

**Health Reform: Safety Net Workgroup**  
**Wednesday, December 15, 2010**  
**North Carolina Institute of Medicine, Morrisville**  
**9:00am-12:00pm**  
**Meeting Summary**

**Attendees:**

*Workgroup Members:* Chris Collins (co-chair), Ben Money (co-chair), Jason Baisden, Anne Braswell, Charles Bregier, Kellan Chapin, Robin Cummings, Katie Eyes, Elizabeth Freeman Lambar, Lin Hollowell, Tom Irons, Susan Mims, Chip Modlin, Connie Parker, Marilyn Pearson, Steve Slott, Elizabeth Tilson, Kristin Wade, Susan Weaver

*Steering Committee Members:* Anne Braswell, Elizabeth Freeman Lambar

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

*Other Interested Persons:* LaTasha Bennett, Lynn Bolden, Tami Eldridge, John Hickory, Christine Hunt Kearsley, Cindy Jones, Markita Keaton, Lilli Mann, Catherine Moore, David Moore, Regina Schaaf Dickens, Chris Skowronek, Flo Stein, Laura Vinson-Garvey, Susan Yaggy

**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, Chief Executive Officer, North Carolina Community Health Center Association, Co-chair*

Mr. Money welcomed everyone to the meeting

**Updates on the Uninsured: 2009 Data**

*Pam Silberman, JD, DrPH, President and CEO, North Carolina Institute of Medicine*

Dr. Silberman reviewed North Carolina uninsured data broken down by age, race, employment status, income, citizenship status, and county. The data will help identify how many individuals will potentially be eligible for coverage in the Health Benefit Exchange (HBE) in 2014. Her presentation can be found here: [Update on the Uninsured](#).

Selected questions and comments:

- Q: How likely do you think it is that employers will pay the penalty instead of offering insurance through the exchange? A: In a pure economic sense paying the penalty instead of offering coverage may make sense. However, currently there are two factors we can look at that may suggest that won't happen. One is that employers are not required to offer insurance now, but they still do. Two is that when Massachusetts implemented its health reform more employers offered health insurance and did not drop the coverage when the recession hit.
  - Small businesses with 25 or fewer employees currently will receive a tax credit for offering coverage. After 2014, they will receive a tax credit for participating in the exchange.
- Q: If an employee has access to coverage through his/her employer and opts not to take it, is that person still eligible for the exchange? A: No. The only exception is if the coverage offered by the employer is over 9.5% of the employee's income.

### **Behavioral Health Integration Model**

*Susan Yaggy, MPA, President and CEO, North Carolina Foundation for Advanced Health Programs*

*Regina Schaaf Dickens, EdD, LCSW, Program Director, NC Center of Excellence for Integrated Care*

Ms. Yaggy and Dr. Dickens discussed the integration of behavioral health services with primary care and ways that the North Carolina Center of Excellence for Integrated Care (COE) is implementing this model in health care delivery locations throughout the state. Integrated care has been shown to increase effectiveness of medication management, reduce depression, improve health status, and increase cost-effectiveness. The COE has partnered with ICARE (Integrated, Collaborative, Accessible, Respectful, and Evidence-Based programs) to establish training and technical assistance to participating delivery locations. Their presentation can be found here: [From Fragmentation to Integration—NC Center of Excellence for Integrated Care](#).

A list of participating locations can be found here: [COE for Integrated Care Cohort Group Development](#).

A chart with various collaborative care models can be found here: [A Range of Goals for Collaborative Practice—Levels or Bands of Collaboration](#).

Selected questions and comments:

- Q: What do you recommend needs to be done about nurses in emergency departments not knowing how to handle mental health patients? A: On the job training is one way to

handle that issue. You don't have to be a psychiatric nurse to work in the ED, but you at least need some education on identifying and assessing mental health and substance abuse disorders.

