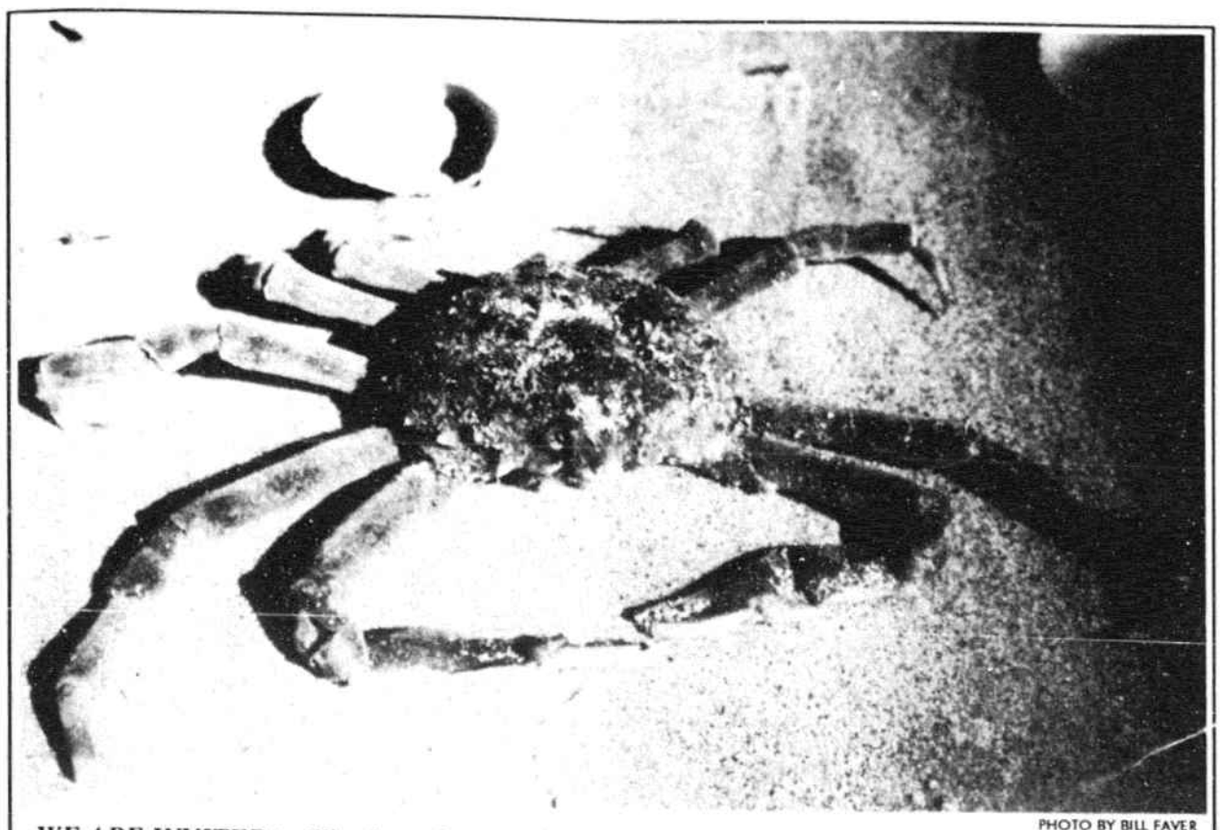

PHOTO BY BILL FAVER

WE ARE INVITED to "live in each season" as we join the many birds, crabs, fishes and other animals along the shore.

Live In Each Season

BY BILL FAVER

Our hot weather this summer reminds us we live in a place where we can experience the seasons in all their glory. We have just enough cold weather and snow to let us know about winter, and we have the most beautiful springs and autumns we could imagine.

FAVER

Our summers are hot and humid, sometimes more so than at others. We hear lots of people remark how nice a cold winter day would be right now; just as we heard some folks yearning for summer last January.

In the writings of Henry David Thoreau, we are reminded to:

Live in each season as it passes; breathe the air, drink the drink, taste the fruit, and resign yourself to the influences of each. Let these be your only diet-drink and botanical medicines...

Be blown on by all the winds. Open all your pores and breathe in all the tides of nature, in all her streams and oceans, at all seasons...

