not accurate enough to provide that type of comparison.

Dr. Silberman noted a couple communities that had some of the biggest problems. In some cases, such as Cumberland and Enslow, one would expect more sources of care than are indicated on the report card.

Comment: Data from the Veterans Association could be helpful and may fill in the blanks here. Non-active duty community members may receive safety net care at the VA hospitals. Tricare theoretically takes care of dependents, but it doesn't always do a good job.

Q: Do these data reflect a patient's choice whether or not to seek care?

A: No, there was no way for us to capture that. These data indicate how many uninsured we know have received primary care services from a safety-net organization.

Comment: There is safety net capacity in some communities that the uninsured are not using.

Comment: This is probably true in some communities, and less so in others. Also, even in communities where safety-net providers exist, it still may be difficult for the uninsured to access services due to transportation issues or hours of operation.

Discussion of Potential Recommendations

The work group next began discussions about the proposed work group recommendations drafted by Dr. Silberman. The work group agreed upon the following recommendations, with comments noted:

Chapter 2: The Uninsured in North Carolina.

The work group recognized that the primary barrier that the uninsured face in obtaining needed health services is lack of insurance coverage. Therefore, the work group suggested that a recommendation be included at the end of Chapter 2:

Rec. 2.1: The North Carolina General Assembly should take steps to make health insurance coverage more affordable, or to expand health insurance coverage to more uninsured individuals.

Ideally, everyone in North Carolina, and in the nation, should have affordable health insurance coverage that meets their basic health care needs. Providing such coverage would reduce the need for safety net providers; although providers who are experienced in addressing the education, transportation, and other non-financial barriers of low income or underserved populations will always be needed.

Until the uninsured have coverage, the work group recognized the importance of supporting and expanding existing safety net capacity to be able to meet more of the health care needs of the uninsured.

Chapter 3: Description of Safety Net Organizations.

The Work group recognized that many uninsured or otherwise underserved groups have a critical need for behavioral health services. Lower income individuals often have a

greater need for these services because they typically live with a lot of financial stress, and may have problems with depression, substance abuse and/or homelessness. The uninsured and low-income may not have the resources to obtain services from private providers. Therefore, the publicly funded behavioral health system is critical to these groups.

The Task Force chose not to examine issues surrounding access to behavioral health safety net services in this report because the state is in the midst of a major transformation of the publicly funded behavioral health system. However, it recognized the need to examine this issue once the state has completed its restructuring. Therefore, the work group suggested that a recommendation about the capacity of the state's publicly funded behavioral health system to address the needs of the uninsured be added at the beginning of Chapter 3:

Rec. 3.1: The Office of the Secretary should take the lead in creating a work group that includes publicly-funded LMEs, behavioral health providers, primary care providers, safety net organizations and representatives of consumer groups to monitor access to behavioral health services for the uninsured and other underserved populations. The Office of the Secretary should examine access to services for both the priority (target) populations and for those with less severe behavioral health problems. In addition, the work group should examine ways to expand the capacity of primary care providers to address some of the behavioral health needs of the uninsured and/or underserved populations. Information should be reported to the Mental Health Study Commission.

Chapter 4: Communities with Greatest Unmet Needs

Rec. 4.1: The NC ORDRHD should assume responsibility to collect data on and monitor the capacity of the safety net on an ongoing basis. The data should include information on safety net organizations that provide the full array of primary care services, as well as those that provide dental, behavioral health, preventive services only or a less comprehensive array of clinical services. In addition, data should be collected on the uninsured who receive services through non-profit or public dental clinics, pharmacy clinics or other specialty providers.

The Work group identified the NC Office of Research, Demonstrations and Rural Health Development as the most appropriate state agency to collect these data on an ongoing basis. One of NC ORDRHD's core missions is to help communities develop primary care and dental capacity to serve medically underserved populations. In addition, the 2004 General Assembly charged the NC ORDRHD to report to the General Assembly on the number of new uninsured patients who have been treated in safety net organizations as a result of the \$7 million Community Health Grants which the General Assembly appropriated. Thus, NC ORDRHD will already be collecting some of these data.

