

One Size Does Not Fit All: Tailoring Case Management to a Community

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The success and pride of the Community Care of North Carolina (CCNC) program is each unique network aligning the community needs of its Medicaid enrollees with resources within its own network. CCNC's community-based, patient-centered form of care coordination with the patient's "medical home" or primary care practitioner has led to estimated cost savings of \$284-\$318 million in fiscal year 2006 and is continuing to demonstrate cost containment while integrating quality initiatives.¹

However, what happens when the needs and resources within the same network differ? What if case management and approach to medical home/care coordination with primary care practices is not a "one-size-fits-all" approach within the same network? This is the case with our network, Community Care Partners of Greater Mecklenburg (CCPGM). Comprised of Mecklenburg, Union, and Anson Counties, with over 100,000 Carolina Access Medicaid and HealthChoice enrollees, CCPGM is one of the most populous Medicaid networks within the state. Serving urban, suburban, and rural communities, CCPGM's approach to case management and provider relations is as diversified as the demographics within the three counties we serve.

Mecklenburg County is one of the largest and fastest growing urban communities in the state of North Carolina, with a 24% growth in population from 2000 to 2007.² As in any large urban community, Mecklenburg County, home of "Queen City" Charlotte, is plagued by increases in crime, substance abuse issues, homelessness, an overburdened public school system, and an increase in unemployment. Although smaller in population, Charlotte is in essence an East Coast city challenged with the same urban issues as Baltimore, Philadelphia, and Washington, DC.

CCPGM implemented Medicaid case management in Mecklenburg County in 2002. Mecklenburg is one of 14 urban counties in the state of North Carolina. To this day, due to population size, Mecklenburg County demands the largest percentage of CCPGM's case management resources. Mecklenburg County has a multitude of community

resources available to assist case managers and provider practices in coordinating the health care needs of Medicaid clients in many other major metropolitan area—large clinics/hospitals, medical specialists, public transportation, homeless shelters, and accessible substance abuse/mental health services. These are basic constructs to assist CCPGM in the day-to-day management and care coordination of our Medicaid patients in this urban setting. CCPGM's Medicaid Program, which focuses on nurse case management and

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provider quality, was new to Mecklenburg County in 2002; however, many of the larger provider practices in Mecklenburg County were associated with large health care systems and these practices were very familiar with quality initiatives and following national practice guidelines in asthma, diabetes, and heart failure—three of CCNC's statewide quality initiatives. The vast majority of Mecklenburg County practices were also very familiar with quality oversight from health insurers, including patient chart audits and practice profiles implemented by CCNC for the Carolina ACCESS Medicaid Program.

As similar as Mecklenburg County is to many other urban centers, it is unique in that it borders mostly rural communities. Outside the county lines of Mecklenburg, Medicaid patients

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One Mother's Experience with CCNC

Lindsey E. Haynes

In 2001, Adrienne from Concord, North Carolina, was introduced to Community Care of North Carolina (CCNC) and has continued to remain enrolled in the program. When asked about how she became involved, Adrienne says, "Once I got pregnant with my daughter, I realized that I needed health insurance. At that time I wasn't working, and as far as the economy was going there were no jobs, and I just wanted to have insurance all the time, so I went to DSS [Department of Social Services] for their assistance." DSS enrolled Adrienne in a new Medicaid program called CCNC, a system of care offering coordinated, high quality health care through a network of medical homes. Once Adrienne's daughter, Brianna, was born she was also enrolled in the program.

Currently, Adrienne's medical home is Northeast Primary Care, and her daughter goes to Piedmont Pediatrics. For Adrienne, her medical home helps her manage "everyday things" from colds to annual check-ups. Brianna's medical home helps manage her asthma, a disease that she has had since an early age. In North Carolina, asthma is one of the most common chronic diseases for children, with nearly one out of every 10 children having been diagnosed with the illness.¹ For Adrienne's daughter Brianna, Piedmont Pediatrics has become an integral part in managing her asthma. Adrienne says, "Once a year she sees the doctor, unless a problem occurs. If her asthma starts acting up, or the nebulizer doesn't work, then I'll take her to the doctor. However, her asthma has been doing pretty good for the past few years."

Another key component of CCNC's medical home model is linking case managers to each and every enrollee. For

Adrienne and Brianna, their case manager is in contact with them often. "Every few months, the case manager contacts me if she runs across my daughter's name on a patient list; she calls to touch base with me to find out how she's doing or if there are any programs for her asthma that I should talk to her doctor about." This regular contact between client and case manager increases patient wellness and saves the program money. Studies have shown that between 2000 and 2002 CCNC achieved approximately \$3.3 million in cost savings for patients with asthma due to decreases in emergency room visits and inpatient hospital admissions.²

For Adrienne and Brianna, having a good relationship with their case manager has led to many positive outcomes. When asked what she has gained through her relationship with her case manager, Adrienne states, "I feel that she helps me manage my daughter's asthma, teaching me things that I didn't know about asthma, or programs or medicines that could help my daughter with her asthma. When I first found out that my daughter had asthma, it was all new to me. I didn't know anything about asthma."

