Prevention Workgroup
Tuesday, August 31, 2010
North Carolina Institute of Medicine, Morrisville
9:00-12:00
Minutes

Workgroup Members: Jeffrey Engel (co-chair), Laura Gerald (co-chair), Alice Ammerman, Dorothy Cilenti, Paula Hudson Collins, Carolyn Dunn, Calvin Ellison, Lori Fuller, Brian Harris, Debra Harris-Hawkins, Meg Molloy, Lloyd Novick, Beth Osborne, Kay Phillips, Barbara Pullen-Smith, Anne Rogers, Gary Rozier, Meka Sales, Jessica Schorr Saxe, Sorien Schmidt, Jeff Spade, Anne Thomas

Steering committee members: Megan Davies, Lisa Harrison, Rebecca King, Ruth Petersen, Serena Weisner, Walker Wilson

NCIOM Staff: Pam Silberman, Jen Hastings, Sharon Schiro

Interested people: Michael Bailey, Margaret Brake, John Dervin, Lee Dixon, Laura Edwards, Casey Herget, Cindy Morgan, Chris Skowronek, Megan Weis

WELCOME AND INTRODUCTIONS
Jeffrey Engel, MD
State Health Director
NC Division of Public Health (DPH)
NC Department of Health and Human Services
Co-Chair

Laura Gerald, MD, MPH
Executive Director
NC Health and Wellness Trust Fund
Co-Chair

Drs. Engel and Gerald welcomed everyone and thanked them for participating in this workgroup. Dr. Engel then asked everyone around the room to introduce themselves.

Overview of Health Reform, Structure of the Workgroups, and the Charge of this Workgroup
Pam Silberman, JD, DrPH,
President and CEO
North Carolina Institute of Medicine

Dr. Silberman gave an overview presentation of the main provisions in the Patient Protection and Affordable Care Act ("Affordable Care Act or ACA") and the structure of the health reform workgroups. Click here to view the presentation: Health Reform overview.

Overview of Workgroup's Specific Provisions from the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010
Pam Silberman

Dr. Silberman gave a more detailed presentation of the health reform provisions related to the prevention workgroup. Click here to view the presentation: Prevention overview. Click here to view the ACA legislative language of the sections that will be covered through the workgroup: ACA provisions addressing prevention.

Selected questions/comments:

- Comment: North Carolina should develop estimates of all the potential costs and savings of the ACA provisions, similar to what Maryland has done. Dr. Silberman noted that we will be working with the state to develop this overall estimate.
- Q: Is it optional for states to provide clinical preventive services for Medicaid recipients? A: We need to check, the statute was ambiguous.
- Comment: The ACA has a provision to authorize the Secretary to award grants to states to carry out initiatives to provide incentives to Medicaid beneficiaries who successfully participate in chronic disease management programs or adopt and maintain healthy behaviors. This might work well in coordination with the disease and care management activities that are provided as part of Community Care of North Carolina (CCNC). (Sec. 4108).
- Comment: The ACA has a provision to authorize the CDC to award competitive community transformation grants (Sec. 4201, 10403). The state could use this grant opportunity to implement priorities of the Prevention Action Plan. We need to start planning for this grant opportunity now.
- Comment: We need to understand what will be covered under the new clinical preventive services benefits. Click here to see the US Preventive Services Task Force recommended preventive services.

Update on NC Division of Public Health Grant Submissions and Implementation Efforts
Jeffrey Engel, MD
State Health Director
NC Division of Public Health
NC Department of Health and Human Services

Dr. Engel discussed the new grant opportunities made available under ACA. For most of the grant opportunities that have become available, the eligible grantees have been state public health agencies. Some of the funding opportunities are formula driven (ie, states will automatically receive funding based on a formula basis if they are eligible); while other funding opportunities have been on a competitive basis. If awarded, some of the program funding will be directed to local communities (for example, support for pregnant and parenting teens or maternal, infant and early childhood home visiting programs). Other grants will be used to build the state infrastructure (for example, the state laboratory grants). Click here for a list of ACA grant applications which DPH has either submitted or are in the process of submitting.

