

Community Care of Wake and Johnston Counties

Paul Harrison

Jim Bernstein's vision of a locally-organized and effective care management program for Medicaid enrollees is alive and well in Wake and Johnston Counties. The Wake County Medical Society Community Health Foundation, with a focus on increasing access to health care for the least advantaged in our community, applied to become a local Community Care Network for Wake and Johnston Counties in late 2002. Prior to that date, there were no organized efforts to coordinate care for chronically ill patients with physicians, hospitals, mental health, and public health providers in this community. Community Care of Wake and Johnston Counties (CCWJC) quickly became a coordinating resource to expand providers' capacity to manage care and patients' needs on a community-wide basis.

CCWJC and Its Process

Currently, CCWJC serves 74,000 patients in association with 100 participating primary care practices in the two counties. Participating primary care practices receive a monthly "per enrollee per month" fee to better manage Medicaid patients with a focus on patients with comorbid chronic conditions, frequently including a mental health diagnosis. CCWJC works with local physicians to ensure patients comply with physician's orders, including filling prescriptions and using medications as prescribed. In addition, CCWJC has established close working relationships with each of the five hospital facilities in the two county service areas. The hospital corporations have allowed CCWJC access to daily discharge summaries for inpatient, observation bed, and ED utilization. CCWJC is able to use this real time data to meet with patients and intervene in the potential cycle of frequent rehospitalization. To this end, CCWJC has posted nurse case managers at WakeMed Raleigh based on the volume of patients served by that facility in order to meet with patients and develop both a personal relationship and a plan of action to prevent rehospitalization. This is a challenging social process, especially when the patient has a mental health diagnosis in addition to comorbid chronic physical conditions. CCWJC created two teams of nurse case managers, adult and pediatric, to follow patients after a hospitalization. For example, a young man with a bleeding ulcer was recently discharged from a local hospital without outpatient prescription medication. However, he was

given instructions to use over-the-counter medications, despite the fact that the patient's discharge summary stated there should be no further use of over-the-counter medications by this patient. A CCWJC nurse case manager intervened by arranging an urgent office visit at the patient's medical home where the patient's primary physician prescribed the proper medication. The case manager worked with the patient to ensure he filled and used the prescription, thereby avoiding an almost certain rehospitalization.

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CCWJC Support for Primary Care, Patient-Centered Medical Home Settings

CCWJC, with its many links to the local health care system, is uniquely suited to support primary care provider's (PCP) patient-centered medical home settings. Nurse case managers work in the medical home settings to intervene with patients who are frequent users of health care services and/or non-compliant with physician's orders. In addition to the real time hospital discharge summaries, physicians are a key source of referrals to the case managers for either noncompliant patients or patients who have a pattern of aberrant hospital utilization. In addition, the Case Manager Information System (CMIS), a Medicaid claims data repository, provides a historic perspective of patients' utilization data, which serves as a third type of referral source for patients with abnormally high or low utilization data. Prescription compliance and hospital

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facility utilization are key indicators in CMIS, which focuses on the frequency of inpatient stays within the past six months, two ED visits within the past six months, or four PCP or specialist visits within the past six months. For example, historic CMIS data revealed a Medicaid patient who had been resident in a local hospital for more than four months. After evaluating this 53-year-old morbidly obese, hypertensive patient with diabetes and kidney failure, a nurse case manager learned the patient could not be discharged because the requirement for outpatient kidney dialysis could not be fulfilled. Specifically, local outpatient dialysis units lacked a patient dialysis chair that could accommodate a patient of their size. The nurse case manager arranged for the patient to be dialyzed while reclining on a reinforced stretcher at the outpatient dialysis center and arranged transportation from home to the dialysis center using an ambulance service with bariatric patient transport capacity, including special stretchers, ramps, and lifts with up to 700-pound patient capacity.

Nurse case managers also provide valuable follow-up with patients including telephone follow-up, home visits, and/or joining the patient for medical appointments. These interventions are designed to strengthen the link to the primary care provider, facilitate greater patient self-management, and link the patient with useful community resources to ensure the highest degree of patient compliance.

Another CCWJC resource for patient-centered medical home settings includes pharmacy initiatives to ensure patient compliance with medications while providing practices support with local pharmacies and pharmacists. A staff network pharmacist employs specialized software in order to contain costs by ensuring that patients receive prescribed medications. By using this tool, the pharmacist is able to develop a snapshot of medication adherence and compliance. The central role of the network pharmacist is to design a clinical approach that focuses on improving drug therapy management, cost-effectiveness, and coordination of local services for all Medicaid patients and especially for those patients designated as aged, blind, and/or disabled in the Medicaid population. The network pharmacist also conducts medication management reviews directly with the patients. Finally, the network pharmacist assists the primary care physician with a better link to local pharmacists by working to ensure that local pharmacists understand Medicaid pharmacy policy, drug information, and unique cost-saving opportunities for low cost over-the-counter medications, such as proton pump inhibitors and non-sedating antihistamines, which have unique covered benefit status under Medicaid.