The data included in this Chapter reflects our best understanding of the capacity of existing safety net organizations to meet the health care needs of the uninsured, and which communities have the greatest unmet needs. However, there are limitations in these data, as noted previously in the chapter. For example, the dataset does not include every possible safety-net organization; and it is difficult at this time to identify whether local health departments are providing comprehensive primary care services to the uninsured or a more limited array of clinical services. Therefore, the NC ORDRHD should use the NC IOM data as a starting point, but make modifications to the data requested and include other safety net organizations in the data as information becomes available.

Q: Does rural health have the capacity to collect the data and monitor the safety net capacity?

A: ORDRHD are allowed to keep 1% of the community health grant funds to pay for collecting the data. However, this may not be enough and we may want to include in our recommendations a provision for ORDRHD to receive more funding for this purpose.

Comment: It makes sense for ORDRHD to be charged with collecting and monitoring the data. Some of this information should probably be reported to a safety net review counsel to ensure that evaluation of safety net providers and communities is consistent.

Rec. 4.2: Safety net healthcare organizations that receive state funding (through Medicaid, public health, or Community Health Grant funds) should be required to report information to the NC ORDRHD on the unduplicated number of and the number of visits (encounters) for uninsured patients who receive comprehensive primary care, dental, behavioral health, or other clinical services. The ORDRHD should create a standardized reporting form to ensure that the data are collected consistently across healthcare organizations. Other organizations that do not receive any state funding (such as free clinics) should be encouraged to provide similar information.

The work group determined that it should require those organizations with some state funding to submit information on an unduplicated number of uninsured and medically indigent who receive primary care services, or number of visits. Secondly, ORDRHD will create some definitions with input from an advisory group and then will ask other organizations that don't receive funding (free clinics) if they will provide the same information. This data will then be provided on an ongoing basis to local health departments, Healthy Carolinian organizations, and other community organizations to develop a better understanding of the safety net providers currently available and what service areas may be unmet for the population. It was also determined that foundations should be encouraged to request comparable data from organizations seeking funds. Foundations would also be provided with the data to be used to identify communities with the greatest unmet needs, in case they choose to put emphasis on awarding grants to these communities.

Comment: Data included in the report card are purely voluntary from some organizations. Should organizations be required to report these data, even if they do not receive state funds? The only groups without state funds are free clinics.

Q: How much time would it require of each facility to gather these data?

A: The time would range by organization and depend on the type of recording/billing system used. Some would be very easy to access, while it may take some time initially to get a program built in other organizations. However, once the process was developed, it wouldn't take much time each consecutive year.

Rec. 4.3: The ORDRHD should share these data with local Community Care of North Carolina groups, Healthy Carolinian organizations, local health departments, NC Association of Community Health Centers, NC Hospital Association, NC Free Clinic Association and local medical societies so that they can use these data to identify areas of unmet need. Similarly, the data should be shared with NC Health Foundations, to help inform their grant making process.

Providing data to local communities serves two functions. First, it is a vehicle to check the accuracy of the data, and to identify other sources of care to the uninsured. Secondly, and most importantly, these data can be a catalyst for local communities to identify unmet needs and to encourage them to develop capacity to serve the uninsured or other medically indigent at free or at reduced costs.

Foundations can use these data to identify communities that are in greatest need of new or expanded safety-net capacity. The Work group recommends that Foundations use these data to give emphasis in the grant making process to communities with the greatest unmet needs (either in terms of percentage of the uninsured who do not have an identified source of care or numbers of uninsured who do not have an identified source of care) and to request comparable data in grant reporting.

Q: Is there a need for some type of shared warehouse where this information could be exchanged?

A: That would require much more advanced technology than currently available within all safety net providers. The costs and magnitude of such a program are probably out of scope of this recommendation/work group.

Comment: It is also important to focus on accessing a small data set, maybe three or four elements, rather than asking for a data warehouse, which could scare people and deter from the project goals/focus.

