June 2-4, 2008, Chapel Hill, North Carolina

Health Resources and Services Administration
Office of Rural Health Policy

Chapel Hill, North Carolina
June 2-4, 2008

Meeting Summary

The 59th meeting of the National Advisory Committee on Rural Health and Human Services was held on June 2-4, 2008, in Chapel Hill, North Carolina.

Monday, June 2, 2008

The meeting was convened by Governor David Beasley, Chairman of the Committee.

The Committee members present at the meeting were: Larry K. Otis (Vice Chair); Graham Adams, Ph.D.; April M. Bender, Ph.D.; Maggie Blackburn, MD; B. Darlene Byrd, MNSc, APN; Sharon A. Hanson, Ph.D.; Donna K. Harvey; David R. Hewett, MA; Thomas E. Hoyer, Jr., MBA; Todd Linden, MA; A. Clinton MacKinney, MD, MS; Michael Meit, MA, MPH; Karen Perdue; Robert Pugh, MPH; Thomas C. Ricketts, Ph.D., MPH; Julia Sosa, MS, RD; and Maggie Tinsman, MSW. Mr. Dennis Dudley attended representing the U.S. Administration on Aging. Members unable to attend were: Deborah Bowman, and Patti J. Patterson, MD.

Present from the Office of Rural Health Policy were: Acting Director Tom Morris; Judy Herbstman; Nina Meigs; Kristi Martinsen; Erica Molliver; Jenna Kennedy, Meghana Desale; and Jennifer Chang.

Tom Morris provided an update on the report to the Secretary for 2007. The report is in the final stages of the clearance process and should be released in August, 2008.

Setting the Context for Rural North Carolina

Bland Simpson, Director, Creative Writing Program, UNC-Chapel Hill.
Thomas C. Ricketts, Ph.D., MPH

Professor Bland introduced the Committee to the culture of North Carolina. He spoke about his father who was a physician in Elizabeth City, NC and the region's farming and fishing cultures.

Dr. Ricketts delivered a slide presentation on the history of North Carolina and also spoke about rural health programs and initiatives in the State.

Workforce and Community Development Panel

Erin Fraher, MPP, Director, North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services, University of North Carolina at Chapel Hill. Tom Bacon, DrPH, Executive Associate Dean and Director, North Carolina AHEC Program, University of North Carolina at Chapel Hill.

Ms. Fraher spoke about three connections between health care and community/economic development. The first connection is health care as a "jobs machine," and she pointed out that health care has the potential to sustain local economies with jobs that are less vulnerable to outsourcing and economic recession. The two other connections are that health care is related to productivity in the workplace and that companies seeking to relocate their operations will examine the adequacy of health care resources in a community. Ms. Fraher then described the transformation of NC's economy from the loss of manufacturing jobs, the increase of employment in health and human services (especially in rural areas), and the significant growth of jobs in the allied health professions. She noted that the fastest growing occupations are in allied health professions including medical assistants, dental assistants, occupational therapists, and respiratory therapists. There are high vacancy rates for many allied health professions throughout the State. For example, one out of every two positions is vacant for Occupational Therapy Assistants. The good news is that the State's investments in allied health and nursing education have a high return because retention of students after graduation is high in the State and graduates seek jobs in local employment settings. Ms. Fraher presented data showing a large percentage of graduates returning to their communities. The not-so-good news is that despite rapid growth and huge demand, the rural education system struggles to supply an adequate number of qualified applicants for health care jobs, faculty at community colleges, a lack of clinical training facilities, high costs of education, and high attrition rates. One of the challenges to moving forward is to increase collaboration between policy makers, educators, and employers on workforce strategies at the local and state levels. Existing health care workforce monitoring is fragmented and a more coordinated response is needed to regulate the supply of health care workers. There is also a need for better information on the locations of jobs; better agreements between community colleges and four-year institutions; and the development of career ladders and programs that allow workers to continuously upgrade their

skills. Ms. Fraher concluded her presentation with a discussion of the examples and benefits that flow from public and private collaborations to address these issues.

