Chapter Six

The Potential for Safety Net Collaboration and Integration

As the numbers of uninsured increase, the patchwork delivery system through which the uninsured access basic healthcare services is being pulled and stretched beyond its capacity. Few communities in our state are able to meet the primary care needs of all of the uninsured, regardless of how many or how few safety net organizations they have. To provide the care needed by the low-income and uninsured population, safety net organizations will need to work together to maximize the use of these resources to maintain and, hopefully, expand care to the uninsured. Nonetheless, there are barriers to collaboration and integration of safety net services in some communities. The Task Force identified these potential problems in order to identify models and incentives, which could encourage these relationships and promote effective collaboration and integration.

It is surprising to some that issues related to collaboration and integration would arise in the course of a Task Force on the healthcare safety net, but many members felt that these were important issues, especially for some communities. However, it is important to recognize that collaboration and integration issues do not arise in every community, and are much less likely in communities with few or no safety net providers. These issues are most relevant in areas where a number of different organizations and agencies have made a public commitment to address the needs of the uninsured and underserved. In these areas, there are questions of resource allocation and effectiveness.

What Is Meant by "Collaboration" and "Integration" within the Healthcare Safety Net?

The Task Force discussed numerous ways in which healthcare safety net organizations could collaborate. These include everything from periodic meetings (to identify gaps, needs, and ways to address these problems), to more elaborate inter-organizational agreements and the merging of clinical and other services. In general, the models could be categorized into two broader concepts: collaboration and integration models. Each is described more fully below, and the chapter includes additional examples of successful collaboration or integration models:

Collaboration models include:

- Convening groups of stakeholders to identify gaps, needs, and ways to address these problems (e.g., community planning efforts),
- Joint projects with joint funding,
- One safety net organization funding another,
- Co-location of services, and
- Best practices or pilot programs.

Integration models include:

- Healthy Communities Access Program (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 (discussed more fully in Chapter 3), and
- Creation of a unified health system for the uninsured.

In these discussions, it became clear that the word "collaboration" is far more acceptable as a term referring to efforts to have safety net organizations work together effectively in meeting the needs of the uninsured and

Healthy Carolinians

Healthy Carolinians is an example of a convening, collaboration model. The Healthy Carolinians group acts as a neutral convener, to bring together everyone with a stake in healthcare issues. Healthy Carolinians groups meet to examine local health statistics and develop plans to improve the health of the community by focusing on health promotion and disease prevention. The goal of Healthy Carolinians is to get the various stakeholders to work collaboratively to address community health needs.

underserved. The term "integration" can involve a much more extensive and formal set of relationships among stakeholder groups. It refers not just to integrating providers, but also the integration of patient populations as well. Integration also raises questions of ownership, which makes some organizations uneasy. Hence, in most circumstances where efforts are being made to achieve greater coordination among the programs and services of interest to this Task Force, it is "collaboration," and not "integration" of services, that is of focal interest and intent.

Problem Definition and Validation

The Task Force identified a number of problems related to the prospect of collaborative or integrative initiatives among safety net providers including, but not limited to, the following. Each is discussed in more detail below:

- Information sharing and confidentiality laws,
- Inclusiveness (or absence of a sense of shared responsibility),
- Feelings of relative advantage,
- Professional economics,
- Political factors,
- Fear of the unknown,
- Physician representation,
- Convener legitimacy,
- Trust,
- Competition for non-economic resources,
- Lack of recognition, and
- Payment versus cost avoidance.

Information Sharing & Confidentiality Laws

When safety net providers attempt to share information as part of collaborations designed to provide seamless and efficient care to shared patients, medical confidentiality laws are often seen as obstacles. While confidentiality laws present challenges for all healthcare providers, the challenges are sometimes greater for providers caring for uninsured patients because the patients often seek care from multiple providers. According to North Carolina data from the Behavioral Risk Factor Surveillance Survey (BRFSS), the uninsured are less likely to report a usual source of care than those with insurance coverage. Only 38.3% of the uninsured report that they have one usual source of care; others report either seeking multiple sources of care, or no usual provider (which may also indicate that they seek care from different sources when they do seek care). In contrast, 68.7% of those with insurance coverage report a usual source of care.[1] In order to provide more efficient and better quality care to the uninsured, safety net providers need to find ways to share information with each other and collaborate on developing a system of care. Innovative safety net collaborations, however, are often stymied by concerns about compliance with confidentiality laws.