Comment: If it is possible to share information that would be helpful because there are people receiving services at more than one primary care location and sharing this information could help identify when individuals receive care from multiple sources.

Q: How publicly available will the data be?

A: They will be publicly available through the Office of Rural Health.

Rec. 4.4: The ORDRHD should report these data to the Secretary, Governor, General Assembly and NC Association of County Commissioners on a yearly basis to help inform policy makers of areas of greatest unmet need.

The work group determined it would be valuable to report these data on an annual basis to the Secretary, the NC General Assembly, and provider associations. In addition, the group discussed the idea that once accurate data are collected, ORDRHD should consider producing a report card with broad distribution. As these data improve, the Work group recommended that they be reported in a report card format.

The work group discussed whether any particular organization has the responsibility to develop safety net resources in the communities that lack adequate safety net capacity. Some thought it was the local health department's responsibility to assure primary care services; but others noted that in many of the communities with the most critical need for safety net resources, the local health department may be so understaffed that it has little capacity to build this capacity. NC ORDRHD has a good track record, but it only works in communities to which it was invited because it believes in a bottom-up approach. The work group discussed the idea of creating a planning package that could be offered to local communities with the support from multiple state entities. The state level organizations could help assess the capacity of local communities to meet the healthcare needs of the uninsured, and the resources that would be needed to build capacity. Community Care of North Carolina networks may be another place to begin a community dialogue, as there is (or will be) a CCNC network in every county that includes local primary care providers, health department, social services and hospital charged with developing systems of care for the Medicaid recipients. CCNC is using a regional approach to expand the program statewide, linking existing programs to contiguous—often more rural—counties. It is possible that the CCNC networks could also examine the broader question of developing care systems for the uninsured. Another suggestion was to hire a full time staff person at the ORDRHD to develop the planning packages, coordinate the different programs, and structure this capacity-building project. This position could collect the data, develop the planning packages, and provide the technical assistance.

Rec. 4.5a: The NC ORDRHD, Division of Public Health, NC Community Health Center Association, NC Hospital Association, and NC Association of Free Clinics should work together to develop a planning package for communities interested in expanding their safety net capacity, including but not limited to, an identification of possible funding sources. These groups should work collaboratively to provide technical assistance to communities. Priority should be given to low-wealth, high-needs communities to help them develop additional safety-net capacity. Cross-county or regional approaches should be considered, particularly for smaller, less populated or resource rich communities.

4.5b: The NC ORDRHD should take the lead in pulling together this statewide collaborative of safety-net organizations that can develop the planning package. Once developed, information should be provided to county commissioners, local health care providers, community collaboratives (such as Healthy Carolinians and CCNC networks), and other interested non-profit organizations about the availability of the planning package and technical assistance.

4.5c: The NC General Assembly should appropriate \$ ____ to the ORDRHD to support the development of safety net planning packages and data collection.

The Work group recognized that one approach would not fit every community. The state-level technical assistance team should help local communities assess their needs and then provide information about a range of options that could be appropriate, and the resources needed to make changes.

Specialty Services:

The Work Group recognized the need to encourage more specialists to serve the uninsured; however, did not have specific recommendations on how this should best be accomplished. The Work Group considered, but rejected the notion of providing tax credits to specialists or other providers who offered charity care; as lots of people volunteer for a variety of worthy causes; and the Work Group did not think that it was sound public policy to single out health care providers for a tax credit not offered to other volunteers. The Work Group also rejected the notion of providing Continuing Medical Education credits to physicians who provided charity care services because this would reduce CME hours, thus undermining the CME effort to ensure that providers stay up to date with changes in medical practice. The work group recommended that we try to gather information from specialists about what it would take to encourage them to serve more uninsured (for example, Fair Share systems, Project Access etc.), however, we also welcome suggestions from the full Task Force.

Volunteerism:

Similarly, the work group did not have specific recommendations on how to encourage greater volunteerism among all types of health professionals in providing care to the uninsured. Other recommendations are welcome.

Chapter 7: Financing Options recommendations:

The group discussed safety-net organization financing, which they believe should be continued and expanded. They noted that the NC Community Health Center Association was the primary group pushing for the Community Health Grant legislation.

