

Health Reform: Safety Net Workgroup
Monday, April 25, 2011
North Carolina Institute of Medicine, Morrisville
9:00am-12:00pm
Meeting Summary

Attendees:

Workgroup Members: Benjamin Money (co-chair), Anne Braswell, Charles Bregier, Robin Cummings, Brian Ellerby, Katie Eyes, Elizabeth Freeman Lambar, Tom Irons, Susan Mims, Connie Parker, Marilyn Pearson, Steve Slott, Flo Stein, Elizabeth Tilson, John Torontow

NCIOM Staff: Kimberly Alexander-Bratcher, Thalia Fuller, Sharon Schiro, Rachel Williams

Other Interested Persons: Fred Branson, Melissa Callaham, Art Eccleston, Tami Eldridge, John Hickory, Markita Keaton, Andy Landis, Susan Saik, Jeff Spade

Welcome and Introductions

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

Mr. Money welcomed everyone to the meeting.

Emergency Care

Charles A. Bregier, Jr., MD, FACEP, President, NC College of Emergency Physicians

Dr. Bregier explained the role of the emergency department (ED) in health reform. Emergency care provides 75% of acute care in the United States but only contributes to 2% of health care costs. The ACA requires all health plans in the health benefits exchange (HBE) to cover emergency services. The bill also requires healthcare providers, including EDs, to improve transitions of care and matches Medicaid reimbursement rates to those of Medicare for primary care providers in 2013 and 2014. The ACA does not address the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA requires hospitals to provide emergency services to everyone until a patient is considered “stable.” This requirement can lead to overutilization and abuse.

The NCCEP created an Access to Care Committee (ATCC) to address concerns over ACA requirements and the current budget crisis. Recommendations made by the committee focus on Medicaid reimbursement rates, access and utilization of the Community Care of North Carolina (CCNC) provider portal to identify patients with chronic pain, alternative networks of care for non-emergency patients, liability reform, and EMTALA reform. ATCCs action plan aims to

identify ED patients that can be better treated in an alternative health care setting. Three groups of patients have initially been selected as appropriate groups for intervention: dental complaints, chronic pain, and behavioral health. Patients in these categories without an emergency medical condition would be referred or transferred to a more appropriate health care setting (i.e., a dentist office for dental complaints).

Dr. Bregier's presentation can be found here: [Appropriate Emergency Department Utilization](#).

A copy of the NCCEP Access to Care Committee's report can be found here: [Access to Care Committee Recommendations](#).

Selected questions and comments:

- There are usually no visible signs of acute pathology in dental pain patients, but EMTALA requires that each patient receive an assessment. The biggest problem with ED care is the cost of the facility. Eighty percent of an ED visit is facility fees, only 20% or so are physician fees.
 - In those cases, the ED doesn't provide much more than a prescription for pain killers.
- The CCNC provider portal is available to providers. It has medical data, visits, imaging history, medication list, etc., for each patient. It does not include real time data. A provider won't be able to see what happened within the past several days.
- Q: Aetna reports that 60% of patients in the ED can be treated elsewhere while the CDC says only 8% have non-urgent medical conditions. What is the disparity on how care was calculated? A: The two studies are comparing different measures. The CDC report focuses on conditions that are not urgent whereas the Aetna report focuses on whether a condition can be treated elsewhere. There is disconnect between what the CDC says and what insurers say. Finding ways to bridge that gap can be done through different avenues of care.
 - One problem is that the patient doesn't always know what is wrong when he/she comes to the ED (i.e., a person with a hurt ankle doesn't know if it's broken or twisted until after visiting the ED).
- Q: Is there an opportunity for educating patients on overutilization? A: One way to address overutilization is to find follow-up care for patients and make sure the patients are able to keep the follow-up appointment instead of coming back to the ED. Many times patients experience barriers to proper follow-up including providers won't accept Medicaid or uninsured patients. We need to improve follow-up care so that everyone that leaves the ED has a appropriate follow-up appointment.
- Q: What other groups, besides the three mentioned, can be more cost effectively seen elsewhere? A: Groups such as those with diabetes or other chronic diseases.
 - Also those with asthma or COPD.

- Some patients go to the ED because they have insurance plans that do not charge a co-pay for ED visits but do for primary care visits.

Emergency Department Diversion—Mobile Crisis

Susan Saik, MD, Medical Director, NC Division of State Operated Healthcare Facilities

Art Eccleston, PsyD, Senior Psychologist, Office of Clinical Policy, DMHDDSAS

Dr. Saik and Dr. Eccleston discussed the role of mobile crisis in diverting patients from the ED. There has been an increased demand on the crisis system due to the economic downturn, loss of inpatient beds, and other changes in the system. The crisis system consists of many community providers including Mobile Crisis Teams. Mobile Crisis Teams are available 24-hours a day, 365 days a year. The teams meet the individual in crisis where they are or as close to his/her home as possible. The team provides a brief intervention and then refers the patient to the proper community support or provider. The purpose of the Mobile Crisis Teams is to reduce emergency room utilization and inpatient admissions for behavioral health conditions that can be better treated elsewhere. Forty one teams serve all 100 counties across North Carolina. The program is funded through state appropriations and Medicaid.

A copy of the presentation can be found here: [Mobile Crisis Management](#).