Healthcare providers must comply with complex confidentiality laws at both the federal and state levels. The federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulation actually facilitates information-sharing for healthcare's core functions—treatment, payment, and healthcare operations—by allowing

Cabarrus Community Care Plan

CCCP was developed in 2001 as a non-profit organization working to improve service provision to the uninsured in Cabarrus County. The local medical society, Northeast Medical Center, the Community Free Clinic, the Cabarrus Health Alliance (local public health department), the Cabarrus Department of Social Services, the Piedmont Mental Health Center, Healthy Cabarrus (the affiliate of Healthy Carolinians), and other types of healthcare providers participate in CCCP. A federal Healthy Communities Access Program (HCAP) grant supports the initiative. CCCP staff screen individuals to determine financial eligibility for the program, which is limited to uninsured individuals and families with incomes below 125% of the federal poverty guidelines. Participants are asked to provide CCCP with permission to share financial information needed to determine eligibility, and health information necessary for case management, among participating organizations. This information-sharing assists CCCP in linking eligible individuals with primary care providers, providing needed medications, arranging for specialty referrals, and covering the costs of hospitalizations. CCCP helps spread the burden of caring for the uninsured population among all the providers in the community. In addition, CCCP staff offer diabetes and asthma disease management services and help coordinate the care of children with ADHD in the Cabarrus County schools.

providers to share information relatively freely with one another for those three purposes *without* the patient's written permission. The US Department of Health and Human Services (DHHS) explained that "given public expectations with respect to the use or disclosure of information for [treatment, payment and healthcare operations] and so as not to interfere with an individual's access to quality healthcare or the efficient payment for such healthcare, the Department's goal is, and has always been, to permit these activities to occur with little or no restriction."[i] The Privacy Regulation builds in other measures to protect the confidentiality of that information in the hands of each of the providers, such as requiring providers to distribute notices of privacy practices and establish written privacy policies and procedures. Taken as a whole, the Privacy Regulation allows providers to share information for basic healthcare activities without onerous administrative burdens, but ensures a baseline level of privacy protection for that information outside of the healthcare delivery context.

In addition to complying with the HIPAA Privacy Regulation, providers must comply with any state law that is more protective of patient privacy than the federal law. Unfortunately, North Carolina's law is not clear regarding the ability of providers—including safety net providers—to share information for the core purposes of treatment, payment, and healthcare operations without the patient's written permission. North Carolina's patchwork of confidentiality laws raises a variety of difficult legal and interpretive issues. For example, some healthcare providers and their attorneys believe that the state's physician-patient privilege law[ii] requires patient permission or a court order for almost all disclosures of health information. Others argue that the privilege is an evidentiary rule only and, therefore, only applies in the context of court proceedings. Two other NC laws allow disclosure of certain information (communicable disease and emergency medical service-related information) for most treatment purposes without patient permission, but limit disclosures necessary for payment and healthcare operations purposes.[iii] Some argue that the limitations in these two laws should extend to all health information because it is difficult to differentiate between types of information in a medical record. There are many other NC statutes and regulations that raise similar issues and questions.

Healthcare providers are committed to protecting the privacy of their patient's health information, particularly sensitive information such as mental health, substance abuse, and communicable disease information. They want to comply with all applicable laws, but are struggling to understand the full scope of North Carolina's law. As a result, providers are interpreting and applying state law rather haphazardly. Some communities, such as Cabarrus County, have developed integrated systems of care that allow information-sharing across agencies for common patients, but other communities are much more cautious in their approach, fearing litigation or other legal repercussions. The current situation is confusing for patients as they try to understand their privacy rights and for providers as they try to better serve uninsured patients. Legislation is needed to clarify state law to ensure that safety net providers are able to share information as part of collaborations designed to provide more seamless care to uninsured patients. Any new legislation should not conflict with the HIPAA Privacy Regulations and should incorporate more heightened privacy protections for particularly sensitive information.