CCWJC has established two pilot mental health co-located practices, which combine both primary medical care and mental health services within one practice. In addition, CCWJC nurse case managers work to integrate patients' mental health needs further through greater coordination with the Local Management Entity (LME), a county agency with responsibility to coordinate mental health care services within its jurisdiction. In this case, the nurse case managers seek to ensure that all patients' mental and physical health

needs are met to the greatest degree possible. CCWJC works to establish linkages between primary care practices, mental health services, hospital discharge systems, and community resources of all types to help manage very sick chronically ill patients. This holistic approach best serves the aged, blind, and/or disabled populations by strengthening the links that best address patients' needs in concert with the patient's primary care medical home.

The management of patients with multiple comorbid conditions dovetails closely with both CCWJC disease prevention and chronic disease management initiatives. Periodic, practice specific chart reviews are used to track progress with quality standards over time for management of chronic diseases such as asthma, diabetes, and congestive heart failure. CCWJC provides resources and information on best practice strategies associated with national standards to support adherence to those guidelines. Nurse case managers provide support for high-risk patients with chronic diseases and work to improve coordination of care by utilizing all of the resources available within the community. For example, in the case of asthma, providers are given tools that align with national guidelines on asthma management, including asthma control tests and asthma management plans, to use with their patients. In addition, the case managers can arrange for an intensive in-home assessment of environmental asthma triggers through joint efforts with Wake County Environmental Services.

Prevention initiatives are closely associated with CCWJC, and the network has created separate prevention tracking reports for pediatric and adult populations. The pediatric tracking list includes body mass index, lead levels, developmental screening, vision, hearing, vaccine, and tobacco use determination. The adult preventive tracking tool includes smoking cessation, blood pressure screening, vaccines, and consideration of a daily aspirin regimen.

CCWJC and Expanded Access to Care for Medicaid Patients

In the past year, CCWJC staff has recruited 16 new primary care practices to Community Care. Some practices are new to the Medicaid program and other practices have converted from Carolina Access I to Carolina Access II or directly to Community Care. Since early 2008, this represents a 25% increase in primary care practices, from 61 to 77 practices. A second access to care effort focuses on increasing the cultural and linguistic capacity of private providers to care for children of Spanish-speaking families, which helps assure timely and easier access for newborn and infant patients.

To help break barriers for this population, the CCWJC medical director, Elizabeth Tilson, MD, MPH, has secured grant funding for Su Hogar Médico (Your Medical Home) through the local John Rex Endowment. The goals include working with 10 primary care practices to increase adherence to federal standards for culturally and linguistic appropriate services. Bilingual and bicultural "practice liaisons" work with

the practices to provide verbal interpretation for patients, written translation of signage, key messages, written patient instructions, and referral and resource information. Another goal of the program is to increase the local bilingual health care work force. Using scholarship support from the grant funds, CCWJC is working with Wake Technical Community College to train qualified bilingual candidates in health care fields, including certified nursing assistants and medical assistants. The intent is that these bilingual health care workers would be hired by local practices, thus increasing their internal language capacity and decreasing the need for the practice liaisons.

CCWJC Future Directions

CCWJC will continue to develop linkages between primary care medical homes and local mental health services (local management entities or LMEs). The LMEs in both counties will be a critical part of that process; however, all resources will be examined and incorporated to assure that mental health and substance abuse are included in the patient assessment in addition to physical health issues. The current limitation on sharing patient data for these conditions continues to be problematic. However, as the problem of patient data sharing is resolved by legislative or regulatory action, CCWJC

will be best positioned within the community to assure that Medicaid patients are served in a holistic fashion.

CCWJC will develop more and more effective strategies to prevent unnecessary hospitalization or hospital utilization. Current reporting tools, mentioned above, offer only a retrospective view of patient utilization. CCWJC is seeking new partners with a proactive focus. Wake County Emergency Medical Services (Wake EMS) is interested in a joint effort to reduce repeat hospitalizations by visiting with patients on a preemptive non-emergency basis to increase the likelihood that the patients' compliance will reduce repeat hospitalizations. CCWJC is exploring data sharing with Wake EMS in order to focus on the needs of the Medicaid population. However, current limitations in data sharing limit the potential of this effort for the moment.

And finally, at least for the moment, CCWJC will work to maximize the most productive and effective use of electronic medical record (EMR) systems, especially in association with the anticipated stimulus package for this purpose and related e-prescribing initiatives. The EMR initiative will seek to combine the interests of the four local hospital corporations and private practice physicians through an integrated community effort that will further enhance all the collaborative efforts described above, with the goal of continually improving the quality of care to the Medicaid population. **NCMJ**

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