

## Cabarrus County: A Study of Collaboration

*L. Allen Dobson Jr., MD, and Torlen L. Wade, MSPH*

While recent attention has been paid to office-based interventions to improve care, innovations in population-based healthcare have had an arguably larger impact on the health of the population. The experience of healthcare providers and community organizations in Cabarrus County, one of the original Community Care of North Carolina (CCNC or Medicaid Access III) pilots and early Healthy Community Access Program (HCAP) federal grantees, demonstrates two important innovations in population-based healthcare: primary care case management of the Medicaid population and integration and collaboration of safety net providers to care for the uninsured. CCNC, now expanded to cover the majority of the state, has had remarkable success statewide by ensuring a medical home for every Medicaid recipient, fostering community-wide collaboration around improved systems of care and employing disease management strategies to improve care. These principles applied statewide have resulted in remarkable improvements in asthma care, decreased hospitalizations, and a resultant savings of \$124 million for state fiscal year 2004 for women and children covered by Medicaid.<sup>1</sup> HCAP grants and the Project Access model of Buncombe County have been used to improve volunteerism and coordination of care for the uninsured. Although every community is different in terms of resources and stages of healthcare systems development, this description of Cabarrus County's experience may define principles and elements of successful provider collaboration and system change.

### History

Cabarrus County has a long history of excellent medical care; often beyond that expected in a community of its size. From the early days when textiles dominated the local economy, Northeast Medical Center (then Cabarrus Memorial Hospital) had a close tie to the textile industry and, in particular, with Cannon Mills. Charles A. Cannon served as Chairman of the

Board of Directors of Cabarrus Memorial Hospital and was an early champion of high-quality healthcare. This close relationship continues today as the Cannon Foundation and Charitable Trusts supports the hospital and many worthwhile health-related projects. One early example was the medical education affiliation with Duke University supported by the Cannon Charitable Trusts, which improved physician continuing medical education and helped recruit many of the early specialists to the community. In the 1980s and early 1990s, in response to rising healthcare costs, there were attempts at healthcare integration through development of a health maintenance organization (HMO) and other managed care endeavors. Although these initiatives were not successful over the long term, they did set the necessary groundwork and provided valuable experience among physicians and other healthcare providers for working together.

### Background of Collaboration

Cabarrus County and its many healthcare providers and agencies had a number of successful collaborations prior to more formally organizing as Cabarrus Community Care Plan, Inc. (CCCCP) to locally manage Medicaid recipients and to coordinate the care of the uninsured. Some notable examples of early collaboration include:

- The *Community Free Clinic*, founded in 1994 by two retired physicians, Drs. George Liles and David Lockhart, receives wide community and provider support and plays a significant role in CCCC by providing a site for eligibility determination, medical care, and pharmacy services for the uninsured.
- The Cabarrus Family Medicine Residency Program, a collaborative venture between Northeast Medical Center, its medical staff, and the physicians of Cabarrus Family Medicine, was developed in 1996 to increase the supply of primary care physicians in Cabarrus County and rural communities in North Carolina.

**L. Allen Dobson Jr., MD**, is the Assistant Secretary for Health Policy and Medical Assistance for the North Carolina Department of Health and Human Services, and Past Chairman of Cabarrus Community Care Plan, Inc. He can be reached at allen.dobson@ncmail.net or 2501 Mail Service Center, Raleigh, NC 27699-2501. Telephone: 919-855-4100.

**Torlen L. Wade, MSPH**, is the director of the North Carolina Office of Research, Demonstrations, and Rural Health Development. He can be reached at torlen.wade@ncmail.net or 2009 Mail Service Center, Raleigh, NC 27699-2009. Telephone: 919-733-2040.

- The Logan Community Family Resource Center was a 1997 collaborative effort between municipal, health, law enforcement, and local government to provide needed services to the medically at-risk, minority population of the Logan community.
- Cabarrus Human Services Center opened in 1998 and includes Piedmont Behavioral Healthcare (mental health agency), Cabarrus Health Alliance (health department), and the department of social services under one roof. Co-location of these agencies has promoted access to care and ease of service.

*“One of the keys to CCCP’s success was the inclusive nature of the organization. While keeping the key providers of care at the center of the organization, there was balanced decision-making and building of trust among the entire medical community.”*

Other notable community organizations that resulted from community collaboration include: Healthy Cabarrus (1998), Mental Health Association of Cabarrus County (1998), Latino Advocacy Council (1999), Parish Nurse Program (1997), Medical Assistance Enrollment Network (1995), and others.

## Organization

In 1998, the community informally organized and applied to become one of the first Access III Medicaid pilots. Access III networks were defined as full-county initiatives that included the majority of physicians providing Medicaid services, the local hospital, the health department, and the department of social services. The goals of the network were to:

- Work directly with those community providers who have been caring for Cabarrus County’s Medicaid recipients.
- Build a public and private partnership where community providers can work together to cooperatively plan for meeting patients’ needs and where existing resources can be used most efficiently.
- Put in place local systems and supports that are needed to achieve long-term improvements in quality, cost, and access for Medicaid recipients; including implementing evidenced-based practice, disease management, case management, high-cost service management, and feedback and accountability.

In 2000, after a community needs assessment identified unmet medical needs for the uninsured, Healthy Cabarrus

convened a task force to apply for the new federal HCAP grants available to communities to improve care for the uninsured. This application and the subsequent award became the pivotal point in the formal organization of Cabarrus Community Care Plan, Inc., a 501(c)3 (not-for-profit) corporation.

