North Carolina Institute of Medicine
Healthcare Safety Net Task Force
Meeting Summary
August 10, 2004
North Carolina Hospital Center, Cary, NC

ATTENDANCE
Task Force Members: Thomas Bacon, Gillian Baker, George Bond, Sonya Bruton, Moses Carey, Mike Cinoman, Dick Daugherty, Leah Devlin, Allen Dobson, Olivia Flemming, John Estes, Rick Gilstrap, John Graeter, Carmen Hooker Odom, Thomas Irons, Earl Marett, Alan McKenzie, John Mills, Shirley Sims, William Pully, Sherwood Smith, Stephen Smith, Jeff Spade, John Sullivan, and Doug Yarbrough.

Steering Committee Members: Mark Holmes, Andrea Radford, Tom Ricketts, Torlen Wade, Aimee Wall, and Tom Roth.

Staff and other: Gordon DeFriese, Annette Dubard, Thalia Fuller, Adrienne Parker, Pam Silberman, and Kristie Weisner.

WELCOME
Sherwood Smith and Carmen Hooker Odom (Co-chairs)

AGENDA FOR WORK GROUPS
Pam Silberman, JD, DrPH
Vice President
North Carolina Institute of Medicine

To begin, Dr. Silberman pointed out the handout, *Walking a Tight Rope: the State of the Safety Net in 10 US Communities*. There are some recommendations in this document that our Task Force may want to consider. Most of the 10 communities are urban so we may want to consider the ideas with the understanding they may not be directly applicable to our communities. The report found that behavioral healthcare was limited, and dental healthcare was non-existent. Primary care was available in all 10 communities. The Emergency Department was used as overflow, particularly for specialty care.

In addition to the work groups we are about to begin, we need to address other issues such as prescription drugs (other ideas besides 340B), how to handle specialty referrals when Project Access is not available, and financing. As mentioned at last meeting, House Bill 1414 was ratified by the 2004 NC General Assembly. This is the first time the NC General Assembly has ever designated money for safety net organizations. The funds will go through the Office of Rural Health (ORH). OHR will create an advisory committee, and the NC Institute of Medicine will help facilitate the advisory committee. At this point, the appropriation is one-time money. If there are other issues that you think we need to think about, we would like to know so we can build it in to the work plan. People have talked about behavioral health as a need, but we are not sure how to address it until the state determines what it will be doing in this regard.

Comment: The NC Department of Health and Human Services (DHHS) has had a first meeting of a behavioral health and primary care group. A lot of the discussion was around the fact that most people who have a mental health or substance abuse problem, usually present at a primary care site. As we work toward reform and look at how we will

> *provide services; heretofore, we have not really looked at this relationship. This meeting provided DHHS a foundation with which to move forward. Another group working on mental health and hospital issues (emergency room use). The state is very aware of safety net and other first line providers.*

Agenda
Today the Task Force will divide into two work groups: (1) Integration and Collaboration and (2) Areas of Greatest Unmet Need. The Integration and Collaboration Work Group will discuss how safety net organizations can work together more collaboratively to expand care to underserved populations. The Areas of Greatest Unmet Need Work Group will discuss which areas of the state have the greatest unmet need for safety net services.

More specifically, the Integration and Collaboration Work Group will analyze the barriers to collaboration (e.g., turf—competition for paying patients may make existing safety net organizations less financially stable; regulatory barriers; lack of community leadership or commitment to collaboration, etc.). The group will investigate the ideas that might encourage collaboration. These ideas might include: community-wide safety net planning groups that could build on existing collaborations, e.g., CCNC[1] networks. In Bertie County, the hospital, public health department, and Federally Qualified Health Center (FQHC) agreed to collaborate before submitting new grants. Ideas might also include best practices or pilot programs, providing incentives to collaborate (in seeking funding foundations or the state), shared funding or other resources (e.g., some free clinics don't have enough space and a few communities have been able to share space in off hours (Pitt County and Buncombe County do this.), cross-subsidization of safety net activities, or other creative ideas to help eliminate barriers.