Absence of a Sense of Shared Responsibility

In considering community-wide initiatives to meet the needs of the uninsured and underserved, the Task Force emphasized the importance of involvement and participation by all key stakeholders. Certain stakeholders in community-wide safety net efforts may not be invited to, or may chose not to attend, discussions related to collaboration efforts. The Task Force heard claims that, in some communities, there is a lack of shared responsibility, trust, and commitment to serving the uninsured. Task Force members expressed the view that the NC DHHS should encourage safety net providers receiving state funding to participate in community-based collaborative efforts.

One critical element of the healthcare safety net that would not be captured by NC DHHS encouragement is the network of private physicians that could, and do, provide care to the uninsured. The Task Force noted the importance of physician participation and involvement in community-wide efforts to address issues related to assuring healthcare services for the uninsured. Many physicians offer uncompensated services with some reg-

i 67 Fed. Reg. 53,182, 53,208 (Aug. 14, 2002)

ii NCGS § 8-53

iii NCGS §§ 130A-143 and -518

Community Care of North Carolina (CCNC)

CCNC is built around local networks of primary care providers, hospitals, health departments, social services, and other agencies that coordinate prevention, treatment, and referral services for Medicaid recipients. CCNC provides additional funds to help pay for case management and disease management services for Medicaid recipients with high-cost, chronic, or complex health conditions. The statewide and local disease management initiatives are based on evidence-based best practices that are developed by a statewide team of primary care physicians representing each network (so that there is local buy-in and a local physician champion from each community). CCNC currently operates in 68 counties, serving approximately 550,000 Medicaid recipients; but the goal is to have the program operate statewide by the end of 2005. While the CCNC networks currently focus on improving the care for Medicaid recipients, these groups may be an appropriate vehicle to develop collaborative models to expand care to the uninsured.

ularity through their private offices, even though they may not participate officially as part of more organized safety net programs. Individual physicians are often "the missing link" and the most fractured piece of local safety net planning efforts. However, many communities still struggle to get private physicians to provide services to the uninsured. One barrier to physician participation is that there frequently is no designated or valid *representative* of physicians as a group to meet with other potential collaborative partners. Leadership plays an important role in recruiting physician volunteers and provision of services by private providers. A representative of local physicians should preferably be a person clearly accountable to local physicians as a group. Organized local medical societies, to the extent they exist and have staff, can serve in this capacity. In addition, communities may be able to work through local CCNC networks to involve local physicians in the provision of care to the uninsured.

Feelings of Relative Advantage

One of the reasons collaboration and/or integration of safety net services may prove to be difficult in a given setting is that some organizations are seen by other safety net providers as having a clear advantage with regard to funding or reimbursement. The perception that some organizations have a relative advantage in terms of reimbursement for care provided to the uninsured, while others shoulder a larger share of the burden, opens the door to turf and political arguments. Safety net organizations receiving funding or reimbursement include some hospitals (particularly teaching hospitals) receiving Medicare Graduate Medical Education (GME) funds and/or Medicaid Disproportionate Share (DSH) payments in recognition of their teaching responsibilities and the provision of care to uninsured patients. Moreover, hospitals are seen as having the facility to "cost-shift" from one part of their overall system to another (or from one type of service or type of insured patient to another). FQHCs receive some federal funds to care for the uninsured, and local health departments also benefit from federal block grant funds that can be used to provide some clinical services. The varying amount of reimbursement for uninsured patients becomes a stumbling block, as safety net organizations are often forced to compete for the same group of paying patients to help cover the costs of caring for the uninsured.

