TASK FORCE ON RURAL HEALTH
NORTH CAROLINA INSTITUTE OF MEDICINE
JANUARY 8, 2014
10:00-3:00

WELCOME & INTRODUCTIONS

Chris Collins, MSW
Acting Director
Office of Rural Health and Community Care
North Carolina Department of Health and Human Services
Co-chair

Paul Cunningham, MD
Dean, Senior Associate Vice Chancellor for Medical Affairs
Brody School of Medicine
East Carolina University
Co-chair

Donna Tipton-Rogers, EdD
President
Tri-County Community College
Co-chair

Ms. Collins welcomed everyone to the meeting and attendees introduced themselves.

UPDATE ON PRIORITIES

Adam Zolotor, MD, DrPH
Vice President
North Carolina Institute of Medicine

Dr. Zolotor gave an overview of the work of prioritizing the strategies from the last meeting. After the community forums, the steering committee recommended that the task force move forward with the three strategies that recevied the most votes from those forums. The steering committee felt it was important to identify at least one priority from each of the three quadrants. Dr. Zolotor's presentation can be viewed here.

The six priority areas for the Rural Health Action Plan are:

1) Educate communities about insurance options available in the marketplace, the possibility of Medicaid expansion, and available safety net options. (access)

2) Work with the formal or informal education systems (including faith communities and other community based organizations) to promote healthy eating and active living. (health behavior)

3) Ensure adequate incentives to recruit health professionals to underserved areas of the

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state. (access)

4) Increase support for quality childcare and education (birth-age five) and parenting supports to improve school readiness. (community/environment)

5) Develop regional industries and local resources. (community/environment)

6) Use primary care and public health settings to screen for and treat people with mental health and substance abuse problems.(health behaviors).

We will address two of those today and then two at each of the next task force meetings. The panels will help us develop action steps for each of the priority areas. J. Nelson-Weaver noted how impressed she was with the process of prioritization and how focused the voting process was on what's best for rural communities not just our priorities.

HEALTHY EATING AND ACTIVE LIVING: OVERVIEW OF EVIDENCE-BASED & PROMISING PRACTICES

Alice S. Ammerman DrPH, RD
Director, Center for Health Promotion and Disease Prevention (a CDC Prevention Research Center)
Professor, Department of Nutrition, Gillings School of Global Public Health and School of Medicine
University of North Carolina at Chapel Hill

Dr. Ammerman provided an overview of evidence based and promising practices in schools in the area of healthy eating and active living. She reviewed several evidence- based school interventions, and the core elements and promising practices necessary for success. She finished with the following summary recommendations: know your community and identify committed champions, get key stakeholders on board, rally, the troops before imposing anything, and after identifying community passions.

Discussion: There was some conversation about how to decide between evidence based programs and promising practices and what best fits the community. There was further discussion about adaptation to the community but not reducing the intensity of the interventions. They discussed the incentives for student participation in these programs. Another participant asked about having programs evaluated and how to move towards practice tested and evidence based distinctions.

Dr. Ammerman's presentation can be viewed here.

HEALTHY EATING AND ACTIVE LIVING PANEL & DISCUSSION

Pat Hansen, RN, MPH
Project Manager, Shape NC
The North Carolina Partnership for Children, Inc.

Ms. Hansen discussed the problem of childhood obesity in North Carolina – including NC's rate of obesity (as compared to other states), and potential health risks of childhood obesity. It is important to invest in children early, and Shape NC aims to address early childhood obesity

using evidence-based strategies and programs in early childhood care centers and communities. Hansen discussed the phase 1 of Shape NC's intervention, which brought together strategies from NAPSACC, POD, and Be Active Kids. Shape NC works in childcare centers and communities to improve nutrition, physical activity, and outdoor environments. Hansen discussed the findings, including improvements in nutrition and physical activity in childcare centers. Hansen also discussed the participating local communities who identified and engaged stakeholders and implemented changes including shared community gardens and improved outdoor play spaces. Hansen also discussed increasing community engagement and evidence-based approaches for next phases.

Ms. Hansen's presentation can be viewed here.

George T. ("Tim") Hardison, Jr., MA
MATCH Project Director
East Carolina University

Mr. Hardison spoke about the MATCH project (Motivating Adolescents wth Technology to Choose Health), a school-based childhood obesity prevention. Hardison discussed the impetus for, and design of, MATCH and the focus on integrating the program with the existing curriculum (currently the Common Core standards). Hardison discussed promising results, including improvement of BMI in 7 of 10 overweight students, and sustainability and expansion of the intervention. He also discussed MATCH results as compared to control group, including greater numbers of conversion to healthy weights, fewer becoming obese in 4 years after intervention and implications for potential health care cost savings. He discussed next steps for MATCH program and current partners and need for support from state policy makers for wider implementation.

Mr. Hardison's presentation can be viewed here.