Dr. Bacon presented on the Area Health Education Center (AHEC) Program, a workforce development initiative that began in 1970s to improve access to health care in NC and elsewhere, especially in rural areas. In NC it involves a partnership of four academic medical centers, the five University of North Carolina (UNC) health sciences schools and community hospitals, and other health agencies across the State. The AHEC core programs in NC are community-based student training; primary care residency training, continuing education for health professionals, health careers and workforce diversity, and library and information technology. The goals are to provide students with an enriched curriculum in primary care, exposure to community practice, community-based research opportunities, and opportunities for multidisciplinary education as part of a healthcare team. Dr. Bacon provided data on the number of students served in both rural and urban areas and the location of primary care residency programs in the State. Retention rates of primary care residency graduates in NC are at 62% for AHEC residencies. Dr. Bacon described the goals for primary care residency training that include a curriculum with more focus on rural and community practice. NC AHEC programs also promote diversity in the health careers workforce through outreach programs and to recruit under-represented and disadvantaged students. Opportunities and challenges for AHEC in NC include diversity initiatives, mental health workforce development, expansion of student enrollments in the health professions, expanded residency training, and the expansion of allied health and nursing programs.

Ms. Tinsman asked the speakers to talk about programs related to Historically Black Colleges and Universities (HBCUs). Dr. Bacon said that there is a rich tradition of work with HBCUs in North Carolina and that they are a major source of potential health professionals. Their students often face special challenges and there is a need to support them as they pursue education in allied health and other health professions. Dr. Ricketts noted that a new pharmacy school has been placed in an HBCU and suggested that other programs could be placed at these institutions.

Mr. Linden commented on the likelihood of reduced federal resources for health professions education and the need to focus on prevention services. Dr. Bacon said that it is difficult to quantify the payoff on health prevention activities, but we must do a better job of it. The new emphasis on quality and safety is beginning to address the problem, but economic incentives are not properly aligned with preventive health care services.

Mr. Hewett asked where young people are going when they leave health professions programs and how we can deal with income issues. Ms. Fraher said that his group is working to

understand why young people drop out of the professions and that more work is planned. Dr. Bacon commented that potential income is a major factor in student choice of a primary care profession and that pay-for-performance may be one way to shift economic incentives more toward primary care by paying more to keep people out of the hospital.

Dr. Adams asked about the importance of having rural seats on student selection committees. Dr. Bacon responded that N.C. had not cracked this problem, noting that the best predictor of where students practice is where they grow up. Many rural students need extra help as undergraduates, but this issue is not unique to North Carolina.

Mr. Otis asked about the use of occupation vacancy data by the State. Ms. Fraher replied that the data helps local communities to understand their needs and also helps community colleges to plan their programs. The data is “eye opening” for those interested in economic development and its relationship to adult education programs.

North Carolina Smart Start Initiative Panel

Ms. Sue Totty representing the President, NC Smart Start.
Mr. Tom Vitaglione, MPH, Senior Fellow, Health and Safety, Action for Children North Carolina.

Ms. Totty said that the Smart Start Program has a unique and strong association with rural health in North Carolina. The program began in 1993 with strong political leadership from Governor Jim Hunt. It encompasses health care, parent education and family support initiatives. It consists of local partnerships funded by the State and governed by local Boards of Directors. The State sets broad policies for the partnerships that are implemented at the local level. All major local service agencies in health and human services are represented on the Boards. There is very strong collaboration among the agencies, especially in rural areas. About 70% of the funding goes towards early child care and education. Thirty percent goes to health care and health education. The State provides assistance on financial accountability and training for local partners. There is a performance-based incentive system that includes indicators for evaluating program effectiveness. There is a statewide reporting system on these measures. The program works in every county of the State and is unique in identifying and exploiting local resources in health and human services. The program is moving forward to place more emphasis on mental health and public health issues. New resources have been made available to address obesity and child behavioral health. Other initiatives include projects on nutrition and physical activity, a pilot program on parenting skills, and family literacy programs.

Mr. Vitaglione first spoke about the political will it took to establish the Smart Start Program. He emphasized the need for a long-term political commitment to building and sustaining the program infrastructure. Governor Hunt was the leading figure and he saw the connections between child health and education and economic development. Early on there was considerable debate on where to place the emphasis between early child care and health, which lead to the decision that 70% of funds would go to child care and the remainder to health. The early focus in health was on childhood immunizations because immunization rates were low in many areas of the State. In 1998, a child health insurance program was started with strong connections to the infrastructure for Smart Start. The State used the Smart Start Program as a way of distributing information about the insurance program. Local Smart Start partners began working on enrollment and other aspects of the insurance program. Mr. Vitaglione also spoke about the problem of access to dental care services in North Carolina. He said that the Smart Start structure has come into play, making it easier to address the issue in rural areas. He also spoke about the performance indicators, noting that there are six categories involving health care services and that every county receives a report on their performance against these indicators.

