

The Evolution and Development of a Largely Rural Network: Access III of the Lower Cape Fear

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Like all Community Care of North Carolina (CCNC) networks, Access III of the Lower Cape Fear, Inc. (ALCF) emerged from the vision of state level leaders Jim Bernstein, Tork Wade, Dr. Allen Dobson, Denise Levis, Dr. David Bruton, and others. In our case, Jim Bernstein and Tork Wade approached Dr. Dan Gottovi and Dr. James Jones to spearhead the development of Access III. With their leadership, ALCF was organized during 2002 and was the first Community Care of North Carolina Network to emerge as a five county operation from its inception; most networks developed to that point started with one or two counties and then joined with neighboring counties. The decision to develop a multi-county network was also stimulated by the decision that a regional network must have at least 30,000 patients to become a network. North Carolina has many rural counties, especially in the east, and five counties would need to band together to meet that 30,000 patient threshold in our region. Thus our original makeup in 2002 included Bladen, Brunswick, Columbus, New Hanover, and Pender counties. Subsequently, Onslow County elected to join our network.

In 2002 the state CCNC leadership outlined these key tenets for the networks: 1) all new networks would have at least 30,000 patients; 2) every network would be governed by a board that functioned as a partnership between hospitals, health departments, departments of social services, and primary care providers; and 3) each network would tackle five key issues: asthma, diabetes, unnecessary emergency room use, lowering prescription drug costs, and managing high risk/high cost patients.

With that outline in place, local areas were asked to bring these networks to life, which would require a key group of local physicians to recruit practices and support the clinical initiatives and an administrative leader to staff and operationalize the vision. That meant the involvement of key local physicians and an administrative leader was necessary to operationalize the vision. In the southeast, ALCF was fortunate to have Dr.

Gottovi, the original founder of Wilmington Health Associates, North Carolina's largest multidisciplinary medical practice, and a key leader of the local and statewide medical community, as the physician charged with organizing our network. Dr. Gottovi, in turn, called on Dr. Jones, a prominent family practice physician and founding chair of the East Carolina University Department of Family Medicine and former head of both the US and the North Carolina Academy of Family Physicians, to be the first chairman of the Board.

Working together, Drs. Gottovi and Jones were able to easily recruit key leaders from the local health departments,

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departments of social services, hospitals, and the physician community in each county to serve on the board. A full board emerged in late 2002, and ALCF was incorporated in November. Once incorporated, Drs. Gottovi and Jones quickly recruited primary care practices in our region to join the network. The program was easy to sell to providers as they were already seeing Medicaid patients, and they had already agreed to serve as a medical home through the Carolina Access Medicaid program. Signing up with our network would increase the management fees from \$1.00 for each Carolina

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Access Medicaid patient assigned to their practice per month to \$2.50 and would bring the practice access to disease management tools and the services of a case manager. It took only a few short months of a practice recruitment campaign involving letters and visits to practices for Drs. Jones and Gottovi to recruit almost all the eligible practices in our region. Today, Access III includes nearly all of the eligible primary care practices in our region, for a total enrollment of 128 practices and almost 50,000 patients.

With practices coming on board and a Board of Directors in place, it was time to begin the recruitment process for an executive director and staff. I was chosen for this position in July of 2003, having had experience as a policy advisor to Governors Jim Hunt and Mike Easley and with experience with working on Medicaid quality and cost containment strategies at the National Governors Association's Center for Best Practices. Luckily for Access III, Dr. Gottovi also agreed to join the staff as a part-time medical director. His duties included serving both on the statewide team of clinical directors, who shape the direction of the program, and leading our local efforts to reach out to practices and providers. Once Dr. Gottovi's family moved to Raleigh, Dr. Jones stepped down as board chair to become our current medical director.

With a clear outline of the clinical issues we were to address, with a Board of Directors, an executive director, and a medical director in place, and with practices recruited, we were ready to start bringing the vision of Access III (CCNC) to life. Practices received portions of the capitation funds to support them in implementing our quality improvement strategies, and networks received their portion to support the case management functions of the network. Our network's budget now includes funds for an executive director, medical director, case management coordinator, 15 case managers, a quality improvement coordinator, a registered dietitian, a PharmD, an administrative support team, and the costs associated with supporting these roles (e.g. training, travel, benefits, insurance, rent, and equipment). In addition, we budget funds for hosting evening meetings with guest speakers to provide continuing medical education (CME) credits for providers and for printing patient and provider educational tools.

As we began to shape our network, it was clear what our focus would be: 1) helping practices and patients to adhere to National Institutes of Health (NIH) treatment guidelines for asthma; 2) helping practices and patients adhere to American Diabetes Association guidelines for diabetes; 3) reducing unnecessary emergency room use by redirecting patients to their medical home for nonemergent care visits; 4) helping providers remember to use the Prescription Advantage List (PAL), a voluntary formulary put in place to save state funds based on what is prescribed; and 5) case managing other high cost/high risk patients. However, how to implement these initiatives was left to each network to determine. Therefore Dr. Gottovi and I, along with the 10 case managers hired in September of 2003, spent many weeks around a conference table determining how we would interact with patients and

providers, what tools we would offer to providers and patients, and what training programs would be put in place to support providers and case managers in implementing our initiatives.

As part of our efforts to engage providers, we determined that we wanted our case managers to be considered an extension of their practices and a part of the patient's care team—a flexible resource to help them with their difficult patients. Therefore, we assigned case managers to a particular set of practices so that they could develop a close, ongoing working relationship with providers and staff in those practices. Our goal was for the provider to refer patients who were having difficulty self-managing the disease to the case manager. The case manager could then conduct a home visit, call the patient on the phone, or meet them in the practice to reinforce the doctor's treatment plan and gather information for the provider that might inform the treatment plan.