- Community-wide, safety net planning groups could be organized to: identify needs or gaps; identify the safety net organization in the community best able to address the needs; avoid duplication.
- Best practices or pilot programs could be disseminated through the North Carolina Community Health Center Association (NCCHCA), Public Health Directors Association, Medical Society meetings, NC Hospital Association meetings, etc.
- Incentives to collaborate. Foundations could require greater evidence of collaboration (i.e., by requiring an economic impact statement with grant proposals. These statements could detail how the new or expanded organization will affect existing safety net resources). New state monies could be used to support safety net activities?
- Shared funding or other resources. Multiple organizations could apply for grant funds that would be shared across agencies; health department buildings could be used for free clinics after hours.
- Cross-subsidization of safety net activities. Hospitals could fund safety net organizations to offer after-hours primary care coverage to reduce the use of the emergency department, or could help hire staff in safety net organizations that could provide unassigned call coverage in the hospital. Duke Family Medicine staffs Lincoln Community Center's outreach clinics. The staff are paid Medicaid rates for the care of Medicaid patients and the differential goes to the Center to help support care for the uninsured.
- Other creative ideas to eliminate barriers. With regard to FQHC regulatory barriers—what if we expand public health boards to meet the 51% user requirement while still meeting state statutory prescribed positions?

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[1] Community Care of North Carolina Program, also known as Carolina ACCESS I, II & III, a statewide primary care case management program.

The bottom line for collaboration efforts is that most communities need additional capacity to address the health needs of underserved populations, but in developing new capacity, we should not harm existing safety net organizations.

The *Areas of Greatest Unmet Need Work Group* will use data we have collect on numbers of uninsured seen by: Federally Qualified Health Centers (FQHCs), state-funded rural health clinics, free clinics, public health clinics, and some AHEC and hospital-based clinics. We are in the process of collecting additional data from hospitals, AHEC clinics and other safety net organizations. Each of the data sources have limitations, e.g., the public health clinics do not specifically collect data on the number of patients who receive primary care, and the FQHCs and free clinics do not specifically report data on county of residence of uninsured patients. We are also missing data for some safety net organizations (e.g., Project Access models, HCAP projects, Greensboro) and for primary care provided by private physicians in offices. It is difficult to come up with an unduplicated count across the safety net organizations. The uninsured may seek services from multiple organizations.

This Work Group needs to help examine and refine the data. In addition this group needs to determine whether we can identify areas of greatest unmet need, based on: the low percentages of uninsured seen in safety net organizations, high numbers of uninsured who are not being seen in safety net organizations, other health data that may indicate primary care access problems (such as ambulatory sensitive admissions), and any other ideas.

Comments and Questions

Q: On the data table, do the percentages represent percents of the population?
A: Some are percentages of the total population ages 0-64 in that county and some percentages are of the uninsured estimates.

Q: Does the data represent visits or people?
A: The data has been divided and converted into people.

Q: What will our expectations be a year from now if the Task Force is successful?
A: If the data group can get trends and indicators of what the health risks of certain areas are, then we may know how to focus programs and avoid duplication. The Task Force may recommend NC General Assembly funding be expanded or extended, and we could help target where this funding should build new clinics. We might be able to measure collaboration or expand project access models. Most of this will not happen in a year.

Comment: One of the by products of all the NC Institute of Medicine Task Forces is that it focuses public policy attention in these areas. The NC Hospital Association, for example, will be looking closely at these issues as they develop their agenda. Charity care and bad debt are increasing. We hope this will lead to good policy choices and ultimately help stem the rising tide of uninsured.

Comment: Foundations receive many requests for funding and don't always know what criteria they should use to determine which communities to fund. We can help them decide. There could be some legislative outcomes too.

Comment: We are hoping to get some creativity from this Task Force on what could be recommended to help the safety net in North Carolina. The NC IOM is charged by its board to do periodic reviews of our recommendations. In 12-18 months we will re-

gather the group to assess what progress has been made. We are typically surprised by how many of the recommendations are implemented or partially implemented. When 60-70% of the recommendations are implemented, we are thrilled, and this is often the case. The Task Force leadership makes a difference in how successful the report is.

INTEGRATION AND COLLABORATION WORK GROUP
Facilitator: Gordon H. DeFriese, PhD
President and CEO
North Carolina Institute of Medicine

Attendance
Gillian Baker, George Bond, Moses Carey, Mike Cinoman, Gordon DeFriese, Annette DuBard, John Estes, Tom Irons, Earl Marlett, Alan McKenzie, John Mills, Steve Smith, Jeff Spade, Torlen Wade, Aimee Wall, and Kristie Weisner Thompson.