Individual Professional Economics

Economic competition interferes with inter-professional collaboration and coordination. Providers are often competing for patients, especially insured patients who can pay for the services they receive. Time spent providing free or reduced-fee services is time that cannot be devoted to the care of insured patients and could cause delays in appointment times and in the performance of procedures. The Task Force is sensitive to the professional economics of healthcare providers who lend their services to community-based efforts to address the problems of caring for the uninsured. For this reason, in some communities, a special effort has been made to distribute the healthcare needs of uncompensated patients so that a small group of providers is not undertaking a disproportionate share of the burden.

Political Factors

There are many political issues involved with a decision to collaborate in community-wide initiatives to serve the uninsured. The perception of ownership of a safety net provider/service and the perceived need for credit for having a given service or program can be important to some stakeholders. These perceptions may keep some organizations from joining collaborative initiatives if they

Guilford Child Health, Inc. (GCH)

Guilford Child Health, Inc. (GCH) is a public-private partnership organized to provide health-care services to low-income children in Guilford County. GCH provides primary care and specialty services to 30,000 children, 95% of whom have health coverage through Medicaid, a third-party payer, or NC Health Choice. The uninsured population visiting GCH is heavily comprised of Hispanics. GCH receives significant financial support from the Guilford County government. Moses Cone Health System and High Point Regional Health Systems are the two owners of the organization, and three members from each organization comprise the GCH board of directors. Three clinic sites are available to patients in Guilford County and care is provided at no charge or on a sliding-fee scale.

In addition to GCH, many of these same partners collaborate to provide care to the uninsured through Guilford Adult Health, Inc. Guilford Adult Health is the medical home to 13,000 patients. Approximately 60% of the patients seen at Guilford Adult Health's two medical offices are uninsured. Moses Cone Health System, High Point Regional Health System, and Guilford County government are major financial contributors to these initiatives. Each member organization appoints a specific number of members to the Guilford Adult Health, Inc. board of directors.

perceive that doing so would require them to relinquish their ownership or decrease the credit their organization would receive. There is also competition for resources that are not necessarily paid by the patients (e.g., donations, volunteers, community goodwill, etc.). Many fear sharing ownership of a local safety net effort might jeopardize these resources and some organizations' identities as key safety net providers within the community.

Fear of the Unknown

Various facets of potential collaborative relationships are not clearly delineated and may be a source of uncertainty for some organizations that are hesitant to either give up or take on responsibility for a safety net service. Some organizations may also have concerns about regulatory requirements when one agency or provider takes a leadership responsibility for a particular service. In these situations, a special effort is required to dispel these fears, to share the experiences of collaborating organizations in other safety net communities, and to formalize policies through open and transparent dialogue involving all stakeholders.

Convener Legitimacy

There are often issues with the legitimacy of the individual(s) or the organization acting as the convener for collaborative efforts among safety net providers. For example, it was reported that it took years for Pitt County to establish enough trust to develop effective partnerships among safety net provider organizations, but these relationships are now strong and effective. Developing partnerships requires the creation of a vision for the future that assures each stakeholder a place in the overall structure and process—this should include a specification of how the various assets in a community can inter-relate more effectively. The leadership for such efforts must rely on local knowledge and the personal credibility of the leader. An outside person could help to facilitate a conversation among local stakeholders, but the group has to be convened by someone well-known and trusted.

Recognition

One of the first steps toward collaboration is to fully recognize the efforts of all safety net providers, regardless of type or category, and to make them aware of their interdependence in helping the community achieve 100% access to the full continuum of care for all citizens, regardless of ability to pay. Failure to recognize the contribution of each of the players can be a detriment to further exploration of collaboration avenues among safety net providers. Most physicians are not really interested in individual recognition, but their combined contributions to meeting the overall burden of caring for the uninsured and underserved often go without recognition.

Payment versus Cost-Avoidance

Task Force members expressed disappointment that, too often, *payment* for services has become a far more important driver of actions within some safety net organizations than merely the *avoidance of cost*. Many felt that efforts should be made to 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 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 to everyone is important. (See the information on Project Access in Chapter 3). The drivers toward assuring the availability of a continuum of care for all stakeholders include: building a business case for participation in safety net service provision, equity (groups needing to feel there is shared responsibility), patient accountability (e.g., patients keeping their appointments), clinics (tracking provided services—prescription medications and treatment), and recognition.

