

Integrating Multiple Service Providers in Service to the Poor and Uninsured: The Critical Conditions for Effective Collaboration

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Roberta Burgess, a HealthAssist Nurse Case Manager, was made aware through community contacts that Mary M. was in trouble. An employed but uninsured 49-year old woman who lived alone in a mobile home, she had become morbidly obese and was about to lose her job. She was woefully under-medicated and rapidly progressing toward disability and irreversible cardiovascular disease. Roberta made a home visit, finding Mary barely able to rise from of her chair or walk without assistance. With the help of Lynn Howard, a project social worker, she found Mary a walker and, with her, embarked on a journey of recovery. First it was necessary to control her diabetes, hypertension, and hyperlipidemia. Regina Coyle, a nurse practitioner, saw her in a series of clinic visits, prescribed appropriate medications, and placed Mary on a carefully limited exercise and weight-loss program. Meanwhile, HealthAssist team members were making contacts with several community and state agencies. The progress toward recovery was slow but continuous, and in 2004 Mary had successful gastric bypass surgery, funded by the North Carolina Division of Vocational Rehabilitation Services. As of this writing, she is employed full-time and soon will require no HealthAssist services. Roberta said recently, "She came by to see me and I hardly recognized her. She looked wonderful!"*

*HealthAssist is the original program component of the Eastern Carolina Community Health Consortium (ECCHC).

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For a long time now, I have, on a few moonless nights every year, fished a flounder net in the lower Pamlico River. Because of its large and flexible 5 1/4 inch mesh, it spares most other fish, and the flounder's physiology allows him to rest on the bottom until I remove him. Around mid-July and extending into mid-September, blue crabs become a serious problem.

The ones I usually catch are free-swimming as "doubblers," meaning they are occupied with the business of reproduction. They get themselves all wrapped up, and I often must break a strand to get them out. One broken monofilament strand doubles the size of the hole formed by the mesh, and pretty soon, as we say Down East, I've

got "holes you could walk through." One might say, stretching the metaphor a bit, that the fisherman's success depends on the "connectedness" of his net. Once it gets really "holey," he'll still catch a few flounders, but most will escape. The healthcare safety net is disturbingly similar. At best it is a fragile, "patchwork array," with certain relatively consistent components, the compromise of any one of which can create a major service gap. A brief look at those components might be helpful.

The Components of the Healthcare Safety Net

Most communities of medium-to-large size have at least one free clinic and even some small rural areas have found ways to provide limited, part-time free health services. In addition to primary care services, these entities often provide medication support, ranging from sample distribution to helping clients access drug company programs and/or purchasing and distributing limited

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medications. In some cases, pharmaceutical assistance is provided, but there is no direct healthcare. Public health departments, in addition to their traditional prevention-focused programs, provide a range of primary care services ranging from minimal to comprehensive, the outstanding example of the latter being in Buncombe County. These exceptional programs notwithstanding, few public health departments can provide medication support outside that required for management of sexually transmitted diseases, pregnancy prevention, and tuberculosis. The community health centers often referred to in this report as federally qualified health centers (FQHCs) are the most economically viable model for comprehensive indigent health services, and some across the state have done so with remarkable effectiveness. Greene County Health Care, headquartered in the tiny rural community of Snow Hill, recorded encounters with over 18,000 people last year. They offer comprehensive primary care including prenatal services, dental care, and an award-winning Latino outreach program. Still, despite the so-called "President's Initiative," new center applications are highly competitive, and regulations prohibit establishing centers in many areas. Private physicians carry a share of this burden as well, depending upon variables such as workload of insured patients, the availability of volunteer "off time," and the availability of Project Access-like programs that allow them to provide donated services within an organized structure. Public hospitals, of course, bear a huge "charity care" burden.

There are many other community organizations and agencies, both public and volunteer, providing human services that are essential to improving the health of low-income people.

How Likely Is Collaboration or Integration to Occur?

Across the board, these services are rarely integrated, though notable exceptions exist. Among them, Community Care of North Carolina (CCNC) has had the greatest impact. Thanks in large part to the visionary leadership of Allen Dobson, MD, President of Community Care of Cabarrus County, and James D. Bernstein, founding Director of the state's rural health program, CCNC has managed to contain Medicaid cost increases, while significantly improving health outcomes and provider and patient satisfaction. Using a nurse case management strategy and depending upon volunteer physician leadership, it has helped communities across the state coordinate services to Medicaid recipients. There are a number of local examples, often operating in coordination with CCNC. Many have been temporarily funded under the United States Health Resources and Services Administration Healthy Communities Access

Program (HCAP). These include, but certainly are not limited to, the Eastern Carolina Community Health Consortium (ECCHC), headquartered in Greenville, the above-mentioned Buncombe County coalition, and a similar one operating in Cabarrus County. In no case has complete integration been approached, but many have achieved broad-based, genuine collaboration among diverse entities.