The Integration and Collaboration Work Group (ICWG) should determine how safety net organizations can work together more collaboratively to expand care to the uninsured. The ICWG is starting with the presumption that most communities need additional resources to try to provide healthcare to the uninsured, and in developing any new programs, we need to determine how we can protect the potentially fragile existing services. The ICWG will try to define the problem (i.e., where is the problem, how large is the problem, and what are the implications?). The group will also identify barriers to collaboration and integration, models that encourage collaboration and integration, and incentives for achieving effective collaboration and integration among safety net organizations. In doing this, the ICWG will develop recommendations for safety net organizations in North Carolina.

Problem Definition and Validation
The group identified a number of problems including: confidentiality laws, inclusiveness (or absence of a sense of shared-responsibility), feelings of relative advantage, political factors, fear of the unknown, physician representation, professional economics, convenor legitimacy, trust, competition for non-economic resources, lack of recognition, and payment versus cost avoidance.

1) Ambiguity in state law (not federal law) makes *confidentiality* a problem. The ability to share medical records has become more difficult because of the Health Insurance Portability and Accountability Act (HIPPA). People interpret the rules in the most extreme ways to protect themselves. The fear of litigation prevents collaboration between the hospitals and other safety net organizations. The hospital has huge liability fears that prevent collaboration.
2) There is a problem in the *inclusiveness* and extent of involvement and participation of all key stakeholders and providers. Not everyone is invited to the table for meetings about collaboration. The Department of Health and Human Services (DHHS) should ask hard questions about why certain groups should get money if they are not willing to collaborate. There is a *lack of shared responsibility*, trust, and commitment.
3) The varying amount of reimbursement for indigent patients becomes a stumbling block. While the hospitals want to provide treatment for these patients, they are still trying to focus on development of programs that pay. Otherwise, the safety net would not exist. There are feelings of relative advantage in caring for the uninsured.

   Comment: We are trying to expand FQHC in Pitt County. The county health department, which doesn't provide a lot of primary care, is concerned about whether this will affect

its prenatal care—the only profitable business it has. The players should be able to come together and work out some sort of agreement. When the people are not willing to do this for the patient's sake, you have trouble.

Comment: We may be able to force collaboration if the facilitator comes to the table with money and says you can't have it if you don't collaborate. Sometimes there are two providers doing the same thing very close together. They may both ask a foundation for money and the foundation doesn't know who to give it to and may think they should do it together? If you know the history of both, it may make more sense.

4) *Political factors* are another barrier. There are many political issues involved with a decision to collaborate. The perception of ownership and perceived need for credit for having a given service or program are often obstacles.
5) *Fear of the unknown* can constrain groups. The unknown may be uncertainty of the implications that go along with giving up responsibility for a service or worries about regulatory requirements when one agency or provider takes on a particular service.
6) *Individual professional economics* interfere with inter-professional collaboration and coordination. Providers are competing for patients. There is a huge amount of wealth brought in by specialty procedures.
7) There are often issues with the legitimacy of who tries to act as a *convenor*. It took years for Pitt County to establish enough trust to develop the partnerships.

Q: Does the convenor have to be a local person to be credible? Are there any examples of another kind of relationship for the convenor?
A: It should usually be someone from within the community for the trust to be established. Developing partnerships takes a person who can create a vision for a community—someone who can build from the assets a community has locally. This person has to have local knowledge. An outside person could help instruct people, but the group has to be convened by someone they trust. People have to want to accomplish the idea you are pursuing. They have to know there is a problem.

Comment: Concern/commitment and agreement on ends and means may require a leader that can change the landscape if they can articulate how and why to do it? Allen Dobson made a business case for getting the groups together in Cabarrus County. It has a lot to do with relationships (trust). [The accompanying diagram is from Conrad Seipp and Malcolm McNair, 1972.]

Concern & Commitment

Agreement On Ends & Means	High	Moderate	Low
High	**Cooperation**	**Exchange**	**Auto-Coordination**
Moderate	**Adduction-Induction**	**Negotiation**	**Arbitration**
Low	**Indifference**	**Competition**	**Conflict**

Comment: To what extent can a non-health provider help define and articulate the problem (e.g., churches). This is a societal problem and is not just up to healthcare providers to solve. Healthcare providers cannot deal with it alone. This is the responsibility of the larger segment of society.

Comment: Potential solutions should expand the sense of responsibility. Does the state have any duty to serve in this role to protect its citizens? The traditional assumption is that the problem will be solved either by the providers or the government. There may be other sources that can help. There are many determinants of health that have nothing to do with access to care.

8) Certain *federal regulations* limit the extent of collaboration between public health departments and FQHCs (i.e., requirements for the physical location of a clinical site, board composition, anti-kickback rules, etc.) There has to be an opportunity for those with competing interests in serving a given population to sit with one another.

