

Building Local and State Partnerships in North Carolina: Lessons Learned

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The first state office of rural health was established in 1973 in North Carolina, and over the years, it has evolved into one of the largest of such offices in the nation. Along the way, many lessons have been learned from both successes and failures in the Office's efforts to build local and state partnerships to meet the health needs of rural and underserved communities. This article touches on a few of the key lessons learned.

Guiding Principles

Jim Bernstein, the founding director of the North Carolina Office of Research, Demonstrations, and Rural Health Development, summed up the core belief guiding the Office since its inception as, "If improvement in [health] care or service is the goal, then those who are responsible for making it happen must have ownership of the improvement process." This core belief is put into practice through a state/local partnership approach to projects and a focus on community investment as the cornerstone of all improvement strategies. Jim established five key principles that for more than 30 years have shaped the Office's partnership initiatives and continue to shape them today:

- Ownership is vested with community participants;
- Roles and responsibilities of all participants, both community and governmental, are clearly defined;
- In-depth technical assistance is provided on a continuous basis;
- Accountability is clear and measured; and
- Meeting patient and community needs remains the focus of all activities.

These guiding principles were originally applied, tested, and refined in the work that brought the Office into existence in 1973—the Rural Health Centers Program. Under the Rural Health Centers Program, the Office provided financial and technical assistance to rural communities in developing community-owned and operated primary care centers. In providing this support, the goals were to foster the development of independent community organizations with the leadership, knowledge, skills, and tools to create and manage a community medical center. Unlike the financial assistance provided by the Office, which was viewed as short-term (three to five years) help to communities during the start-up period, the Office's technical assistance was always seen as a long-term commitment. Not only would technical assistance be available to help community boards prepare for their oversight and policy role and to help health center staff carry out their clinical, practice, and financial management responsibilities, it would also remain a key component of the ongoing operation of the center. The principle behind this commitment to long-term technical assistance was that the Office would be more than just a traditional funding

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agency. It would be a partner with the community. While this commitment to partnership began during the feasibility and start-up phases of a new health center, it would continue well after a health center became operational. Office field staff still work with health centers that opened their doors more than 30 years ago. In rural communities, where local resources are limited and where the loss of a clinician can close a health center's doors, being able to turn to the Office for recruitment or emergency fill-in help or for help addressing financial and other crises has been an essential part of the state/local partnership. Each of the 85 health centers developed by the Office as part of the Rural Health Centers Program, is unique. Designed by individual communities to meet their particular needs, the health centers range from single practitioners in remote rural areas to multi-site, multi-provider operations serving several counties.

Throughout the 33-year history of North Carolina's Rural Health Centers Program, there were no major changes in the guiding principles, only refinements. The one significant refinement was an evolving definition of community. In the early 1970s, when there was a critical shortage of primary care providers throughout rural North Carolina, the focus was on securing care for all residents. As the supply of primary care physicians, nurse practitioners, and physicians became more plentiful, the office shifted its attention in the 1980s to providing access to care for low-income and underserved populations. Today, 80% of Rural Health Center Program funds support the direct provision of primary care to low-income and uninsured persons.

Although the principles were originally adopted to guide the Rural Health Centers Program effort, they are now used to guide other community-based initiatives and services within the Office, which are designed to improve the care of underserved and medically vulnerable populations, including the:

- *Medical and Dental Placement Program*, which recruits physicians, nurse practitioners, physician assistants, and dentists to serve in rural and underserved communities. In the last 30 years, more than 2,000 medical and dental providers have been placed in 96 of the state's 100 counties.
- *Farmworker Healthcare Program*, which targets the unique healthcare needs of seasonal and migrant farmworkers across the state by building up local delivery and outreach systems in high-impact areas.
- *Critical Access Hospital Program*, which assists small rural hospitals in securing Critical Access designation and, most importantly, promotes the formation of hospital networks that can improve the quality of services and financial stability. The program also assists partner hospitals with long-range planning, data analysis, grant-writing, and architectural and design assistance;
- *Prescription Assistance Program*, which provides prescription assistance software and technical assistance to community practices that help low-income residents obtain prescription drugs; and
- *Community Care of North Carolina*, which manages the care of Medicaid recipients through community health networks that are organized and operated by local physicians, hospitals,

health departments, and departments of social services. Fifteen Community Care networks serve more than 650,000 Medicaid recipients and are creating the management systems needed to achieve long-term improvement in quality, cost, and health outcomes.

Over the Office's history, the importance of the five principles listed above has not changed and perhaps are the most important lessons that can be drawn from the Office's experiences. However, additional lessons have been learned along the way. These lessons can be divided into those that stemmed from work with local partnerships and those learned from work with other state-level partners.

Lessons Learned from Partnerships with Communities

Respect the Community's Perception of Their Needs

While academicians or state officials may have identified a need in a particular community, until the community acknowledges the problem, any attempts toward resolution will have mixed results. Education and outreach may be the necessary first steps in engaging a community to address their healthcare needs. Alternatively, the correct decision may be to step back and wait, but be prepared to step in when the community is ready.

Find and Nurture Local Leaders

Local leaders and champions are critical to developing sustainable healthcare initiatives in communities. Early on, Jim Bernstein recognized that community leadership was the critical component in the success of any community-based initiative. When dedicated leadership was absent, there were almost no prospects for successful community development. On the other hand, strong community leadership can offset other weaknesses in the development process. Leadership was so important that Jim made a concerted effort throughout his career to identify and nurture potential leaders at the community level.