From the beginning, CCCP’s governance structure included both providers of care and community organizations. A large Board of Directors represented physicians, the hospital, mental health, the health department, social services, free clinic, schools, dentists, and other community agency/organization representatives. A smaller executive committee provided day-to-

day oversight. As with each CCNC network, Medicaid provided a \$2.50 per member per month fee to the network to provide for management support. The HCAP grant provided needed project assistance in developing and delivering care to the poor uninsured. The network hired “care managers” who had a broad responsibility in assisting providers and patients. Another key function of the network was development of a Medical Management Committee, representing the major primary care practices charged with being the medical home for patients. Their role was development and implementation of disease management and utilization management initiatives at the

practice and community level. In Cabarrus, that function fell to an already established disease management group at Northeast Medical Center. CCCP’s role was to support and coordinate existing resources, rather than develop new infrastructure. One of the keys to CCCP’s success was the inclusive nature of the organization. While keeping the key providers of care at the center of the organization, there was balanced decision-making and building of trust among the entire medical community.

## Ongoing Projects

In addition to projects implemented as part of statewide Medicaid disease management efforts, CCCP was able to pilot new initiatives for the state and also work on local initiatives. Examples of statewide projects include asthma disease management, diabetes disease management, Prescription Advantage List (more cost effective prescribing), emergency department utilization reduction, and high-cost/high-risk case management.

CCCP was also part of initial pilot programs for the dental screening and fluoride varnish project in the zero-to-three-year-old Medicaid population, therapy services utilization management, poly-pharmacy in the nursing home project (which reduced and improved medication use among nursing home patients), and the current depression and mental health integration initiatives.

Examples of local projects include a community-wide attention deficit disorder (ADD)/attention deficit hyperactivity disorder (ADHD) management project tracking 1,481 students with ADD/ADHD; expansion of the dental care system for the poor

and uninsured; and the HCAP grant, which funded the community-wide system for care of the uninsured. Through the HCAP program, 1,400 uninsured individuals received care in 2004, representing more than \$2 million dollars in free physician services, and \$1.2 million in free medication.

## Notable Results

Although each of the above projects has shown improvements based on community and practice report cards, the most significant community results have been with regard to diabetes. Practice-based disease management for diabetes in Cabarrus County was initially championed by Dr. Doug Kelling, a local internist. His early work led to the development of a disease management center supported by NEMC. The Disease Management Center established a diabetes registry that tracks over 6,000 diabetic patients. The data measurements include hemoglobin A1C, low-density lipoprotein cholesterol, blood pressure, eye exams, aspirin, ACE inhibitor use, and monofilament exams. Patients are followed in the registry regardless of insurance type or extent of coverage. These data, in addition to practice improvement data, are collected and allow evaluation of care of the uninsured and Medicaid recipients compared to the privately insured population.<sup>2</sup>

The bankruptcy and subsequent closure of the largest employer in Cabarrus County, Pillowtex, created the largest layoff in North Carolina history. The increasing uninsured population combined with ongoing medical needs of former Pillowtex employees, and a growing Latino population for which disease management data indicated a lack of adequate access to care, significantly exceeded the community's ability to provide care. In response to this, CCCP led the effort to open and secure funding for a new Community Health Center.

CCCP's efforts in managing the Medicaid population have resulted in significant cost savings for the state and local community. This is clearly the most significant success to-date. Despite having a higher than average per patient cost in 2001, CCCP was able to show an overall decrease in per patient Medicaid cost over the next three years of 5% (or \$18.4 million).

This measure best approximates utilization and is compared to a 10% increase for the state over the same period. Based on state estimates, total Medicaid expenditures in Cabarrus County, likewise, were less than would be expected over the same period and resulted in a savings of more than \$1.01 million in local tax revenue.<sup>3</sup> Continued improvement is expected as CCCP begins management activities for the aged and disabled populations covered by Medicaid and other populations.

## Lessons Learned

There are some basic principles that can be drawn from the Cabarrus experience as well as experiences in other CCNC communities.

- Community ownership is a *must* if these efforts are to be effective.
- A "medical home" for every patient remains the backbone for improving healthcare quality and access.
- You can't do it alone. Partnership, inclusiveness, and collaboration are keys to success.
- You must develop and support systems that change care at the practice and community levels.
- Physician leadership of the care improvement process is essential for long-term success.
- You have to measure outcomes. You get what you measure, but it is important to start measuring *something*, even if it is a single measure.
- Early success builds trust and makes future initiatives easier.
- Lasting change will take time and reinforcement.

Improvements in care quality, access, and savings seem to be additive (i.e., the totality of care improvement at the community level seems to be greater than the individual initiatives).

The promise of a more integrated community health system based on a primary care medical home and collaborative systems of care at the local level is attainable and should help prove the value of further development of the Community Care of North Carolina program. **NCMedJ**

---

## REFERENCES

- 1 ACCESS Cost Savings—State Fiscal Year 2004 Analysis. Letter to Mr. Jeffrey Simms, Assistant Director of Managed Care, NC Division of Medical Assistance, NC Department of Health and Human Services. Mercer Government Human Services Consulting. Phoenix, AZ. March 24, 2005.
- 2 Disease Management Center, Northeast Medical Center, Concord, NC. 2004.
- 3 Program Expenditure Reports 2001-2004. Division of Medical Assistance, NC Dept of Health and Human Services, Raleigh, NC.