   Q: Are there issues with respect to federal anti-kickback or other fraud laws (e.g., self referral)?
   A: FQHCs have a safe harbor provision (exemption from anti-kickback) that is used as an excuse not to work together. Certain laws are used as a shield to prevent collaboration.

9) There is also *competition for resources that are not necessarily paid by the patients* (e.g., community good will, donations, volunteers, etc.) Many fear dividing ownership might jeopardize these resources and their identity in the community.
10) *Recognition* is another factor. Failure to recognize the contribution of each of the players is a problem (e.g., physicians and community health centers). Most physicians aren't really interested in individual recognition. Our goal should be 100% access to the full continuum of care. We need an awareness of our mutual dependence. This is the first step toward collaboration.
11) *Payment* versus *cost avoidance* is a motivator toward safety net participation. The return on investment needs to be restated in terms of quality and health status.

    Comment: We should explore alternative views that are not driven by units of service. The safety net system could be a great area in which to demonstrate how we can be driven by health promotion—using quality and health status as the drivers. Each player in the continuum of care system is being asked for a contribution in exchange for a certain benefit (e.g., recognition as a group/profession). Being able to articulate the return on investment (ROI) in terms of community health, etc. to everyone is important.

    Comment: The drivers for continuum of care for all stakeholders include: building a business case, equity (groups need to feel there is shared responsibility), accountability for patients (e.g., they keep their appointments), clinics (tracking provided services—prescription medications and treatment), and recognition.

12) One physician barrier to participation is that there is no *representative* of physicians as a group to meet with the collaborative. Physicians must be identified as a part of the safety net. Only certain constituencies have enough money to pay a staff person to represent them. This is the missing ingredient and the most fractured piece of getting physician participation in an organized way. The representative needs to be accountable to the physicians. Medical societies, to the extent they have staff, can serve in this capacity.

Are there problems with safety net provider collaboration and integration? Do the terms collaboration and integration refer to very different phenomena?

Is collaboration at "all costs" necessary, or do we just want some rules we all obey?

Comment: Forced collaboration should not be our goal.

Comment: Competition is not always bad. There is some value to competition, but collaboration doesn't always bring in new dollars. Only about 30% of the safety net

patients have money, and are therefore, competed over. These things (competition and collaboration) are not mutually exclusive.

Comment: There is always room for improvement, whether it is integrating services or some other type of collaboration. We should think of collaboration as a continuum of beginning with coordination and cooperation and ending with collaboration. Integration is a process to accomplish this, but not the only way. Integration could fall anywhere along the continuum.

Comment: Some feel integration is a threatening term. Integration suggests you may lose some of your identity, where collaboration does not. We need to be more thoughtful at how we integrate the patient population, too. This not just about integrating the providers. This is one angle we often miss.

Barriers to Collaboration

- Turf
- Competition for paying patients, making existing safety net organizations less financially stable
- Regulatory barriers
- Lack of community leadership or commitment to collaboration
- No tradition of collaboration, hence no vision of what might be possible
- Inability to see the problem of the uninsured as a societal versus healthcare problem
- Some of the expenses of clinical operations are a problem because of efficiency of use
- Lack of clinic-based "care navigators" (system navigators). Managers must be co-located with service providers. This is different from case managers. Nurse case managers are expensive and social workers aren't as good for making the medical decisions that a nurse can make. Patients may be unaware of or intimidated by programs. It also helps to have care navigators and eligibility people in the same place.
- Lack of consumer knowledge of how to access or use existing facilities and services
- Agreement among providers on common eligibility criteria. This is hard to come up with, but collaborating providers should accept a patient who is determined to be eligible.
- Perception of overwhelming burden and need
- Lack of perceived value of safety net services in the community (business community, etc.).

  Comment: We can work through chambers of commerce. Businesses want to know how to get more affordable health insurance, or how to get providers to reduce their fees. The companion to value analysis is cost. There is a cost to not participating. The business community is not going to want to fund all groups—hence, collaboration/coordination is needed so requests can be considered as a group. There is a disconnect between the companies that provide no insurance and the cost of care provided by the safety net. County commissioners can influence the business community/Chamber of Commerce.

Models for Achieving Effective Collaboration and Integration

There are at least three potential categories of models we can use to begin thinking about this: *collaboration* models, *integration* models, and *convening* models.

Collaboration Models

- Community-wide planning efforts to identify gaps, needs, and ways to address these problems.
- Joint projects with joint funding

- One safety net organization funding another
- Co-location of services
- Best practices/pilot programs
- Others?