- Q: Is the curriculum for basic education of nurses missing something? A: There's a huge need across all health care disciplines for this type of education. Primary care practitioners get a brief rotation in psychiatry while psychiatrists have little medical care training despite prescribing drugs. The Health Professional Workforce workgroup is addressing some of these issues.
- Medicaid has opened codes such as substance abuse screening and motivational interviewing to help encourage practitioners to provide integrated care.
- Exchanges will have a minimum benefit established which will define parity.
- One barrier to patients receiving integrated services is a co-pay issue. Often patients will end up with multiple co-pays if they receive primary care services and behavioral health services in the same location. Is there anything we can do about this issue? A: It is an argument for furthering integrated care versus co-location of services. Other challenges for integration are that some providers have to bill behavioral health to separate agencies and that behavioral health benefits are not comparable between payers.
- Integration works very well with primary care when using a brief intervention model. Problems arise when there is a more serious behavioral health or substance abuse issue. It is very disruptive when a patient with behavioral health or substance abuse issues blows up at a primary care clinic.

### **Farmworkers and Health Access**

*Elizabeth Freeman Lambar, Program Director, NC Farmworker Health Program, Office of Rural Health and Community Care, NC Department of Health and Human Services*

Ms. Lambar presented information on the health concerns of farmworkers in North Carolina and how the North Carolina Farmworker Health Program's (NCFHP) Enabling Services Model helps farmworkers overcome barriers to care including language/cultural differences, lack of insurance, lack of transportation, and fear. Farmworkers face dangerous working conditions and sometimes live in substandard housing which can affect their health. General health concerns of farmworkers include hypertension, diabetes, oral health, depression, accidents, sexually transmitted infections, and tuberculosis. The NCFHP uses outreach workers to identify farmworkers. The outreach workers then share information about clinics, conduct health assessments, and link farmworkers with services. Her presentation can be found here:

[Farmworkers in North Carolina.](#)

Selected questions and comments:

- Q: How do you treat undocumented workers in these clinics? A: The funding we receive from the Bureau of Primary Health Care has no rule that excludes patients based on legal status and we don't even ask for legal status. It is something to keep an eye on because they are excluded from the ACA. However, states can still make decisions on how to serve patients in migrant health centers.
- If you don't treat these people then you are putting the whole population at risk. It doesn't matter if they are documented or not.
- A percentage of funding is required to go towards migrant health workers. How do you define migrant health worker in order to meet that requirement? A: We categorize a migrant farm worker based on H2A status. We are advocating increasing the H2A program so that farmers can get more legal workers. We need to protect workers that are vital to our economy and our food supply.

## **Student Updates**

*Christine Kearsley and Lilli Mann, Students, UNC Gillings School of Global Public Health*

Ms. Kearsley and Ms. Mann gave a summary of three projects they have worked on during the fall semester for the workgroup. The first project was to identify safety net providers in each county to determine areas of high need. The second project was to create a spreadsheet with information on which federally qualified health centers (FQHCs) in the state do not have access to critical access behavioral health agencies (CABHAs) in their county and to compile contact information for CABHAs that share a county with a FQHC. The third project was to produce a brochure on the National Health Service Corps (NHSC) loan repayment program provided to providers in health professional shortage areas (HPSAs). Their presentation can be found here: [Student Project Update](#).

A copy of their report can be found here: [Casting the Safety Net](#).

Selected questions and comments:

- Hopefully we can use this information to find areas that are underserved in primary care, behavioral health, and dental care in North Carolina. We can then try to get more HPSA designations.
- Your project to link CABHAs and FQHCs could also be extended to hospital emergency departments. Safety net referrals for follow-up care after visiting the ED are needed.

## **Workgroup Discussion**

The workgroup discussed what information they would like to see at future meetings including health information exchange and health benefit exchange information, how the safety net uses health information systems, dental access issues, retail health information, and snapshot updates from other health reform workgroups.

## **Public Comment Period**

- Expansion to all FQHCs is critical. However, unless there is accountability for the operation of existing ones then there will continue to be communities underserved. We are working with less and less and doing more and more. It is getting hard to serve everyone and take on this kind of responsibility. At some point our organizations are at risk.
- The demand for dental care, especially emergency dental care, is growing exponentially. I think dental health is probably the most overlooked issue when it comes to safety net organizations.