Serve as a Resource

Over time, the Office has developed skill sets in a variety of areas to provide technical assistance to communities. Through this cadre of specialized technical expertise, the Office is able to assist communities in establishing non-profit corporations, organizing fund-raising and community-awareness campaigns, designing and building facilities, recruiting and hiring providers and staff, and overseeing medical operations. Because of the growing complexity of healthcare finance and reimbursement, the Office provides extensive technical support to health centers in all aspects of financial management. Rural health centers, such as Black River Health Services and Saluda Medical Center, developed 30 years ago, still retain a close working relationship with the Office. The Office also serves as a resource to other North Carolina agencies and to staff from other states.

Lessons Learned from Partnerships with State-Level Partners

Find and Create Flexibility within a Traditional Bureaucracy

State governments traditionally do not have a reputation for being the most flexible of institutions with which to work. The Office has balanced the need for reporting and accountability with the need for fast and straight-forward processes. While many policies cannot be changed, the Office has always tried to view rules and requirements from the perspective of those most affected by it. Therefore, whenever possible systems are designed to minimize the impact of bureaucracy while assuring that all state requirements are met.

Learn from Failures as Well as Successes

Not every good idea translates into a successful project. The Office has had opportunities to become involved in healthcare projects that were not tied to its long-term focus on building and supporting community-based systems designed to improve access to care. Although some of these non-core projects went well and made a contribution, other ventures were a struggle because they were not aligned with the Office's core values and skill sets. Non-core projects must be selected carefully to ensure they do not detract from what matters most.

Address Problems at the Appropriate Level, Whether It's Local, State, or Federal

While the Office emphasizes empowering local communities to address their own healthcare issues, there are often regulatory and legislative issues that impact communities, which can only be addressed at the state or national level. The Office has weighed-in on both state and national policy issues. In the mid-1970s, Jim Bernstein was active in developing the Rural Health Clinic Services Act (P.L. 95-210) legislation, which created reimbursement mechanisms for services provided by nurse practitioners and physician assistants in underserved rural communities. More recently, the Office, through the Community Care of North Carolina program, has worked with the North Carolina Department of Medical Assistance to create new provider delivery and reimbursement models that emphasize case management and continuity of care.

Build Bi-partisan Support

Rural health issues when seen from a local perspective are neither Republican nor Democratic issues, they are community issues. By focusing on supporting community-solutions to community problems, the Office has been able to build a broad base of support for its work during both Republican and Democratic state administrations.

Collaborate and Build Partnerships

Much of the Office's work has been accomplished through collaborations and partnerships at both the community and state level. Since its inception, the Office has viewed partnerships and collaborations as an essential part of its mission.

Community Care of North Carolina is one example of the importance of collaboration. Its success is dependent on the collaboration and commitment of both state and local organizations. This program has achieved notable improvements in care quality and cost-effectiveness for Medicaid recipients by fostering community-wide collaboration around improved systems of care and by employing disease and case management strategies to improve care. The Office also tries to promote partnerships at the community level among different providers and agencies. In Bertie County, the Office helped to facilitate a closer working relationship between the local hospital, county health department, federally-funded community health center, and regional health system. As a result of this partnership, a multi-agency health campus has been constructed in this rural county allowing residents easy access to several providers and services in one location.

The need for collaborations and partnerships will continue as the Office works with others to address the current and future challenges in providing access to quality healthcare for rural and underserved populations.

Challenges Facing Rural Healthcare

There are several challenges facing rural healthcare. Some have been faced before, while others are new.

Increasing Number of Uninsured

As the traditional employment base of manufacturing and textiles leaves and as increasing numbers of immigrants settle in rural communities, the number of uninsured places additional stress on fragile safety net systems of care.

Aging Infrastructure and Physical Plants

Many of the health centers established by the Office are celebrating 25 or more years of service to their communities. Unfortunately, the physical facilities are beginning to show their age. In addition, the need for up-to-date and reliable computer networks to handle the routine business of healthcare has also increased. Finding significant levels of funding for capital and information technology infrastructure will continue to be a challenge.

Access to Mental Health Services

Accessing affordable mental health services in rural communities is a growing challenge. Primary care practices and emergency departments often become the providers of last-resort for mental health issues in their communities. There is a growing need to both improve the ability of primary care providers to care for patients with behavioral health needs and to improve the ability of local systems to integrate and coordinate behavioral health services and primary care.

Access to Pharmaceuticals

Even with the implementation of Medicare Part D, many rural residents with limited incomes face challenges obtaining necessary medications. Rural health providers often find themselves cobbling

together solutions from sample medications and pharmaceutical company donation programs to meet their patients' prescription medication needs.

Workforce and Staffing Issues

Rural healthcare faced a physician shortage in the 1970s due to the retirement of large numbers of general practice physicians. This shortage was dealt with in part through enhanced recruitment and retention efforts and by the widespread introduction of nurse practitioners and physician assistants into rural areas. Now rural health is facing another projected shortfall in primary care and key medical specialties, and once again, creative and collaborative solutions will have to be found.

Conclusion

More than 30 years ago, Jim Bernstein shared his vision for what a state office of rural health could be and what it could do. His philosophy of nurturing community-based solutions to community healthcare programs has contributed to the development of more than 80 rural health clinics across North Carolina and the implementation of other initiatives targeted at providing care to the underserved in North Carolina. The lessons learned have come from putting his philosophy and vision into practice. **NCMedJ**