

**Health Reform: Safety Net Workgroup**  
**Thursday, October 14, 2010**  
**North Carolina Institute of Medicine, Morrisville**  
**1:00pm-4:00pm**  
**Meeting Summary**

**Attendees**

*Workgroup Members:* Chris Collins (co-chair), Ben Money (co-chair), Jason Baisden, Kellan Chapman, Robin Cummings, Cindy Ehlers, Brian Ellerby, Katie Eyes, Elizabeth Freeman, Chuck Frock, Susan Mims, Chip Modlin, Connie Parker, Marilyn Pearson, Steve Slott, Karen Stallings, Flo Stein, Elizabeth Tilson, Ramon Velez, Kristin Wade, Susan Weaver

*Steering Committee Members:* Marti Wolf

*NCIOM Staff:* Kimberly Alexander-Bratcher, Thalia Fuller, Pam Silberman, Rachel Williams

*Other Interested Persons:* Marie Britt, Rebecca Carina, Lee Dixon, Tami Elderidge, Bo Heath, John Hickory, Christine Kearsley, Beth Melcher, Markita Moore, Howard Peckman, Maggie Sauer, Jeff Spade, Laura Vinson-Garvey

**Welcome and Introductions**

*Chris Collins, MSW, Deputy Director, Office of Rural Health and Community Care Assistant Director, Division of Medical Assistance—Managed Care, NC Department of Health and Human Services, Co-chair*

*E. Benjamin Money Jr., MPH, CEO, North Carolina Community Health Center Association, Co-chair*

Mr. Money gave a brief welcome to the group and then invited those present to introduce themselves.

**New Safety Net Models**

*Beth Melcher, PhD, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, North Carolina Department of Health and Human Services*

Dr. Melcher gave a presentation about the new Critical Access Behavioral Health Agencies (CABHA) model in mental health, developmental disabilities and substance abuse care. Clinical integrity and quality disparities across providers have been a problem in North Carolina recently and the new CABHA model seeks to improve integrity and quality by reducing fragmentation of services. The CABHA model restricts which agencies can provide behavioral healthcare with strict regulations. Her presentation can be found here: [MH/DD/SAS Models](#).

Selected questions/comments:

- Q: What is the total number of people in care? A: In FY 2010, there were about 108,000 people receiving mental health and substance abuse services. A majority of these patients were on Medicaid.
- Q: Counties that only have one CABHA have the option to target one specific population (i.e. children). Assuming there is no CABHA in the county to serve other populations, is it possible to keep people in non-CABHAs until there is a CABHA available? A: We are working now with non-CABHAs to relocate patients. We are also working to extend CABHA services to underserved counties. Some patients currently in care may not transition because they are either finished with treatment or because they will not meet eligibility requirements after re-evaluation.
- Q: What are the hours of the walk-in clinics? A: The hours vary. We wish for them to at least have after work and weekend hours, which many do. Hours depend on the level of funding the clinic has.
- Q: Do all clinics have TeleHealth? A: All clinics have psychiatry available whether through TeleHealth or face-to-face. About 30 clinics have face-to-face psychiatry, the rest have TeleHealth.
- Q: Is CABHA funding used to covering the uninsured or for building capacity? A: Both. The primary intent is to create capacity.
- Q: What does the distribution of resources for CABHAs look like? A: There are some counties with more CABHAs than they can support, and in those cases we are trying to shift services to other locations. Underserved counties need to try to recruit and bring in additional resources. Rural communities that cannot afford to build facilities need to have more mobile services, TeleMedicine, or co-location of services to save money.
- Q: What are the most common reasons applications for CABHAs are not successful? A: The biggest reason is failure to properly fill out the forms. However, there are issues of not having enough practitioners qualified in certain areas and a lack of licensed individuals.
- Q: How does iCARE fit in with CABHAs? A: The NC Foundation for Advanced Health Programs and the Center of Excellence has funding to work with LMEs and CABHAs to work with primary care providers to increase psychiatric care in primary settings. They are also working to bring more primary care into psychiatric settings. One day we may have a CABHA with primary care integrated into it or see a FQHC become a CABHA.
- Comment: Wake County is currently working to integrate a substance abuse CABHA with primary healthcare.

*Marti Wolf, RN, MPH, Clinical Programs director, North Carolina Community Health Center Association*

Ms. Wolf gave a presentation about the quality of FQHCs in North Carolina and the next steps they are taking to tackle the challenges of Health Reform. North Carolina has a very good record of providing quality care at a low cost. Future priorities are to improve access to quality health care and services, strengthen the health workforce, and to build healthy communities and improve health equity. Her presentation can be found here: [FQHC Quality and Outcomes Initiatives](#).

Selected questions/comments:

- Q: During a demonstration project to give retinol screens to Medicaid patients, we found that many had not been screened for many years. Medicaid does not pay for these sorts of screens unless they are done by an ophthalmologist's office. Are there any plans for Medicaid to cover these sorts of screens in safety net organizations? A: There are some safety net organizations getting retinal photography machines. We can assume they are planning on covering more services such as this one. One problem is the lack of ophthalmologists to perform the screening in safety net locations.
- Q: Have there been problems with providers? A: The problems depend on the health center. Some have more problems than others. Rural communities have more trouble enlisting providers than urban areas.
- Comment: Even after 2014 we will still have a significant number of uninsured persons. Massachusetts did see a drop in the percentage of uninsured people they saw in safety net organizations after they implemented their state health law. Private providers in that state also had a significant drop in the percentage of uninsured patients.