Overall, Adrienne's experience with CCNC has made her a strong supporter of the program. Responding to the question of what could be improved about the system, Adrienne responds, "Nothing right now, I'm very pleased."

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1 North Carolina Department of Health and Human Services. Asthma in North Carolina. <http://www.asthma.ncdhhs.gov/docs/asthmaMainNCFactSheetFINAL-1.pdf>. Accessed May 29, 2009.

2 The Henry J. Kaiser Family Foundation. The Kaiser Commission on Medicaid and the uninsured: Community Care of North Carolina: putting health reform ideas into practice in Medicaid. Washington, DC: The Henry J. Kaiser Foundation Family; 2009. Publication no. 7899.

living in Union and Anson Counties experience a very different lifestyle than those residing within the county lines of its urban neighbor. CCPGM began Medicaid case management in Union and Anson Counties in 2004. Less than 15 miles east from the busy and very metropolitan uptown area of Charlotte begin the rural communities of Union and Anson Counties. As a CCPGM nurse case manager who had performed case management in Mecklenburg County, I quickly learned that health care in these communities is very different and, as such, our approach to case management and working with the provider also had to be different. Medicaid enrollees in Union and Anson counties have small satellite community hospitals, limited public transportation, very few physician specialists or

specialty clinics and, in general, fewer community resources. In addition to limited resources, practitioners in Union and Anson County also have a different approach to medicine and health care. In Union and Anson Counties, providers have established a long-term presence within the community and extensive relationships not just with their patients, but with the patient's entire family. This best practice reflects the warm, caring approach given to each individual client.

Another issue we considered when establishing our strategy for Union and Anson Counties was the changing demographics. The population in these counties has almost doubled in the past several years, and there is a growing Spanish-speaking population. However, due to funding issues, these communities

have not been able to keep up with the growing demand for community resources. Providers have been overwhelmed with pressure to provide more and improved services to an increasingly diversified population with fewer resources.

In introducing our program in the rural settings of Union and Anson counties, we decided to begin with the most important and simplest approach—establish trust with our provider practices. This sounds straightforward; however, because most of our providers were community providers who had practiced in these rural settings for several years, they had already established intimate relationships with their clients and between each other. We were the outsiders, introducing the new concepts of case management and provider quality initiatives into their health care system. Our strategy was to approach our providers by first listening and identifying the most pressing Medicaid need within their practice. For example, if a provider was preparing for a state Medicaid asthma chart audit, I would first address their asthma audit needs with tools available in our program. Or, if they had Medicaid billing issues, I would ask our state Medicaid managed care regional consultant to visit the practice first. If certain Medicaid clients were routinely not showing-up for appointments, I would call the patients to discuss any possible barriers that made it difficult to go to their doctor's appointment. With time, by listening to, respecting, and addressing their concerns, we established positive provider relations with our Union and Anson County primary practices and in turn built trust for our new Medicaid program.

This relationship, built upon a partner/patient advocate role with the Union and Anson clinical care providers resulted in better outcomes for patient care. Practices viewed clinical resources such as asthma action plans and patient education materials as a benefit to their patients, not as an intrusion to their practice. Also, providers became open to quality feedback and reporting as I visited their practices to explain the quarterly state quality reports and helped them to prepare for state Medicaid chart audits. Providers also began proactively sharing with me concerns they had about Medicaid clients or changes to their practice. This allowed me to be more proactive in arranging for patient services and resulted in decreased time "putting out fires."

We also decided to draw on a key strength of a rural setting—a very strong sense of community—which is something that an urban setting often lacks. We collaborated with community leaders and primary stakeholders in the community to work more closely together and thus enhance the resources already in place. Instead of "recreating the wheel," over time we established partnerships in the community with existing programs and found the opportunities were endless. We also wanted to provide convenience for clients by incorporating parenting classes into existing parent meetings or holding classes in community church locations. Sensitive to the lack of public transportation in these communities, CCPGM often coordinates patient education classes in the evening to allow patients' family members to drive them to the classes. This is not necessarily the case in Mecklenburg County, where most

patient education classes can be held during the day as patients can take public transportation.

CCPGM works with the Union County Local Interagency Coordination Council (LICC). The LICC's objective is to coordinate agencies within Union County serving children ages birth to five and ensure that care for children with special needs is well-coordinated. CCPGM is currently collaborating with the LICC to update the Union County Early Intervention Resource Manual for providers. The Resource Manual acts as a referral guide for physicians and their practice staff to assist them in identifying an appropriate agency that can assist a child with developmental delays. The efforts of the LICC support the coordination of care for children with special needs in the community.