Integration Models

- HCAP models with integrated information systems and referral networks
- Project Access models that integrate primary care, specialty referrals, hospitalizations, and have a source of payment for medications
- Creation of a unified health system for the uninsured
- Others?

Convening Models

Healthy Carolinians is an example of a convening model. The Governor's Task Force on Healthy Carolinians awards certification to communities who have broad-based community partnerships which represent the needs of the disadvantaged and whose mission is prevention based. An Application for Certification must be written which demonstrates that the community is addressing at least two objectives from *The Report of the Governor's Task Force on Health Objectives for the Year 2010*. Access to care is one of the Healthy People 2010 objectives. The certification process helps provide more focus on partnership objectives and activities in the community, attracts grant opportunities, and enhances credibility with possible funding sources such as county commissioners, state legislators and many foundations. Certification also provides an opportunity for increasing visibility within the community and sustaining the momentum of the Partnership. The Pitt County group, in many ways, was born out of Healthy Carolinians as was the Appalachian group. Buncombe County Healthy Carolinians grew out of Project Access.

Healthy Carolinians is the closest thing to a neutral body that exists all over North Carolina. Healthy Carolinians includes everyone with a stake, and they have regular meetings and also monitor the statistics. Many Healthy Carolinians groups have funded staff. To be a recognized Healthy Carolinians partnership, groups have to be certified by the state and have annual reports, etc. Healthy Carolinians brings the goal of a health-focused system of care to the table. They help the community refocus on the health of the community rather than the healthcare of the community. The state mandates that Healthy Carolinians focus on health disparities. Not all Healthy Carolinians are the same, however. Some would be better at this than others. At a minimum, we need to engage Healthy Carolinians in this issue. Ninety counties are covered by Healthy Carolinians. There are several multi-county Healthy Carolinians.

Incentives that Encourage Collaboration and Integration

In addition to the incentives mentioned in the plenary session, the Work Group discussed the following possibilities.

- Community-wide safety net planning groups
  These could build on existing collaborations (e.g., CCNC networks)
- Best practices or pilot programs
  - Provide incentives to collaborate
  - Foundation or state funding
  - Technical assistance/staff support
  - Grant preparation and submission (fund raising)

  - Technical assistance in evaluation and report preparation
  - Data and descriptions of possible models (MARP for example is helping)
  - Technology
- Shared funding or other resources
- Legislative change on confidentiality-state can do this within confines of HIPPA. State law is the barrier.
- Cross- subsidization

Q: What is cross-subsidization? Should the funding follow the population instead of the reverse? Would this incentivise providers? Are there models where this has been implemented?

Recommendations

- Effort should be made by the NC Department of Health and Human Services (DHHS) in partnership with associations of safety net healthcare providers to clarify state laws regarding the confidentiality of medical records so that assignment of clients and the services of providers in different clinical sites can be offered more effectively and seamlessly.
- The NC General Assembly should enact legislation that guarantees the portability of medical records and their confidentiality.
- Community-level safety net planning efforts should include all stakeholders and providers and give emphasis to creating a generalized commitment to common goals and the inclusiveness of all stakeholders and providers in this effort.
- Community-level safety net planning efforts should insist that local physicians play an active role.
- Community-level safety net planning efforts should begin from a clear delineation of individual stakeholder- or provider-vested interests (financial stakes) and clarity about federal or state laws, rules, or regulations that could limit the ability of certain stakeholders to share in the collective effort to meet the needs of safety net clients (in other words, collaboration has its costs).
- Community-level safety net planning efforts should assure the recognition of all stakeholders and especially those who have made a firm commitment to participation in safety net development and service provision.
- Pharmaceutical acquisition/purchase and distribution could serve as a focal issue likely to attract all stakeholders to collaborative endeavors in the interest of serving the uninsured.
- NC DHHS (or some other agency or organization) should undertake to disseminate detailed descriptions of various "models" or "best practices" found to work well in particular communities. Models should give emphasis to situations where funding follows patients needing care, not the providers of that care.
- Both public and private funding agencies should develop clearer and measurable criteria of "collaboration" and use such criteria in decisions regarding future safety net program support.
- Leadership should include providers of care and they should be represented when issues are discussed.
- The business of drugs and their availability should be incorporated as a major focal point.
- Safety net program funding should be tied to proven collaboration, for which better criteria should be developed.

The group was asked to send model program ideas to Gordon DeFriese.