Discussion then began to focus on the idea that the Community Health Grant funds are only one-time funds. It is hoped, and expected by some, that the program funds will be renewed next year. However, a number of group members mentioned the importance that grant funds be give to projects with a plan for sustainability. In the long run, the General Assembly may not want to be providing operational support to non-state agencies and be involved in issues of accountability, particularly when health departments are already struggling with funding. Because the initial appropriation was nonrecurring, the three organizations helping to distribute funds (ORDRHD, NC Community Health Center Association and Division of Public Health) tried to ensure that the programs funded with grant funds would continue even if the General Assembly did not continue its appropriations. However, the hope of the work group was that the funds would be built into

the appropriations budget to support and expand the capacity of safety net organizations to serve the uninsured. In addition, the work group through it was important to also provide support to non-profit safety net organizations that do not currently qualify for state funds.

Rec. 7.1: NC General Assembly should continue and expand the appropriations supporting safety-net organizations that provide primary care, dental, behavioral health, etc. to the uninsured and medically indigent. Additional funds should be available to include other non-profit organizations that have a mission to serve the uninsured and medically indigent.

MEETING SUMMARY FROM THE WORK GROUP INTEGRATION AND COLLABORATION WORK GROUP

ATTENDANCE

Gillian Baker, George Bond, Mike Cinoman, Gordon DeFriese, Leah Devlin, Bob Fitzgerald, Johanna Irving, Andy Hartsell, Alan McKenzie, Ben Money, Wanda Sandel , Jeff Spade, and Kristie Weisner Thompson.

August review

This Work Group began its deliberations in August with the assumption that every community needs some assistance in providing for the uninsured and with the goal of helping safety net agencies to evolve without threatening existing services. The group followed an agenda that attempted to identify the problems, barriers, models, and incentives for collaboration. Some recommendations were formulated from the initial discussion and will be modified by group members before the October meeting.

Problems included confidentiality laws, inclusiveness, feelings of relative advantage, political factors, fear of the unknown, representation of physicians, cost avoidance, etc.

The group agreed that Community planning often proceeds by a different course in different communities and that collaboration should not be forced. At this point, we do not know how much competition exists among the safety net organizations, but it is clear that competition exists.

With regard to the confidentiality law, we discussed how interpretation of the law is the problem, not the Health Insurance Portability and Accountability Act of 1996 (HIPAA) itself. Many patients in this safety net need help with medical instructions, but the current interpretation of HIPAA regulations makes it difficult. Providers will not share information with anyone other than the patient.

Discussion

Q: Will the Task Force recommend certain models be used in communities depending on the mix of primary care agencies in that community? For example, would we recommend, X County should try to get an FQHC? Or would we use our knowledge that X counties have both a health department and hospitals and should therefore, take a particular action?

A: The Task Force can decide how specific to get, but typically Task Force recommendations aren't that prescriptive. All communities and health departments are different so it would be difficult to recommend prescriptive strategies.

Comment: One of the essential services of any health department is to assess the availability and access of healthcare within their jurisdiction. If planning processes for the safety net are not funneled through or started with the health department, then an existing system is being bypassed. There is a physical health department presence in every county. We don't need to start from zero in any county.

Q: How would non-health department groups feel about a recommendation that health departments should be the starting point? How could this become a recommendation?

A: It is not really a recommendation, but an acknowledgement. Every community should take a look at their available resources. Safety net providers should recognize each other's existence.

Comment: We need to convey the message that collaboration is critical and that agency changes affect the other agencies.

Comment: Maybe communities need technical support to help them find and convene the stakeholders.

Comment: The most needed component of community safety nets is the private-provider representation. The private-sector physicians are the most unorganized part of all this. Every community has a continuum of care. We should include more than primary care. We should also include specialty care, dental, etc. There is a need for additional information on the extent and volume of care provided by all safety net organizations and providers. Where is the strong physician participation?

Comment: Health Departments should add access to care to their regular community assessments.

