

Flexibility in a CCNC Network: The Northwest Community Care Experience

Elizabeth Gamble, MSPH, MD; James Graham, MHA; Kelly Livengood, RN; Lorelee B. Inman, RN; Ronald E. Gaskins, MBA, MPA; Linda J. Michalski; Rebecca Eleanya, MBBS, MPH

Northwest Community Care Network (NCCN) operates in six counties (Surry, Wilkes, Stokes, Davie, Yadkin, and Forsyth) in northwestern North Carolina. In 1998, the Office of Rural Health and the Department of Health in Surry County began a managed care pilot project for the county's Medicaid population. These pilots, then known as Carolina Access II, were "developed to enhance recipient access to primary care, to improve the coordination of care, and to reduce recipient reliance on hospital emergency departments."¹ In 2003, the project was expanded to all counties in North Carolina and Community Care of North Carolina (CCNC) was created, comprised of 14 networks across the state. Surry County joined the five other counties listed above to form Central Piedmont Carolina Access II. Originally a limited liability corporation, in 2005 Piedmont Carolina Access II became Northwest Community Care Network, a not-for-profit organization currently serving over 72,000 Medicaid recipients. The governing board is made up of each participating county's public health director, the NCCN medical director, and a representative from North Carolina Baptist Hospital.

The change to not-for-profit status, subsequently made by each network in North Carolina, has allowed for a broader range of projects and has removed barriers to grant applications. The NCCN board governs fiscal as well as operational activities and is charged with approving all projects undertaken by the network. This governance structure allows for flexibility in addressing the core tenets of CCNC as well as incorporating local and regional interests and resources. All of the current

projects at NCCN embrace this flexibility and utilize local resources, an approach reflected in the uniqueness of the projects and initiatives, case management, and network administration in NCCN.

Projects and Initiatives

Of the over 20 specific clinical projects currently active in NCCN, eight originated from the central CCNC office. These include the Behavioral Health Initiative, the Kate B. Reynolds Stroke Reduction Grant, the Chronic Care Program for the Aged, Blind, and Disabled, Emergency Department Diversion, Congestive Heart Failure Management, Improving Pediatric Access through Collaborative Care (IMPACC), Yadkin Healthy Carolinians/Stanford Model Self-Management, and Intensive Pharmacy Management/Network Pharmacist. The goals for CCNC projects are characterized by clear goals for the populations served, but the means to achieve them are not centrally prescribed. Each CCNC network is able to undertake different approaches to fulfill the goals of each program.

This flexibility allows for increased experimentation and the rapid spread of subsequent knowledge of effective practices and methodologies. This freedom and individualization have allowed for the success of many of NCCN's programs.

This flexibility was useful and effective for implementing the Behavioral Health Initiative, since the model had to be modified to the individual resources, interests, and constraints of each practice in NCCN. This necessary modification was

*The strength of
CCNC has been its
ability to address
issues in a timely
and innovative
manner.*

Elizabeth Gamble, MSPH, MD, is the medical director for the Northwest Community Care Network and an assistant professor of internal medicine at the Wake Forest School of Medicine. She can be reached at [ergprl \(at\) earthlink.net](mailto:ergprl@earthlink.net).

James Graham, MHA, is the executive director of Northwest Community Care Network.

Kelly Livengood, RN, is the lead case manager in Forsyth County for the Northwest Community Care Network.

Lorelee B. Inman, RN, is a network coordinator for Surry County for the Northwest Community Care Network.

Ronald E. Gaskins, MBA, MPA, is a network support manager for the Northwest Community Care Network.

Linda J. Michalski is the operations manager for the Northwest Community Care Network.