Dr. Hansen asked the speakers about barriers to collaboration and federal/state funding for the program. Ms. Totty replied that there is a large appropriation from the State and a funding formula for supporting the local partnerships. Some federal money has been available for special projects in such areas as child abuse prevention. The program is also working with public health and its funding streams.

Ms. Perdue commented that her state of Alaska had been impressed by the Smart Start model and that it is a good model for the Committee to consider in its discussion of program integration and collaboration.

Mr. Meit raised the issue of data collection at the county level and recommended that the Committee address the need to collect more and better data in rural areas. There is a lack of rural data at the county level and below.

Medicaid Demonstrations on Medical Homes – Community Care Network of North Carolina Panel

Mr. Torlen Wade, Senior Consultant, NC Foundation for Advanced Health Programs, Inc.
Dr. Tom Wroth, Assistant Professor, Department of Family Medicine, UNC-Chapel Hill.
Mr. Brian Toomey, CEO, Piedmont Health Services.

Mr. Wade presented an overview of Community Care North Carolina, a program that has developed a medical home model of care for Medicaid beneficiaries. The goals of the program are to improve quality, develop community networks of care, improve care for chronic illnesses, and fully develop a medical home for beneficiaries. He said that North Carolina is still a rural state with no managed care and a loosely organized medical system. Most medical practices are small and there is no real coordination of care. The original vision for Community Care included the concepts that care would be managed through public/private partnerships at the community level. It would be led by physicians and emphasize quality improvement and continuity of care, not reduced costs. The program began in 1998, and there are now 14 Networks covering the entire state, with 800,000 enrollees. The Networks are non-profit organizations that include safety net providers. Each Network has a medical management committee and case management workers. The Networks receive a fee from Medicaid for providing case management services. Physicians receive a fee for coordinating care and information systems costs. Key innovations through the program are the development of physician-guided networks, evidence-based treatment programs, and the additional resources that have been made available for high-risk patient care. The speaker said that the next steps in program development are to improve the management of chronic conditions, enhance patient self-management, and provide more effective integration of specialty care.

Dr. Wroth presented a definition of medial home as follows: “Organized care around the relationship between a patient and a personal physician within a practice setting that uses systems-based tools to consistently deliver the key attributes of patient-centered care.”

He showed the locations of 14 Networks around the State and described them as an extension of the primary care teams. An important feature of the program is that the Networks engage physician practices in quality improvement initiatives, and the practices are audited to provide information on the quality of care they provide. Specific quality improvement initiatives are addressing such areas as child development, coordinated care for the uninsured, low birth weight, and diabetes care. Dr. Worth described how the Networks help individual practices in care management, understanding Medicaid policies, development of clinical guidelines, leveraging community resources, and patient self-management strategies. He presented some tools that have been developed for physician practices to help patients manage their own conditions, including patients with low literacy levels. Practices receive quarterly reports on the care they are providing. He said that patient chart audits have become a powerful tool for helping practices understand how they are performing. He provided data showing outcomes in asthma treatment, care of diabetics, and in other areas. The lessons from North Carolina’s program are: 1) Engaging physicians has been the key to improving outcomes for the Medicaid population; 2) There are factors beyond financial incentives that will engage physicians in the

Medicaid program such as their desire to improve quality and engage in a healthy competition with other practices; and 3) Case management, especially when co-located, can become an extension of the care team. In conclusion, Dr. Worth said that the key attributes of the program are replicable in other states and may have relevance to non-governmental programs.

Mr. Toomey spoke about one of the Networks under Community Care North Carolina, the Piedmont Health Services, Inc. He focused on how Piedmont is meeting its mission of creating a primary care home and how it is working with community partners. He said that a medical home has several core elements: accessibility; continuous care; comprehensive care; patient-centered care; coordinated care; compassionate care; and competent and culturally effective care. He provided demographic data on Piedmont clients, saying that 65% live below the Federal poverty line and 57% are uninsured. About 24% are on Medicaid and there are large percentages of minority populations served. Piedmont had 102,138 medical visits in 2007 and dispensed 180,000 prescriptions. Piedmont works in close collaboration with the UNC health care system and other groups. Piedmont is working to break down “silos” of care in North Carolina by assuring a high quality medical home with access to specialty services, case management, and coordination of pharmacy services. Future goals include the development of IT systems to track service utilization, costs, and clinical outcomes for the population served.

Mr. Hewitt asked whether Medicare quality assurance measures apply to the North Carolina Medicaid Home program. Mr. Torlen replied that the program is not trying to align with Medicare, but is looking for opportunities to coordinate with Medicare on quality measures.