Paula Hudson Collins also reported that the NC Department of Instruction submitted a grant for abstinence based education that would be in compliance with HB 88 (the Healthy Youth Act). This federal funding for abstinence based health education was reauthorized under the ACA, but there is more flexibility in how the funds are administered.

Selected questions/comments:

- Comment: We anticipate that there will be a lot of additional grant opportunities that are made available before the end of the federal fiscal year.

Workgroup Discussion of Next Steps

- Q: The federal grant opportunities are coming out quickly, and public health is under significant pressure to submit grants. How do we bring communities of greatest need into what DPH is doing?
- Comment: The workgroup discussed the importance of collaborating with local communities in seeking funding and implementing new prevention programs. But we need to discuss what collaboration really means. If community based organizations have to compete against state agencies, it will be difficult for them to get funding. We need to make sure that the funding and programs get down to the communities that have the greatest needs.
- Comment: We have had experience in North Carolina with Adolescent Pregnancy Prevention grants targeting the federal funding to Tier 1 counties. We could use a similar approach where the state applies for funding, but then targets the monies to communities in greatest needs in distributing the funds.
- Comment: The ACA emphasizes evidence-based programming, but that is sometimes difficult to implement. Implementing evidence-based programming with fidelity requires an infrastructure to support and provide technical assistance to local communities as they implement the program.
- Q: The spreadsheet of funding opportunities that the NCIOM put together could foster competition rather than collaboration. It's hard to get out of "business as usual" unless there is a structure to do this. We need to know which groups are considering applying for different funding, so that we can submit grants collaboratively. Alternatively, is there a way to write grants generically so partners could be included later? Can NCIOM create a form that track's who is applying for what grant.
  A: The NCIOM doesn't have the staff to be able to track all the grant submissions. But, if groups send us notice of grant opportunities, we may be able to distribute those to the workgroup and then let workgroup members distribute the notices more widely.
- Comment: Some of the local health departments, especially those in poorer counties, have such limited resources that it will be difficult for them to apply for new grants. County readiness is a huge problem. It is a problem for nonprofits as well as for local health departments.
- Comment: When possible, we should build on the existing infrastructure at the local level, such as local health departments, Healthy Carolinians partnerships, or Cooperative Extension.

- Comment: We know that the CDC will be funding Community Transformation grants. We should be thinking strategically now about community transformation grants, and working with community partners now in anticipation of those funding opportunities.
- Comment: We also want to build evaluation into grants. We need to know whether what we are doing is making a difference in population health.
- Comment: We also need to do proactive outreach to the public to educate them about the new coverage available under the legislation—for example, first dollar coverage of preventive services and immunizations.
- Comment: Funders may be able to help. We should not be afraid to talk about what we need state funders to do to help.
- Comment: Some insurers are already ahead of what the USPSTF requires. For example, the Diabetes Advisory Council (DAC) recommended glucose strips, but USPST does not currently include coverage of glucose strips in their list of recommended clinical preventive services. Some NC insurers are already covering this. We do not want to backtrack if North Carolina insurers have more comprehensive coverage.

Summary of Key Discussion Points:

1. We need to look at communities with greatest need and work with them to build capacity.
2. We need to build on existing strengths, but not be limited by them. We want to partner with existing organizations in the community, including local health departments, Healthy Carolinians, academic institutions, community partners, Cooperative Extension, Accreditation/Center for Public Health Quality, and the faith-community.
3. We need to develop a connector system to ensure that local community partners and non-profits can be linked in to new initiatives.
4. We need to focus on implementing outreach and education about the new clinical preventive services to clinicians, consumers/patients, and insurers.
5. We want to create short-term and longer-term strategies. The state may need to submit grants that have a quick turn around (short-term strategy), but we should be starting to partner now with local communities for those grant opportunities that we expect in the future (longer-term strategy).
6. We want to focus on evidence-based strategies.
7. We need to think more about role of funders and insurers in promoting prevention; both in what they will be required to do under the ACA, and what else they may be willing to do voluntarily.