Grow green with spring... yellow and ripe with autumn. Drink of each season's influence as a vial, a true panacea of all remedies mixed for your especial use...

For all nature is doing her best each moment to make us well. She exists for no other end. Do not resist her...nature is but another name for health.

While Thoreau here is writing about living off the land in a piece he calls "Huckleberries," we can appreciate the meanings for us today who experience the healthful aspects of the natural world. We know we can find exercise and rest, excitement and contentment, and refreshing change of pace in a natural setting. Such settings at this season of the year can renew us and help us put our purposes and problems in better perspective.

What better advice can we get than to "live in each season" and to enjoy this special season along the coast? So, "breathe the air, drink the drink, taste the fruit, and resign yourself to the influences of the summer as you join the birds and the fishes and the crabs and other creatures along the seashore.

MORE LETTERS

Engineer Offers Explanation For Shellfish Waters' Opening

EDITOR'S NOTE: The writer is one of two engineers from Powell Associates of NMB, Inc., under contract to the towns of Sunset Beach and Calabash to consult on the towns' proposed central sewer system.

To the editor:

Reference is made to a letter published in the July 22 edition of the Beacon from Mr. Frank Nesmith regarding the temporary opening of waters to shellfishing on July 10.

According to N.C. Shellfish Sanitation Branch records, certain estuarine waters in the Sunset Beach and Bird Island area were temporarily opened on July 10, 1993, and then closed on July 19, 1993. Shellfish Sanitation records also show that similar openings occurred for 31 days in 1990, and that Jinks Creek was opened for six days in 1991.

What is most interesting about this most recent temporary opening is that the opening included all estuarine waters between the Intracoastal Waterway and the Atlantic Ocean from the N.C./S.C. state line to Ocean Isle Beach, with the exception of the estuarine waters directly between the island of Sunset Beach and the mainland west of the Sunset Beach bridge (the Blane Creek area).

In other words, the opening included Mad Inlet, Tubbs Inlet, Jinks Creek, and all waters west of the island of Sunset Beach to the state line, even including Little River Inlet, but specifically excluded the Blane Creek area. Why?

There were 40 sampling locations within the area for which samples were taken on July 6 and 7, 1993, and tested for fecal coliform counts. Of the 40 samples tested, the highest fecal coliform count was measured at sampling station 33 on Blane Creek adjacent to the island of Sunset Beach. This station showed a fecal coliform count of 79.

The next highest fecal coliform count measured was 23, which was observed at two sampling stations. One of these two stations is the confluence of Little River and the waterway, and the other, the Calabash River at Calabash.

During periods of extended dry weather, the groundwater level gets lower. Tidal fluctuations do influence the groundwater elevation, but the degree of influence diminishes rapidly with distance inland from the ocean. Mainland pollution of estuarine waters from septic tank systems, and from other sources as well, should be significantly reduced during dry weather periods. It is therefore not surprising that with no rainfall and a lowered groundwater elevation that estuarine water quality, in general, will improve.

But, based on our investigations to date, it is also not surprising to see an elevated fecal coliform count around the island, despite the lack of rain, as the island is more susceptible to tidal influence on groundwater elevations. Our previous investigations have shown a link between septic tank systems and water quality in the groundwater and immediately adjacent estuaries around the island. Samples taken by the Brunswick County Board of Health on June 30, 1993, in the canals and estuaries around Sunset Beach, as reported in the *Beacon*, provide further substantiation of the conclusions of our investigators.

We hope this information may be of benefit to Mr. Nesmith and other interested readers.

James R. Billups
North Myrtle Beach, S.C.

Baby, You Can Drive My Car

Lynn Carlson

I've suspected all along that there would come a day of atonement for my misspent youth. It's so close now I can smell it.

By the end of this summer, my 15-year-old son Patrick will possess legal authority to operate a motor vehicle as long as I am there. In the "death seat." Curled in the fetal position with my face contorted in a silent scream reminiscent of Edvard Munch's "The Cry."

This is serious business for both of us. For three hours a day for the past two weeks, we've left home every morning at 7:30 to get him to driver's education class, after which he has—without pleading, threatening or any manipulation whatsoever from me—actually studied the manual.