Rebecca Eleanya, MBBS, MPH, is a project manager for the Northwest Community Care Network.

the result of the upheaval in the mental health system in North Carolina occurring at the time the initiative was being implemented. The original practice for this project had been a site for a demonstration grant funded by the Duke Endowment and was led by Dr. Jane Foy at Wake Forest University Pediatrics. The NCCN network was able to take that example of co-location (where a behavioral health practitioner is located in a primary care clinic) and expand it into four more practices, with each of the practices uniquely incorporating NCCN's experiences and the practice's own parameters. This includes a "reverse co-location" project in a safety net outpatient psychiatric practice where a primary care practitioner has been moved into the psychiatric location.

For the Kate B. Reynolds funded program, NCCN built on the work of Dr. David Goff at the Wake Forest University Division of Public Health and his GLAD Heart Trial, which used academic detailing to increase awareness of hypertension treatment and risk guidelines for cardiovascular disease.² Because it proved so effective, the academic detailing guide was then shared with the other two CCNC networks participating in the project. With the Chronic Care Pilot in Surry County, network coordinator and lead case manager Lori Inman assembled a team that developed a program for identifying, evaluating, and better managing the chronic health problems of the aged, blind, and disabled (ABD) population. Dr. Jim Wofford at the Downtown Health Plaza, which has an ABD population of approximately 2,800 patients, is currently developing an individualized program to help with overutilization of the emergency department.

NCCN's local projects demonstrate the great strength of CCNC: local engagement. The network integrates input and contributions from all levels and asks participating practices and local partners to engage NCCN with questions and ideas for bettering the program. The key link in this process is the free flow of information among the member practices, case managers, county medical directors, and the network staff. In each county there is a county NCCN medical director who serves on the Network Medical Management Committee, as well as his or her county's steering committee. Many interesting and creative projects have come out of these group meetings. One example is the Davie County Day Care Asthma/Obesity Program, which is lead by the medical director in Davie County. This program is looking at the management of asthma in day care and developing asthma action plans for these children as well as diet counseling for the children and the parents. The Chronic Pain Program in Wilkes County began after the local Wilkesboro Healthy Carolinians group and the medical director noted a large number of unintended deaths from prescription narcotics. This program has expanded with the creation and incorporation of the Lazarus Project which involves giving nasal naloxone to each person who is prescribed a narcotic and arranging the use of a case manager in the emergency department of the county hospital. Dr. Su Albert, the Wilkes County medical director, championed the use of a family nurse practitioner in a nursing home in order to evaluate the cost savings and quality improvement in nursing home care

gained by placing a physician extender in that setting. Lastly, Project INFORM, an intensive diabetes management program that is based on the interventions in the Action to Control Cardiovascular Risk in Diabetes (ACCORD) study³ works to improve compliance and glycemic control with patients at the Downtown Health Plaza—home to NCCN's largest Medicaid population. Additional NCCN projects include Stokes County Diabetes, Stokes County Mental Health Coordinator, a Hospital Readmission Study, the Surry Diabetes Patient Education Program, an Uninsured Medication Project, an Obesity Roundtable, and a Masters of Public Health Practicum.

The NCCN has also benefitted from the presence of the Translation Science Institute (TSI) at Wake Forest Baptist Medical Center, an important local resource for NCCN, in particular the community engagement component. Dr. Jane Foy, already involved with the Behavioral Health Initiative, joined NCCN's Medical Management Committee. She felt that the model of a physician-based network was one to be emulated by TSI and, due to the increase in the infant mortality rate in Forsyth County in 2007, the network formed a coalition with TSI, the Infant Mortality Reduction Coalition at the Forsyth County Health Department, Triad Baby Love, Mom Baby, the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill, and the Departments of Pediatrics and Obstetrics and Gynecology at Wake Forest University Baptist Medical Center. The first work to come out of this coalition was the 17-P Project. With the help of an epidemiologist at TSI, the coalition designed a study examining improvement in infant mortality, morbidity, and pre-term birth rate with the increased use of 17-hydroxy prednisolone caproate (17-P). These interventions included university-based educational outreach (academic detailing) to all providers of prenatal care in Forsyth County, general public education of the benefits of 17-P, and postnatal and intraconception education to pediatricians, as well as parents and other caregivers, on children born pre-term.