Over the past several months, our program took the initiative to form the Union County Asthma Coalition in collaboration with the Clean Air Coalition, the Union County Health Department, Smoke Free Union, and the CMC Union Hospital Respiratory Care Unit. Although in its infancy stages of development, the Union County Asthma Coalition has participated in community health fairs and was successful in placing asthma articles in local community newsletters to increase asthma awareness. The Asthma Coalition has also been successful in implementing school programs focused on education and air quality. CCPGM also works in close collaboration with public school nurses, meeting with them on a regular basis to coordinate health services for school children receiving Medicaid or HealthChoice.

For several years, CCPGM has offered newborn parenting classes called "Healthy Beginnings," in partnership with the Parenting Coalition at Union County Health Department and the Help Crisis Pregnancy Center. One of the goals of this class is to improve parent education on issues related to the safety and welfare of the newborn child, while achieving the goal of reducing inappropriate emergency department (ED) visit utilization. In addition, CCPGM provides Healthy Beginnings classes at parent meetings for the Head Start program and, with a growing Latino population in Union and Anson Counties, CCPGM has partnered with the United Way Latino Outreach Specialist to provide Health Beginnings classes and health information in Spanish.

Just as we faced challenges with the network providers for our new Medicaid program, we were also challenged by our clients and the most appropriate approach regarding case management of chronic health problems, frequent ED visits, and hospital readmissions. In communities lacking in public transportation, community programs, support groups, and financial resources, this was very difficult. We decided to incorporate the same simple strategy of relationship building with our clients that we did with our providers. We were pleasantly surprised that our providers supported us in building strong client relationships by referring patients to our program. For example, children with frequent ED visits for asthma episodes were often referred to me by the primary care provider. I followed-up with the parents and patient, ensuring they understood the importance of their asthma maintenance

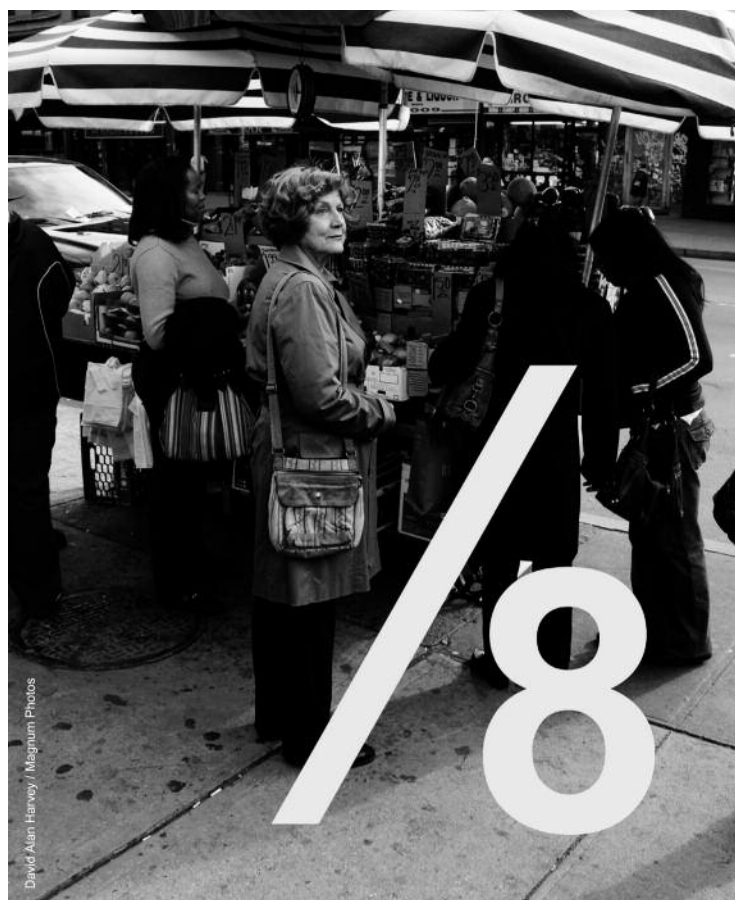
medication. Clients and providers are often pleased that a little asthma education and follow-up can reduce ED visits and subsequent asthma episodes. In rural communities, the emergency room is often much further away than in urban communities, so reducing asthma episodes becomes even more important in counties such as Union and Anson. Also, as a nurse case manager, I often meet clients in the clinic setting at the provider office where our presence is much more

welcomed. As a result, our clients were more open to talking with us about barriers to their health care needs.

The rewards have been great and are due to this grassroots approach. While we will certainly have continuing challenges as our population grows and demographics change, we hope to continue to build many more close relationships and look forward to the continued growth of our program and that of others. **NCMJ**

REFERENCES

- 1 Community Care of North Carolina website.
<http://www.communitycarenc.com/>. Accessed April 10, 2009
- 2 North Carolina Office of State Budget and Management website. 2007 certified count population.
http://www.osbm.state.nc.us/ncosbm/facts_and_figures/socio_economic_data/population_estimates. Accessed April 10, 2009.



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