Suzanne Lazorick, MD, MPH, FAAP
Associate Professor of Pediatrics and Public Health
ECU Pediatric Healthy Weight Research and Treatment Center
Associate Director of Community Research and Prevention

Morgan Whitehurst
Senior Coordinator
EL Roberson Senior Center – Tarboro

Ms. Whitehurst discussed implementation of evidence-based programs for older adults, including chronic disease programs. The primary focus was self-efficacy in health management for older adults, with over 1000 participants, followed for 3 years. Evaluation measures included indicators of health status and health care utilization, including hospital stays (number and duration). Results showed improvement in physical activity rates, cognitive function, and self-reported general health. They also showed less fatigue, disability, and number of outpatient visits. It is estimated that this program saved $10 in health care costs for every $1 spent. The program consists of (non health professional) facilitators running hour-long weekly sessions for 6 weeks, for between 6 and 15 participants.

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Adam Zolotor facilitated discussion. Pam Silberman asked Willona Stallings to discuss Faithful Families. Stallings discussed FF as a strong partner – a multi-week curriculum focused on healthy eating and physical activity from a faith-based perspective. FF uses health department representatives to go into faith-based communities and explore how they can address improved nutrition and physical activity (works with Eat Smart Move More). Silberman asked Hardison to discuss specific elements of MATCH programs – he explained how teachers use nutrition and activity-based concepts to teach other subjects (percentages, etc.) and also increased teaching of physical activity and nutrition. Zolotor asked about cost for a school to implement – Hardison said that each school receives a stipend for a MATCH coordinator (approx. $3000/school, $10-20/child/year).

Selected comments/questions:

- participation of school nurses and/or link between students' medical homes. How can this function as a chronic disease model and use this program as linked to doctors and medical homes?

- Should we rely on schools to be motivated to implement these programs – should there not be someone who pushes these programs and tries to pull additional stakeholders into requiring implementation?

- How do we get the broader medical community involved? Focus on cost savings.

- Has this reduced absenteeism?

- MATCH may want to look at correlating with parents' work hours saved (due to not having sick children) – this could be attractive data for economic developers as funders

- how much do we know about what the parents are learning from their children? Lazorick – kids write essays at end of experience, mentioning family participation, kids as agent of choice; anecdotes from teachers regarding parents' mention of kids' involvement.

- where is MATCH, geographically? Hardison – currently in 12 counties in Eastern North Carolina, with pilot in Cherokee County, SC.

- how much does being from the community impact the message within the schools? Hardison – can talk to teachers, "been there done that"

- Have we identified an intervention for the 18-64 range? Whitehurst – chronic disease model could be scaled to this. Faithful Families also addresses all ages. Zolotor – best results for communities vary.

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NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state

DISCUSSION OF POTENTIAL ACTION STEPS

How should communities select interventions/programs? What are stakeholders? Program components? How do we make recommendations?

Dr. Silberman – We know from research that socioecological model works best, meaning we want to support multiple interventions in multiple areas that build on one another.

Selected comments/discussion:

- health department community health asssesments – bring community together to review data, set priorities – include reps from schools/education systems

- Dr. Silberman – must be cautious to not go too far beyond schools – our discrete priority areas will be diluted; in order to reach schools, we need to do a top-down approach – how do we get to the state board or Department of Public Instruction, or – get legislature to mandate. And – how do we do bottom-up approach? Eat Smart Move More coalitions, community health assessments

- are we focusing on environmental interventions or individual interventions?

- not built environment, not health system related. Focus on community change. Focus on formal educational structure K-12.

- of our priorities, nothing really includes older adults – we need to bring them in.

Dr. Silberman – could we do an ABC recommendation:
A - Early education (preK)
B – School (K-12)
C - Community (families) – as wrap-around to support A and B

- we should stick to 5 recommendations (not several components to each)

- What about sustainability? Are the partners that would be involved in sustainability involved in the recommendation?

INSURANCE EDUCATION: OVERVIEW

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

Dr. Silberman provided an overview about the uninsured in North Carolina and potential sources of coverage. She discussed subsidies for individuals, the federal marketplace to purchase insurance, outreach, education, and enrollment assistance. She reviewed lessons from the past that can be applied to the ACA implementation. She also addressed issues specific to rural communities.

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Dr. Silberman's presentation can be viewed here.

INSURANCE EDUCATION PANEL & DISCUSSION

Sorien Schmidt
State Director of North Carolina
Enroll America

Ms. Schmidt introduced Enroll America and explained its role in the ten states with federally facilitated marketplaces without a state agency to take the lead. Get Covered America is the consumer face of the organization for the campaign. The strategy is to focus on the who, what, where, and when of the enrollment process. She explained the five areas of focus that they cover including the March 31st enrollment deadline, what services are covered, and that people cannot be denied based on a pre-existing condition. North Carolina is unique in having an 800 number to call and make appointments to enroll in insurance with an assister. use paid staff to create teams of volunteers to spread the message and collect names and numbers of people who are interested in enrolling. North Carolina is the only state that allows Enroll America to call people and schedule an appointment with an in-person assister because of the 800 number. When the focus was on Wake County, they filled all their appointments in 3 days. In rural communities they have focused on areas with active volunteers.