For the past several Sunday afternoons, he has disappeared to the carport with a handful of cassette tapes to spend hours washing and waxing our vehicles and cruising all ten feet of driveway to the sounds of bands with names like Green Jelly.

He even bought a can of paste wax with—and only I know how incredible this is—his own money.

"I'm going to be driving them, so I want them to look good," he says, his expression as sincere as the witch's must have been as she sat Hansel and Gretel down to a sumptuous meal.

I am thankful for driver's ed. It's one facet of my parental responsibility I cheerfully abdicate to the N.C. Department of Public Instruction.

I grew up in South Carolina, where you could get a daytime driver's license at 15. I got mine after my dad took me out in the country and put me behind the wheel of a '64 Chevy Impala until I could stay in the right lane without having to squint and line up the chrome hood trim with the shoulder of the road.

My only classroom training was what we called "hamburger on the highway" films from the Highway Patrol. These gruesome shockumentaries were shown in health class—usually after lunches of cold greasy barbecue and warm coleslaw—in a futile effort to dissuade our classmates who owned GTOs and Super Sports from exceeding the posted speed limits. As if they had any brains to leave on the pavement...

I'd like to think that the kinder, gentler modern method of driver's education will leave my only child with a keen sense of responsibility and a profound awareness that the most dangerous thing about a motor vehicle is the loose nut behind the steering wheel.

For his own protection, I wish I could find him a Chevy like the one I drove. By 1969 standards, it wasn't a big car. Today, it would be a veritable land yacht, with length and breadth of steel able to withstand almost any serious assault by Hyundai or Toyota.

A side benefit would be that he'd only be able to afford a fraction of the cruising I could get for my 32.9 cents a gallon (plus a quart of transmission fluid every fill-up.)

My childless friends attempt to soothe me into this new era by saying things like, "Just think, you won't have to run any errands after he gets his license. You can send him after groceries, to return the videos, to take the cat to the vet..."

Like I don't remember the fact that as a teenager I never ran a single errand that took less than four hours. And that I have yet to produce a dime of change from those many fives, tens and twenties with which I was entrusted.

Like I don't remember that any errand, be it only a half-block mission to fetch the dry cleaning, was a call to cruise every high school hangout in town. In my little town these included Hardee's, the Tastee Freez and the football stadium, any of one which was five miles from another.

It was necessary, of course, to stay at each place for a little while in order to see and be seen. And Mama surely would understand how all that errand-running had left me with a hunger only a chili cheesedog and fries could satisfy, even though supper might be on the table at home that very minute. After all, it was just a couple of bucks. Her bucks.

They don't call it a trip to the cleaners' for nothing.

GUEST COLUMN

Program Reduces Medicaid Costs, Improves Care Quality

BY W. VANCE FRYE

Ten years ago, the Kate B. Reynolds Charitable Trust received a proposal to fund a program designed to achieve two objectives that many people considered to be in direct conflict: to reduce Medicaid costs and to improve the quality of health care for Medicaid recipients.

Today, after three grants from the trust totaling $744,000 and thousands of hours invested in education, training and coalition-building, Carolina ACCESS, a managed health care program, has proved its merit and is being expanded to reach almost every person in North Carolina who is eligible for Medicaid.

That it has taken 10 years for the demonstration project to get this far illustrates that changing the health care system takes time, patience and cooperation. It also illustrates that, with the proper approach, costs can be reduced at the same time quality of care is improved.

The Division of Medical Assistance, which operates the state's Medicaid program, projects that Carolina ACCESS will generate a net savings for the state of $778,000 in Medicaid costs this year, $2.0 million in 1994 and $3.5 million in 1995. Full implementation of the program could result in savings of $30 million a year. At the same time, thousands of people—many of them children and the elderly—now have their own personal physicians for the first time.

As the nation struggles with the question of how best to reform the health care system, North Carolina has already begun to address the problem through Carolina ACCESS. It is becoming a model for other states, and many people see it as a bridge between today's system and the health care delivery system of the future for the nation's poor.

The project was conceived and has been nurtured along by Jim Bernstein and staff of the North Carolina Foundation for Alternative Health Care Programs (NCFAHCP) in conjunction with the Division of Medical Assistance, a unit of the Department of Human Resources. The original concept of the foundation was to build public-private partnerships that address health care needs in the state, and Carolina ACCESS was an excellent example of what could be attempted.