Selected questions and comments:

- Often a psychologist or psychiatrist sends patients to the ED to get medical clearance but that isn't necessary.
- Q: What percentage of mobile crisis patients are new patients? A: For the 114 assessed in the ED, 35-55% were not connected to the LME. It is hard to get those who are not connected to our system into the system correctly. We need to keep people from entering system at the wrong point: when someone calls 911 he/she goes into the medical system and when someone calls law enforcement then he/she enters the legal system. It is helpful to do screenings to identify people before they have a crisis. Also, we need to make sure those in the ED are linked to services before they leave.
- Q: When someone shows up at the ED and Mobile Crisis responds, how much of the costs have already been incurred? A: By then a full medical screening exam, lab tests, cat scans, etc., have been done. Thousands of dollars have been spent before Mobile Crisis arrives.
- A project with CCNC identifies frequent users of EDs and reaches out to them to provide a combination of primary care and medical home services. The program has been able to identify and divert people and saved \$120 million in ED costs. The problem was getting people to participate. Many of those identified don't have a lot of family support. However, the participants have created a community within the group and started

supporting each other outside of the program. The program is going to be implemented in some other locations this summer.

Emergency Department Diversion—Safer Opioid Prescribing

Fred Wells Brason II, Project Lazarus, Wilkes County Carolinians Council, Northwest Community Care Network

Mr. Brason gave an overview of Project Lazarus, a community-based drug overdose (OD) prevention program. The rate of unintentional ODs in the United States in 2007 was 9.18 per 100,000. In comparison, the rate in North Carolina was 11.5 per 100,000. The rate was 46.5 per 100,000 in Wilkes County. The high rates of OD deaths in Wilkes County prompted the development of a new program to prevent opioid abuse and OD deaths.

The Wilkes County Chronic Pain Initiative changed opioid prescribing policies in the local ED by lowering the number of doses prescribed at a time and refusing to refill opioid prescriptions in the ED (a patient must go through his/her primary care provider). The initiative also began substance abuse prevention programs in the community and advocated to increase the number of substance abuse treatment facilities in the state. After three years, the program had effectively reduced the number of ED visits related to substance abuse and ODs, saved money and improved care and access.

Project Lazarus provides naloxone rescue to patients within the specified target populations, which includes patients on opioids for chronic pain. Naloxone is a drug that counters opioid pain killers and therefore prevents an OD from causing harm or death. Within the first two years of the program, Wilkes County has seen a 13% drop in the number of ED treatments related to OD and substance abuse saving over \$16,000 per avoided OD episode.

Mr. Brason's presentation can be found here: [Project Lazarus](#).

A copy of Wilkes Regional Medical Center's prescribed pain management policy can be found here: [Prescription Pain Management Policy](#).

Data on the number of ED visits related to drug poisoning and substance abuse can be found here: [NC Emergency Department Visits, 2009](#).

Selected questions and comments:

- If people with substance use disorders are diverted from one source, but not treated, then money won't be saved. They will change counties or change drugs. There needs to be more treatment out there.

- Community Care of Wake and Johnston Counties is finding that Medicaid patients are bypassing the system by not using Medicaid cards and just buying the drugs with cash. Narcotics are relatively cheap.
 - We need to look at the idea of having to show an ID to receive a narcotic. There is a 70% Controlled Substances Reporting System use rate in Wilkes County (one of the highest rates in the country) and a 21% rate in the state.
- Fort Bragg has begun to give naloxone kits to active duty soldiers. About six to seven thousand soldiers are on opioid medication out of about 32,000 on base. We are talking with Veterans Affairs about addressing overdoses.
- Q: Are there any specific examples of communities setting up programs in the central or eastern part of state? A: One program has been started in Robeson County. Also, CCNC networks in Moore County, the Sandhills, and Montgomery County are looking at these types of programs.
- Q: Are there any recommended policy changes that could be instituted in North Carolina to reduce the ability of prescription drug users to jump around within the state to access drugs? A: More dollars for prevention and treatment would be a good start.

Grant Updates

- The compromise in the federal budget resolution for 2011 eliminated \$600 million from the annual health center funding. The Health Center Trust Fund will probably be used to cover the money already awarded through grants. There will be limited opportunity to expand community health centers in the future. In the best situation, North Carolina may have two or three new access point grant applications funded. The lack of new and expanded community health centers will be an additional access issue in 2014 because more people will be insured through Medicaid expansion.
- The \$730,000 state appropriations to reimburse doctors for services provided to migrant farm workers is being cut completely. Migrant health sites are going to have to look at other resources for the uninsured. The migrant population is one of the populations that have the least access to care due to barriers. EDs will get increased usage from this population.
 - The volume of patients in the ED goes up 10% every year; most patients are uninsured and underinsured. ED use will skyrocket due to these cuts. While we understand that there are budget issues, this is not cost effective.
- All of these financial cuts have a real compounded effect. Cutting funds to education and health care prevents people from moving up the socioeconomic ladder. Increasing the number of people in the middle class as opposed to keeping them in the permanent underclass is the best way to save Medicaid dollars, etc.
- Potential sources of financing could be universities such as Duke and UNC-Chapel Hill. They are trying to expand access by recruiting primary care physicians. Could they be

interested in increasing access in other ways such as through new community health centers? Also, could retail facilities help increase access (i.e., Walgreens, CVS). We need to go outside the box in some way.

- The House Committee voted to cancel the Capital Grant for school-based health centers; however, it appears that this is unlikely to happen. The submitted Capital Grants applications will receive notice of whether or not they receive an award by July 1. Grants for the years 2012 and 2013 will also still be awarded.

Next Meeting—May 23 at 9:00am

The next meeting in May will focus on pharmacy. The meeting in June will focus on making recommendations.

Public Comment Period

- We all have to do more collaboration because it is the only way we will survive all these financial cuts. The incubator project has been such a gift to this state. That work was not for naught, it generated dialogue within communities, education and training and a willingness to find alternative routes for care. There were benefits beyond the number of access points. It will continue to pay off for the state over time.