Adam Linker
Policy Analyst, Health Access Coalition
North Carolina Justice Center

Mr. Linker explained that the NC Justice Center is doing outreach and education focused on getting people engaged in the long term. In rural areas, they found that it is important to be on the ground and spend time in the community. He brings his family to the events and makes deep connections in the community. Community churches have been an important partner in rural areas. In Rockingham County, a particular church has allowed scheduling appointments with in-person assister in the community. He also noted that the press and radio are more easily accessible in rural areas. Libraries are also another trusted partners. Before an event in a community, their staff spend time on the ground in the community. Some of the challenges are overcome by involving the community in the planning of the community events and enrollment opportunities.

Reuben C. Blackwell, IV
President & CEO
Opportunities Industrialization Center - Rocky Mount

Mr. Blackwell explained that OIC got into the business of primary medical care in 2005. All the clinics in the community that served poor people shut down. OIC is now a federally qualified health center and has statewide and national partners. The issue of affordable care is about survival and overcoming disparities. OIC is the only place with extended hours that serves people regardless of the ability to pay. 40% of their patients are uninsured. They have a partnership with churches, radio, and other community organizations. A particular young man was paying $318/month for private insurance, then was unemployed, and now has the best

insurance he's ever had for only $18/month. The OIC staff have trained other people in the community to help people register. From mid-November to December, their two staff have already talked to 500 people and registered 300 in the small rural community of Rocky Mount.

John Eller
Director
Catawba County Social Services

Mr. Eller explained that Catawba County has dispersed rural geography that make it difficult to reach out to everyone. They are focused on how to reach the people that may not come to DSS, the rollout of NC FAST, and XX. He started meeting with hospitals about two year ago. They negotiated that hospitals would pay the 25-50% share of FTE for a position that can discuss food benefits, the healthcare marketplace, and other benefits in the hospital. Through Blue Points (BCBSNC), they have accessed people in the local community that did not access social services.

Discussion:
Zolotor noted that they are trying to get people engaged. Mr. Blackwell focused on specialty care for people with chronic diseases who have been avoiding care rather than be diagnosed and not be able to receive care. Mr. Eller is focusing on the whole person and all the needs they might have not just health care. Ms. Schmidt noted that some Enroll America offices are doing eligibility pre-screening, but in NC they recommend that people apply for social services or places to determine their eligibility. At OIC, they also engage politicians and community members so that they understand what services they offer and what their clients need. Chris Collins, Acting Director of the Office of Rural Health and Community Care, noted that HealthNet funding is going to Community Care Networks to help support care for some of the uninsured. Joy Reed, DPH, noted that the federal funding is going away to support indigent care in safety net providers. Dr. Silberman noted that 13 new FQHC sites were funded in North Carolina, but in 2016 their base funding will be cut.

Additional selected comments:

- Discussion of stigma – complaint about not being eligible for benefits but not supporting Obamacare; debate is politicized and people aren't getting the information; Enroll America sticks with the 5 points and doesn't use the term Obamacare

- People who haven't had insurance before or in a long time may not be aware of how to use insurance properly and maintain this coverage.

- The biggest hurdle has been the malfunctioning of the website. 15,000 – 18,000 applications stuck in cyberspace from the federal marketplace

- states who opted out may still get applications for Medicaid for people that would have been eligible if the state expanded Medicaid

- The missing partner is the commercial insurance to help educate and promote the use of the insurance.

- Of the American Indian tribes, 8 of the 9 tribes are no federally recognized. Is there a concerted effort to reach out to them? FQHCs, Legal Aid, etc.

- Hospitals – some involved in outreach and enrollment ex. UNC, some talking about offset cost of insurance, all financial policies publically posted on NCHA website, sharing good practice

Panel thoughts about how to improve: more volunteers and paid staff, consistent materials that can go to anyone that wants them, dedicated point of contact for questions; DSS should be frontline (can screen for everything), get share of FTE from community hospitals, consistent messaging across agencies; map or inventory of qualified entities for navigators/assisters, share map/inventory with state entities and partners, specific outreach to hospitals to let them know who to reach out to; state response to not expanding – what should public agencies do to combat indigent care; advertising/media campaign; designated place to go to get people enrolled; not be afraid of talking about the ACA

DISCUSSION OF POTENTIAL ACTION STEPS

Selected comments:

- Dr. Silberman reviewed the suggestions of the panel on how to improve outreach and enrollment.

- Since there isn't a lot of funding for paid navigators, it would be helpful to link volunteer organizations to the navigator and/or CAC entities. Infrastructure is a major barrier to volunteers and linking them to organizations. In the West, SHIIP volunteers are used to extend the workforce.

- Not only patient stories, but community best practices are important to collect.

- The Benefit Bank prepares taxes and is planning to help with enrollment. National tax companies may be able to help with enrollment.

- The steering committee will review the discussions to formulate draft action steps for the task force.