Dr. MacKinney asked whether the demonstration was having any beneficial “spill over” effects on non-Medicaid patients. Mr. Torlen answered that quality improvement tools used by the program can benefit all patients.

Dr. MacKinney then asked how the program defines 24/7 access for patients. Mr. Torlen said that the contracts with providers stipulate that patients can make contact with providers at all times.

Public Comment

Governor Beasley asked if there were any public comments. There were no comments and the meeting was adjourned until Tuesday.

Tuesday, June 3, 2008

On Tuesday morning the Subcommittees departed for site visits to the following locations.

Workforce and Community Development Subcommittee: Members of this Subcommittee traveled to Rocky Mount, NC for site visits at the Edgecombe Community College and the Area L. Area Health Education Center.

At-Risk Children Subcommittee: This group traveled to Siler City, NC for a “Child Watch” Tour that included stops at the Paul Braxton Center Playground, Chatham Hospital, Piedmont Community Health Center, and the Chatham County Health Department.

Medical Home Subcommittee: This Subcommittee traveled to Greenville, NC for meetings at the Pitt Memorial Hospital Foundation Building. The group also visited the James Bernstein Community Health Center.

The Subcommittees returned to Chapel Hill on Tuesday afternoon for Subcommittee meetings.

Wednesday, June 4, 2008

Vice Chairman Larry Otis convened the meeting and called for the Subcommittee reports.

Ms. Julia Sosa reported for the At-Risk Children Subcommittee. She said that the visit to Siler City Head Start had highlighted language barriers faced by the program and that the Head Start staff displayed impressive bi-lingual skills. A presentation by staff at The Family Resource Center demonstrated a focus on single mothers and fathers. There was also a presentation on early health intervention strategies for children and the use of evidence-based health assessments. The Family Resource Center has developed a single application for the use of multiple assistance programs available to children. Programs on childhood abuse were innovative and abuse was included in the assessment measures. Ms. Sosa also reported that the NC Smart Start program has been successful in implementing childhood obesity programs. She then discussed some of the barriers to caring for children with mental health issues and familiar issues related to transportation.

Mr. Meit reported for the Workforce and Community Development Subcommittee. He summarized presentations on allied health workforce that were provided by the staff at Edgecombe Community College. There is a close collaboration between the College and the health care sector in recruitment and education of allied health workers. Major barriers to expanding the allied health workforce include the needs of many students for remedial courses and the fact that some students exhaust their financial resources while completing the remedial work and are then unable to pursue their education in allied health disciplines. A very important message from the presentation was that associate degree programs offered by community colleges can save money for local hospitals by reducing their recruitment costs. The

Subcommittee also heard about an integrated high school/associate degree program for allied health students that could be a model for other states. There was an informative discussion of the added costs to Community Colleges for allied health education including expensive equipment, training in clinical settings, and higher faculty salaries. At the AHEC the Subcommittee learned that there is strong support for this program in NC and that most funding comes from the State. There was a wide-ranging discussion of programs and initiatives at the Center.

Dr. Ricketts commented that early counseling of students entering junior college in NC did not have an appreciable effect on dropout rates.

Mr. Morris commented that the Subcommittee report could emphasize the critical relationships between local rural economies and community colleges.

Mr. Hewett reported for the Medical Home Subcommittee. He said that the site visits had helped the group to refine a definition of medical home and exposed some of the challenges and promises of the model. Much was heard about the challenges of moving toward electronic medical records and the importance of combining case management workers with physicians and others in the health care team. The group learned that it is hard to document cost savings from the model and that the management of patients with chronic diseases may have the biggest financial return. Financial payments for case management are extremely important to the program. Mr. Hewett concluded by saying that the medical home concept is not entirely a "bed of roses," but it does have great potential.

Committee Business

Ms. Jennifer Chang called for general comments on the report chapter outlines and any suggestions for additional research that should be undertaken by staff.

Mr. Hoyer commented that the beginning of the report should emphasize the theme of community collaborations and relationships.

Mr. Otis stressed the need for brevity and conciseness in the report.

Mr. Morris reminded the Committee that the States are an important audience for the report and this should be a consideration in how the report is drafted.

Mr. Hoyer suggested that Governor Beasley might be asked to distribute the report to the National Governor's Association.

Ms. Chang spoke about the September meeting (September 24-26) in Minnesota. She asked the members to make early travel plans for the meeting.

Public Comments

There were no public comments and the meeting was adjourned.