Efforts to Encourage Collaboration

In its analysis of the barriers to collaboration (e.g., 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 Task Force investigated ideas that might encourage collaboration. These ideas included:

- *Community-wide, safety net planning groups.* Community planning efforts can start by focusing on needs or gaps and on identifying the safety net organization in the community best able to address the needs with the least amount of duplication. Community wide efforts should be broadly representative of the community and include healthcare providers, businesses, colleges and universities, faith-based organizations, social service agencies, non-profits, and other interested groups.
- *Best practices or pilot programs.* Best practices in community collaborations or integration models could be disseminated through the NC Community Health Center Association (NCCHCA), the Public Health Directors' Association, NC Medical Society meetings, NC Hospital Association meetings, Area Health Education Centers programs (AHEC), and other appropriate forums.
- *Incentives to collaborate.* Foundations or state agencies could require greater evidence of collaboration, such as 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.
- *Shared funding or other resources.* Multiple organizations could apply for grant funds that could be shared across agencies. For example, 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 departments, or could help hire staff in safety net organizations who could provide unassigned call coverage in the hospital.
- *Other creative ideas to eliminate barriers.* With regard to FQHC regulatory barriers—there was some consideration of potential efforts to expand local health boards to meet the FQHC's 51% consumer/user requirement, while still meeting state statutory prescribed positions on these boards. It is not clear that this would either be possible or, by itself, would do much to enable local public health departments to qualify as neighborhood health centers.

HealthAssist, Pitt County

HealthAssist is a community partnership developed in Pitt County to provide healthcare and other services to the indigent, uninsured population. It serves between 600 and 800 clients at any given time. The four areas of service include a quasi-insurance program, pharmaceutical assistance, healthcare and social/education services, and case management. To qualify for any of these services, an individual must be uninsured and have an income below 125% of the federal poverty guidelines. The HealthAssist insurance program provides free or reduced-cost outpatient primary care through volunteer local private physicians, the Greene County Health Care (FQHC), and the Brody School of Medicine at East Carolina University. Hospitalization is provided at no charge at Pitt County Memorial Hospital. Four Community Resource Centers (CRCs) serve as enrollment centers, provide space for examination rooms, and employ case managers who assist clients with healthcare and other social service needs. The prescription medication program makes generic and brand name medications available with small copays.

Recommendations

In its consideration of specific efforts to encourage collaboration among safety net providers and other stakeholders statewide, and particularly at the community level, the following recommendations are offered by the Task Force:

Confidentiality

North Carolina's law regarding the confidentiality of medical records is often seen as an obstacle when safety net providers attempt to share information as part of collaborations designed to provide seamless and efficient care to common patients. To clarify the law for safety net organizations so they can provide more continuous care for their shared patients, the Task Force recommends the following:

Rec. 6.1: The NC General Assembly should enact legislation that clarifies existing state confidentiality laws to ensure that safety net providers are allowed to share identifiable health information with each other when providing care to the same patients, consistent with applicable federal law. The legislation should include heightened protections for particularly sensitive information, such as mental health and communicable disease information.

Best Practice

In addition to the confusion over the laws for sharing medical records, most safety net organizations do not have the resources or staff time to devote to researching effective modes of collaboration. It would be helpful if descriptions of successful models were available in one location. Having access to descriptions of successful models may reduce some of the fears and initial barriers to creating partnerships. Funding will be integral to this process. North Carolina foundations could help the state-level Safety Net advisory council convene a best practices summit of safety net organizations to help communities identify ways to expand collaboration between safety net organizations and strengthen community capacity to meet the healthcare needs of their residents. To help communities and safety net organizations find and implement successful models of collaboration, the Task Force recommends:

Rec. 6.2. The NC Office of Research, Demonstrations and Rural Health Development should collect and disseminate descriptions of various models of collaboration and integration found to work well in particular communities.