Q: Are we suggesting the health department take initiative where no other exists? This means the health department might have to be the convenor.

Comment: The health departments are required to do community health assessments every four years and update them every year. The assessments have never been funded. It has been recommended that all health departments be funded for this. The state provides departments with a certain amount of county data. Hospitals and medical societies often help fund these assessments.

Comment: The Health Department community assessments are responsible for covering a broad range of health issues (environmental, bioterrorist, preventive, etc.). It is important that the Task Force specifically includes access to care as one of those issues.

Comment: Health Departments need technical assistance on analysis and interpretation of the data collected in the community health assessments. We don't know how many healthcare providers a community should have. Should we recommend that ORDRHD be improved so it can provide this technical assistance?

Comment: The North Carolina Community Health Center Association (NCCHCA) provides technical assistance to community health centers. The Association works in a collaborative fashion. Health departments always look to the ORDRHD for this assistance.

Comment: Right now ORDRHD is not a good place for technical assistance. Many centers don't have great relationship with them because ORDRHD, while opening a new center, may

be damaging another. Some people don't trust rural health—primary care physicians get anxious when a state-funded clinic comes to town and so do health departments. It's a 30-year history dating back to when the ORDRHD started.

Comment: Ironically, some of the toughest places to facilitate collaboration are in urban areas.

Comment: We should go an extra step and describe how you might bring the various care giving agencies together. Duplication is a real problem.

Comment: We want more collaboration, but we should at least be coordinating. It may be difficult to determine who the sponsor should be. It would seem like a health department.

Comment: We need to provide examples of best practices and incentives because nothing is going to happen without incentives.

Q: Are we talking about collaboration in care planning or care delivery. Collaboration among various organizations can produce a better system of care.

Comment: We should avoid dictating who the convenor must be.

Comment: We could incentivize partners with a seed grant. Like the Healthy Communities Access Program (HCAP) model, funding could be used to improve the system of care instead of patient care. It could be like a county-based HCAP initiative that is funded through a private foundation.

Comment: Many communities have nothing—no tax base, no funding from county government, no physicians, etc.

Comment: We should specify some direction for how communities can have a viable safety net. We at least should say that urban communities tend to need this thing and rural communities tend to need that. Maybe we should have a web portal where a community can see what is needed.

Comment: We could designate a couple of years to organize groups to focus on the safety net in North Carolina? Acting as role models, the state-level groups could collaborate (NC Hospital Association, Division of Public Health, NC Primary Care Association, etc.) on how to advise local groups on how they could convene for collaborative efforts. The state-level group could help the local groups define their problem (Is it technical assistance, information, etc). Until we help the communities identify their greatest need, we won't be able to improve the situation. We need to find away to help the communities understand what their care needs are. The state group could be responsive to the local groups rather than instructive to them. The larger groups should have a defined list of objectives.

For example, state-level organizations could convene their technical support experts to come up with plans for providing technical support. We could think about innovative programs that could develop from existing ideas. The 340b program being expanded in Wake County

is an example of how a community can build from one good program. This approach would allow communities to capitalize on their strengths and find champions for their goals.

Comment: Community Cares already has many of the right players at the table and is trying to expand statewide. This could be added to the Community Cares agenda. Another idea might be to recommend the NC Medical Society organized this. It could be very powerful, but it would take a different kind of commitment than there is right now.

Comment: If we can get some of the basics elements in place, great things are going to happen. If you can get Community Care to serve as the convenor, even if it is focused on Medicaid, some Community Cares groups will start folding in the uninsured because it has a broader application. Pitt County is an example of how this can happen.

Comment: A lot of great things have grown out of the 340b program. Agencies can be creative like the Wake County Medical Society has been with the 340b program. A community must at least have access to a program like 340b to get started. Once people start understanding how these things work, they will be innovative and figure out how to make it work in their community.

Comment: Most of the recommendations affect the safety net infrastructure. One of the groups that should be at the table is business. Who are the other collaborators that we need? Besides health insurance, there are other ways that businesses could be involved. The faith community is another group that should be at the table.