The Essential Elements of Community-Level Collaboration

As I have traveled around the state to advise others engaged in this work, I have spent many hours reflecting on the elements of successful programs. The following five components are, I believe, the essential ones:

- **The Right Kind of Leadership.** Organizational self-interest ("turf") and mutual mistrust are the absolute enemies of collaboration. Public service and charitable entities are far from immune to these and cannot easily set them aside. One who leads these coalitions must be generally well-known, absolutely trustworthy, and have the maturity to put aside personal biases and respond in a non-reactionary way to negative or confrontational situations. Often these are physician leaders, like Allen Dobson in Cabarrus, Lindsey De Guehery in Wilson, and many others.
- **A Clear, Simple, and Continually Reinforced Value.** Collaborators must agree upon a common value that can be easily articulated. In the eastern North Carolina group, we agreed that all are committed to improving the health status of poor and low-income people, *period*. When conflict has arisen or our spirits have lagged, we have stopped and asked, "What are we here for?" reinforcing this core value. Early on, we agreed on a simple sentence that captures the essence of this element: "We will do what is right, we will do it well, and we will do it together."
- **A Source of Funding.** Many would list this component first. I do not for two reasons. First, acquiring funding before genuine collaboration has been achieved is a sure prescription for failure. All of us who are engaged in this work can cite numerous examples. Secondly, it is not only possible to build a coalition of committed partners with little or no outside funding, it is essential. If the entities involved are not committed to each other and the coalition's core value, the program will fail whatever its financial condition. On the other hand, programs that can demonstrate in a grant application or site visit that genuine collaboration is present are far more likely to be funded.

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■ **Inclusiveness.** No community is likely to be successful in bringing all stakeholders to the collaborative table. Still, coalitions should make it their goal to do so. In building the ECCHC, we faced numerous threats. Perhaps the most serious one was the historically strained relationship between the components of the University Medical Center and Greene County Health Care (GCHC). Program leaders recognized early on that GCHC could bring extraordinary strength to the coalition, and GCHC leaders, likewise, saw the need for healthy partnership. Solving this problem required clear communication about issues of disagreement and demonstrated commitment from both parties to rebuilding trust. This was slow and difficult work, but its success was assured from the beginning by the mutual commitment of leaders from both entities to effective collaboration. Much of this work was done in a highly productive series of private meetings between the GCHC Executive Director, Doug Smith, MBA, and this author. In another example, these same entities are cooperating in the construction of a 15,000 square foot community health center in northern Pitt County, with GCHC agreeing to operate the center as an expansion site. This expansion could compromise an important program

operated by the Pitt County Health Department, its prenatal care clinic. Because the Pitt County Health Director, Dr. John Morrow, is an active coalition leader, discussions among the appropriate parties were held early on and the potential conflict averted.

■ **Flexibility.** Finally, successful coalitions, like my flounder net, must have sufficient flexibility to stretch as much as possible without tearing. Sudden changes in political priorities, funding streams, population need, etc., are inevitable. Such flexibility requires a constant reinforcement of the mission and an underlying spirit of optimism, a belief that doing what is right will ultimately be both successful and rewarding.

My own observation, as one coalition leader, is that I am responsible for upholding this spirit among our partners, and to work continually to praise and thank those who do the day-to-day work. When I find myself discouraged, I remember our vision, and say to myself, often aloud, "We will do what is right, we will do it well, and we will do it together." **NCMJ**

*Margaret lives in her own place
with her own stuff.*

Tracie helps to make it possible.

"Margaret is 85 and sharp as a tack. But her health makes it tough to get around. Tracie wants to help out in her community, but she has a busy job. *Faith in Action* brought them together. It's people of different faiths who volunteer to shop, cook, drive, or just check in on some of the millions of Americans with long-term health needs.

If you're like me and have wondered how you can make a difference, volunteer with *Faith in Action*. A neighbor's independence depends on you and me."



FAITH
IN ACTION

— Della Reese. *Entertainment Legend.*
Faith in Action Believer.