*Jason Baisden, Executive Director, North Carolina Association of Free Clinics*

Mr. Baisden gave an overview of what the North Carolina Association of Free Clinics is doing to prepare for the 2014 Health Reform. Currently the Association is looking at how Massachusetts free clinics handled the state's health reform, at alternate business models, and at the current challenges and strengths of operating free clinics. His handout can be found here: [NC Association of Free Clinics and Health Care Reform](#).

Selected questions/comments:

- Q: The biggest challenge in 2014 is going to be enrollment. Have your organizations started thinking about doing enrollment online to get those eligible enrolled? A: We are still doing assessments. Social workers will help enroll eligible persons in some organizations since they already do so currently. Hiring a patient navigator or conducting staff training on enrollment is another possible option.
- Q: What happens when you have a child of undocumented parents who is a US citizen? How do you prove they are eligible? A: Tax records will show if they are eligible unless his/her parents have been paid under the table. In difficult cases such as this situation, the

DSS will probably be called in to handle the case instead of simply enrolling the person online.

- Comment: One of the strengths of free clinics is that they often offer urgent/acute care which prevents unnecessary ER enrollment and primary care overload. This service saves money and gives more availability to priority patients in ERs and primary care settings.
- Q: Why does Massachusetts still need free clinics? A: Clinics offer many services that some people would not have access to, even with insurance (i.e. dental services). In 2009, MA was reporting that the waiting list for some primary care visits was 36-50 days for new patients. Many primary care access points closed doors to new patients which led to an increase in ER use. The sudden shock of the higher number of insured patients caused other places to be overloaded despite MA being well supplied with health professionals.
- Comment: We need to keep as many safety net entities in NC as we can throughout health reform.

### **Update on School-Based Health Centers Grant**

*Connie Parker, Executive Director, North Carolina School Community Health Alliance*

Ms. Parker updated the workgroup on the federal grant. A new version of the federal grant is more user-friendly for those interested in applying. There are 3 categories of awards: operation and renovation, construction, and equipment. North Carolina is working on an appropriation for an operational grant. Operational funds are a significant need for school-based and school-linked health centers. Current federal awards will be announced in the spring.

### **Areas in State of Greatest Needs—FQHCs/DMA/CCNC**

*Chris Collins, MSW, Deputy Director, Office of Rural Health and Community Care, Assistant Director, Division of Medical Assistance—Managed Care, North Carolina Department of Health and Human Services*

Ms. Collins explained preliminary data collected about high need areas in North Carolina. The [data](#) includes the number of children on Medicaid linked into care in each county, the number of adults on Medicaid linked into care in each county, the opinions of CCNC and managed care consultants (MCC) on whether there is an access issue in their respective counties, and FQHC status of each county. She proposed adding other categories such as if an individual's lack of care is due to an access issue.

Selected questions/comments:

- Comment: The numbers of uninsured children and adults about to be eligible for Medicaid in 2014 would be a good addition to this chart.

- Q: What does the future look like in terms of new access points? A: We have communities contemplating FQHC. The next likely opportunity is for 2013 federal grant funds.
- Q: Would expanding a current center count as a new access point? A: Expanded medical capacity is a separate grant from a new access point.
- Comment: We need to know more about where there is no access to FQHCs, not just where there are none physically located.
- Comment: To bring resources to areas with low access and high need we need to increase Health Professional Shortage Area (HPSA) designations for primary care, dental care ,and mental health services. A private provider located in a HPSA can bring in a behavioral health professional (i.e., psychiatrist, licensed clinical social worker (LCSW), etc.) who will then be qualified for federal loan repayment as incentive to practice in the HPSA.

### **Workgroup Discussion**

- Mr. Money gave a short update on grants. NC received 4 grants for community health center construction. Elizabeth City, Lillington and Ahoskie are joining with ECU's new dental school to provide teaching sites for students and to provide dental care to underserved areas. Blue Ridge will be building a new facility to replace the old one which was condemned.
- Retail Primary Care:
  - Comment: Retail primary care, such as that provided by Wal-Mart, CVS, etc., is becoming a factor in access issues.
  - Comment: It would be good to have a conversation about a way to link retail primary care so it does not interfere with the continuity of care.
  - Comment: In Green Bay, WI, they use "minute clinics" as points of access to enter the primary care system. Patients can see retail primary care providers for mild health issues (i.e. cold or flu) because they are built into the system. The retail primary care providers help with patient access and fit into a broader health system.

### **Public Comment Period**

- Comment: The new St. Mary Dental Clinic in Wilmington, NC, is doing very well. Q: Would "being in the basement of a church with no rent payments" disqualify the clinic from being a member in the Free Clinic Association? A: No, it would not.
- Comment: There is no surprise over the numbers for New Hanover County on Ms. Collin's data sheet. If the numbers are that bad for patients with Medicaid, you can imagine what they are for the uninsured. It would be interesting to see a map of the distribution of mental health services and who is getting access to them (i.e. are the uninsured getting access to them?). Thank you for what you are doing here.

The next meeting of the Safety Net workgroup will be held on Monday November 15, 2010 at the NCIOM offices in Morrisville from 1:00 PM to 4:00 PM.