Comment: If the state decides not to make counties pay for their share of the Medicaid match, would the Task Force consider recommending that county commissioners retain the local match for safety net needs? Some might argue the money should go toward education since education levels are a primary determinate of health status. Counties have so many needs that it would be a fight.

The Work Group agreed to revise the list of recommendations and prioritize them via email.

Potential Recommendations

1. The Task Force acknowledges the fundamental role of the local health department to assess community health status broadly, including the availability and adequacy of the full continuum of healthcare services in each county. The periodic community health assessments submitted by each health department should include specific reference to the adequacy of personal healthcare services and include the participation of all stakeholder safety net provider organizations.
2. Given the limitations of available resources to meet the continuum of care needs of uninsured populations, the collaboration of all safety net organizations is essential.
3. There is need for better and more complete information on the extent and volume of care provided by all safety net organizations and providers. (Technical assistance is needed on the analysis and interpretation of these data in a standardized way across all NC communities.)
4. Community-level safety net planning efforts should begin from a clear delineation of individual stakeholder or provider vested interests (financial stakes) and clarity about federal or state laws, rules or regulations that could limit the ability of certain stakeholders to share in the collective effort to meet the needs of safety net clients (in other words, collaboration has its costs).
5. Effort should be made (by NC DHHS in partnership with associations of safety net healthcare providers) to clarify state laws regarding the confidentiality of medical records so that assignment of clients and the services of providers in different clinical sites can be offered more effectively and seamlessly.
6. The NC General Assembly should enact legislation that guarantees the portability of medical records and their confidentiality. The NC General Assembly should clarify its confidentiality laws, and in doing so should specifically permit providers to collaborate (and share information) in the course of caring for a common patient.
7. Community-level safety net planning efforts should recognize the separate, but interdependent, dimensions of “concern and commitment to action regarding the uninsured” on the one hand, and “agreement on ends and means” on the other.
8. Pharmaceutical acquisition/purchase and distribution could serve as a focal issue for collaboration. It is likely to attract all stakeholders to collaborative endeavors in the interest of serving the uninsured.
9. Additional financial support should be given to the Office of Research & Demonstrations and Rural Health Development (NC DHHS) to provide general technical assistance of various kinds to emerging community health planning efforts (and collaboration should be expected with other public and private organizations who

- can render technical assistance to emerging safety net organizations and planning efforts).
10. Set aside funds to encourage collaboration among existing safety net organizations (e.g., state-funded HCAP program), building on the funds appropriated in the last legislative session.
 11. Other collaborators who should also be included (e.g., business and industry, colleges and universities, faith communities, etc.)
 12. NC DHHS (or some other agency or organization) should undertake to disseminate detailed descriptions of various “models” or “best practices” found to work well in particular communities. Models should give emphasis to situations where funding follows patients needing care, not the providers of that care.
 13. Both public and private funding agencies should develop clearer and measurable criteria of “collaboration” and use such criteria in decisions regarding future safety-net program support.
 14. Public and private funding agencies should develop (either themselves or through contract agencies) and make available technical assistance to emerging safety-net provider organizations and community-based planning efforts with regard to:
 - financial planning,
 - healthcare information systems, record access and confidentiality,
 - federal and state laws and regulations affecting the provision of safety-net services,
 - the organizational aspects of interagency cooperation with such issues as eligibility determination.
 15. Hospitals should consider hiring safety-net organizations to provide unassigned call coverage for after-hours care
 16. Local boards of public health could be augmented to meet the 51% consumer constituency representation and thereby make them eligible to participate in additional federal programs through which funding is available to support care for the uninsured. (This needs to be checked out; may be an oversimplification and not realistic...probably none are motivated to becoming FQHCs.)
 17. Create opportunities to bring together safety net providers (on statewide or regional basis) to facilitate discussion, collaboration and integration across organizations.
 18. Create on-going state-level Safety Net Advisory Council that can continue to encourage collaboration at state level after NC IOM Task Force completes its work (expanded to include other safety net organizations, e.g., free clinics, hospitals, Project Access models, etc.)