Rec. 6.3. In addition to healthcare providers, local safety net collaborations should encourage the participation of business and industry, colleges and universities, faith-based organizations, social service agencies, non-profits, and other interested groups in community collaborations to provide care to the uninsured.

Rec. 6.4. North Carolina foundations should help convene a best practices summit of safety net organizations that will focus on collaboration and integration. This summit would help local communities identify ways to

Henderson County Collaboration: AHEC, Public Health, and Free Clinic

The Hendersonville Family Practice Residency Program (HFPRP), which is part of the Mountain Area Health Education Center, the local health department, and the free clinic, are working together to expand care to the uninsured. The HFPRP provided 38,000 outpatient visits, and 6,013 inpatient visits in 2003, many of which were to uninsured patients. The teaching faculty and residents also provide care to the uninsured at the health department and free clinic. One of the HFPRP faculty members serves as Medical Director for the local health department, providing much of the $550,000 in uncompensated care provided during the year. Another HFPRP faculty member serves as Medical Director for the free clinic. Furthermore, faculty and resident volunteers at the free clinic provided more than 300 volunteer hours and 1,400 patient visits in 2003. In addition, these groups, along with other community partners, formed a local health network to address the healthcare needs of the poor and uninsured in Henderson and Transylvania Counties. The Health Resources and Services Administration recently awarded a $900,000 Healthy Communities Access Program grant to further their efforts.

Duke University Health System (Duke) and Lincoln Community Health Center (Lincoln) Collaboration

Duke and Lincoln developed a joint initiative to provide two satellite health clinics in Durham. The first clinic, located in the Lyon Park Community Family Life and Recreation Center, was so successful that it has expanded space and clinic hours and spurred the development of the second clinic, near the Walltown neighborhood of Duke's East Campus. Duke Community Health, a division of the Department of Community and Family Medicine and the School of Nursing, administers and staffs the clinics under a contract with Lincoln. Lincoln receives cost-based reimbursement from Medicaid for the patients seen by contracted Duke providers. Lincoln, in turn, pays the providers the same rates they would have received directly from Medicaid if the patients were seen in Duke clinics. These local health clinics provide affordable healthcare to all patients, regardless of insurance status. Patients served under this collaborative have access to all of Lincoln's services, including pharmacy and enabling services, such as transportation, case management, nutrition counseling, and interpreter services.

build and strengthen their capacity to meet the healthcare needs of the growing uninsured population, and to reduce barriers to interagency collaboration and integration. Summit participants should include representatives of existing safety net organizations at the state and local levels. One of the outgrowths of this summit would be to develop clearer and measurable criteria of collaboration to guide future decisions for safety net program support by public and private funding agencies.

Hospital Collaborations

Hospitals continue to look for ways to reduce non-emergency use of their emergency departments. Many safety net providers are able to provide urgent care, which could take some of the burden away from hospitals. In Lee County, the hospital pays the health department to provide care to patients after normal business hours. Recommendation 6.5 is meant to encourage collaboration between hospitals and safety net providers for non-emergency medical needs.

Given the fact that hospitals in North Carolina have shouldered a tremendous burden of after-hours and non-emergency care for uninsured and underserved populations, the Task Force recommends:

Rec. 6.5: Hospitals should take the lead to develop collaborations with local safety net organizations to help ensure that the uninsured have appropriate medical homes and after-hours care for persons requiring non-emergent attention.

Ongoing State-Level Collaborations of Safety Net Organizations

Many of the safety net organizations need technical assistance and leadership as they consider collaborative efforts. In an effort to create a body that would continue state-level discussions of these issues and serve as an example of collaboration, the Task Force recommends:

Rec. 6.6: The NC Institute of Medicine should create an on-going state-level Safety Net Advisory Council that can encourage state-level and local safety net collaborations and can help monitor the implementation of the Safety Net Task Force's recommendations. The group should include the full array of existing safety net organizations, including health departments, federally qualified health centers, free clinics, hospitals, medical societies, Project Access and Healthy Communities Access Programs, medication assistance programs, and other non-profit agencies providing care to the uninsured.

References

1 Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: US Department of Health and Human Services, CDC, 2002.