

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