Case Management

The primary directive for all CCNC networks is to provide case management to all enrolled Medicaid patients as a means of improving quality of care and reducing costs. The unique NCCN model of contracted nurse case management within health departments allows the network a direct connection with local communities and county leaders through the county health departments. This allows for easy, timely referrals to local programs, such as Baby Love (maternity care coordination), child service coordination, Health Check coordination, and school nurses, along with awareness of community programs to which to refer our clients/family members who are under- or uninsured. In addition, this arrangement expedites clinical involvement in public health issues such as lead exposure, air quality, violence, and diversity—all of which affect the Medicaid population.

Forsyth County has two large tertiary care hospitals—North Carolina Baptist Hospital and Forsyth Medical Center.

Managing patients in these two health care systems generates issues that do not arise in the other counties of the network. In particular, transitional care has required the creation of a transitional case manager to span the gap in care between hospital discharge and reconnection with a primary care provider. In other counties, the number of patients is more manageable and transitional care can be integrated into the scope of care of the regular case manager.

Of NCCN's six counties, three have one case manager, another has two, the fifth has four, and Forsyth County has eight. A bimonthly case managers' meeting serves to bring case managers together for updates of individual county activities, to participate in group trainings, and to foster collegiality. Because of concerns raised by the case managers about the use and abuse of personal care services, several of them are becoming or are certified to evaluate patients for these services. The case managers have been instrumental in developing a communication bridge with county Departments of Social Services (DSS). There is now a network DSS liaison whose job is to sustain and improve the communication between the network and local DSSs. Many of our case managers have voluntarily obtained case management certification. Case managers are the substance of our program and without their hard work, insights, ideas, and suggestions, none of the work of NCCN could or would be done.

In addition to the nurse case managers, the network has a full time pharmacist who participates at all levels by attending steering committee meetings and meetings of the Medical Management Committee. In addition, she also does individual medication reviews, visits practices, and consults with case managers. She was instrumental in developing the pharmacy

home for our network and helped the network build strong allegiances with local pharmacies.

Administration

The NCCN administration staff consists of five people who are employees of North Carolina Baptist Hospital and contracted to NCCN as a management group. The original group has expanded the number of projects and has adopted the chronic care approach to patient management. NCCN now has an executive director, support manager, operations manager, and an administration assistant. This group works together as a team in running the network with weekly staff meetings in addition to case management and project meetings. There is also a monthly management team meeting with the same staff for larger issues such as project reviews, budgetary decisions, and goal setting. This team approach has allowed NCCN to develop a horizontal management environment as opposed to a pyramid structure, with the free flow of ideas across, up, and down the organizational structure. NCCN's executive director is the leader of our group but rarely makes a decision without consulting all the members of the management team. Ultimately, the Board is the final arbiter in the business of the network.

The strength of CCNC has been its ability to address issues in a timely and innovative manner. This has been accomplished by allowing different approaches to answering the same question and encouraging solutions at all levels of the organization. At Northwest Community Care Network, we feel that we have prospered by replicating and utilizing this model of flexibility and ingenuity. **NCMJ**

REFERENCES

- 1 History of CCNC. Community Care of North Carolina website. <http://www.communitycarenc.com>. Accessed May 27, 2009.
- 2 Rosenberger EL, Goff DC, Davis CC, Blackwell CS, Bertoni AG. Control of blood pressure in North Carolina primary care: baseline data from the GLAD Heart Trial. *NC Med J*. 2008;69(6):441-446.
- 3 ACCORD Study Group; Buse JB, Bigger JT, Byington RP, et al. Action to Control Cardiovascular Risk in Diabetes (ACCORD) trial: design and methods. *Am J Cardiol*. 2007;99(12A):21i- 33i.