Although it is a quasi-governmental organization, NCFAHCP has transcended state politics. It was established in 1982 during the administration of Democratic Gov. Jim Hunt, received support during the two terms of Republican Gov. Jim Martin and continues with Hunt again in the Governor's Office.

The goal of Carolina ACCESS is to provide quality health care services to all citizens, regardless of their ability to pay, without exhausting the state's limited resources. Its original objectives were to:

- Improve access to comprehensive and quality health care for the poor;
- Improve the participation of primary care physicians in Medicaid;
- Reduce inappropriate use of emergency rooms, specialists and in-patient services;
- Strengthen the patient/health care provider relationship;
- Promote the educational and preventive aspects of health care;
- Maximize the investment in care for recipients.

Those were lofty objectives, considering the challenge in changing the system. To achieve them, NCFAHCP had to deal with a large number of parties, many with vested interests. It also had to obtain waivers from the Health Care Financing Administration, secure massive changes in the state's computer systems and create behavioral changes among Medicaid recipients.

The role of the Kate B. Reynolds Charitable Trust has been to provide the funding for the administrative, technical and educational support needed to get Carolina ACCESS on a sound footing. NCFAHCP provided staffing throughout the nine startup years. Now that the program is established, full responsibility and control has been transferred to the Division of Medical Assistance, and the two foundations can give their attention to other innovative programs.

The demonstration project was conducted in Wilson County in the mid-1980s at the request of the medical community there. During the first year of operation, the average number of hospital days per Medicaid patient declined by 58 percent. The net savings to the state and to Wilson County was more than $300,000 in that 12-month period. Ironically, the two private clinics that were involved in starting the project have been dissolved by the participating physicians, and Wilson County is rebuilding its program.

In 1991, after two years of preparation, the demonstration was extended to Durham, Edgecombe, Henderson and Moore counties. Local implementation continued to advance painstakingly, gaining private support and recipient participation while responding to territorial concerns of local government units.

The results in these counties mirrored the results in Wilson. An independent report by the Office of State Budget and Management documented a net savings of $25 per Medicaid recipient between September 1991 and February 1992 in the initial five counties.

Currently, 16 counties are participating in the program: Beaufort, Buncombe, Burke, Caldwell, Durham, Edgecombe, Forsyth, Greene, Harnett, Haywood, Henderson, Madison, Moore, Nash, Pitt and Wayne.

The Division of Medical Assistance wisely has resisted pressure to hurry the program across the state. The division is adding counties only as they indicate a desire to participate and demonstrate a capability to implement and sustain the program. Approximately 85,000 citizens are enrolled now, and it is projected that enrollment will increase to 300,000 within two years.

In the participating counties, Carolina ACCESS has the support of primary care physicians, private clinics and hospitals, the Department of Social Services, the Department of Public Health and local governmental leaders as well as the recipients of Medicaid. These local coalitions have been built one at a time across the state.

As a managed care program, Carolina ACCESS enlists the participation of primary care physicians and allows them to accept any number of Medicaid patients up to 1,200. Physicians usually take only a small number of patients until they become comfortable with the program. They agree to provide Medicaid recipients with 24-hour availability of primary care or referrals for other necessary medical services, just as they would do for their other patients. In addition to their normal fee for services, they receive a $3-a-month administrative fee for each Medicaid patient assigned to them.

Medicaid recipients are permitted to choose their primary care physician from among the list of participating physicians in their county. Once they have made that choice, all of their health care is coordinated through that physician. If they try to see another care-giver, they are told that they first need the approval of their primary care physician. This practice has reduced inappropriate use of emergency rooms, has virtually eliminated the duplication of services and prescription costs and has provided a continuity of preventive care that reduces the likelihood of more expensive care later.

The dilemma for all states has been how to provide quality health care services to all citizens, regardless of their ability to pay, without exhausting the state's limited resources. While many states have focused on reducing costs through their Medicaid managed care programs, North Carolina has attempted to find ways to get more mileage out of current resources. Few states have changed the delivery and utilization of health care services as successfully and substantially as North Carolina has been able to do through Carolina ACCESS.

Vance Frye is director of the Health Care Division, Kate B. Reynolds Health Care Trust, Winston-Salem.