We also decided that we were primarily in the business of the education and reinforcement of national, evidence-based treatment guidelines for managing certain chronic illnesses. We started our efforts with asthma. Dr. Laura Gerald, a practicing pediatrician and the state's asthma consultant, served as a guest speaker at evening meetings of network clinical leaders where we offered Level 1 CME credit. These were held in central locations throughout our six-county network. At the meetings, providers were educated about NIH asthma guidelines and given tools developed by CCNC and our own network that boiled those hundreds of pages of guidelines into simple prompt sheets that would help the provider at the point of care to stage the patient's asthma severity, prescribe the right medications for each stage, and offer each patient an asthma action plan to help them know how to self-manage their asthma and know what to do in the case of an attack. Our purpose was to make "doing the right thing" for the patient much easier to do for the provider, regardless of the patient's insurance type. We hoped the gains in care quality would impact all patients in the practice.

The case managers worked as embedded quality improvement resources in their practices, working with staff to determine how to best integrate the disease management tools into the practice's work flow. In addition, all of the case managers pursued a four-and-a-half month distance learning asthma management certification course, offered by the National Respiratory Training Center, and used their extensive asthma education to help reinforce the doctor's treatment plan with the patient. They would conduct home visits and assess the asthma triggers that may be in the home (e.g. smoke, pets, cockroaches, and strong chemicals), talk to families about eliminating such triggers, explain proper medication use with parents and children, help label daily maintenance medications versus rescue inhalers, and go over the doctor's asthma action plan to ensure everyone understood how to follow the provider's instructions for managing asthma daily and in the event of an attack.

The results of our combined efforts with providers and patients regarding asthma were dramatic. Before we began

our educational efforts, a baseline review of a random sample of charts in our network for the four key NIH asthma guideline measures: percent staged, percent stage II-IV on a controller medication, percent with an action plan in the chart, and percent flu shot given. That initial review indicated that 20% of asthma patients had the severity of their asthma staged, 73% of those were stage II-IV with a maintenance medication prescribed, no charts had an asthma action plan in place, and 23% had a flu shot documented. Just one year after we began our educational efforts, these numbers jumped from 20% to 46% staged, from 73% to 96% stage II-IV on a controller medication, from 0% to 71% of charts with an asthma action plan in place, and from 20% to 40% with a flu shot documented. The key to preventing asthma attacks is whether a daily maintenance medication is prescribed for those with more severe asthma, so we were thrilled to see that number climb to nearly 100% and to have it remain at that level each year thereafter. More importantly, a review of claims data for asthma patients with an inpatient visit over the same period of time shows a decline from almost 20% of asthma patients having an inpatient visit to 11%, a 45% drop in inpatient rates.

On a more personal level, the importance of our work can best be demonstrated with an example of the relationship between provider, patient, and case manager. Dr. Jugta Kahai, a pediatrician in Oak Island, North Carolina, had a nine-month-old asthma patient who had multiple other complex medical and respiratory issues. The parent's mother spoke Spanish and had some transportation barriers, but came to the doctor with an interpreter and seemed to understand the instructions given. Despite Dr. Kahai's precise instructions, the patient wound up having such severe asthma attacks that he was repeatedly taken to the emergency room and wound up getting admitted to the Pediatric ICU at UNC Chapel Hill. Dr. Kahai referred the case to Connie McMurry, her Access III RN case manager, for a home visit. Upon arrival, one of the culprits was clear. While attempting to keep her house immaculately clean and free of dust triggers, the patient's mother was scrubbing the surfaces of their tightly confined trailer with a solution of bleach. The chemical exposure in the confined space triggered the acute asthma attacks. Ms. McMurry also learned that the mother had discontinued use of the oxygen and the apnea monitor ordered by Dr. Kahai because she had not understood their importance. Ms. McMurry was able to congratulate the mother for her good cleaning habits but educate her about safe cleaning techniques and the importance of the oxygen and the apnea monitor. Ms. McMurry also learned that the mother could not follow the prescription instructions as they were written in English so, working with our PharmD, the case manager had those prescriptions translated into Spanish. Over time, Ms. McMurry also learned that the child was having episodes at daycare where his care givers did not understand how to care for a child with asthma, including the importance of keeping him out of the sand box. Ms. McMurry scheduled a time to teach approximately 50 daycare employees about asthma

and how to identify signs and symptoms, avoid triggers, and give medications as directed on the asthma action plan. Thanks to a host of interventions by the provider and case manager, the patient is now three years old and is much healthier. He has had some relapses due to the severity of all of his issues but has had far fewer trips to the hospital and enjoys a much better quality of life.

Subsequent to rolling out our asthma management program, each disease state initiative thereafter was rolled out in a similar fashion with evening meetings for providers. CME credit was available, quick reference tools for the treatment guidelines were on hand, and extensive education and training was provided to case managers to ensure that they could be effective health educators for the patients. In addition, our network hired a quality improvement coordinator who was charged with visiting practices, often with the medical director, to provide them with performance feedback from the state's annual chart review process in which the adherence to national guidelines for asthma and diabetes is measured through a review of a random sample of charts. Providers use the feedback to tweak their processes to better incorporate the guidelines and better manage their patients. The quality improvement coordinator also visits practices to apprise them of any new initiatives or special programs we are undertaking and helps us to recruit practices that have yet to join our network.

Today, North Carolina's Community Care effort is beginning to move in a different direction. There is a realization that we must strive harder to improve the health of the complex and costly aged, blind, and disabled (ABD) Medicaid population, the 25% of the Medicaid population who account for 75% of Medicaid costs. To do so requires addressing the needs of patients with multiple comorbidities and utilizing a different approach to working with practices and patients. Rather than rolling out an initiative for every chronic disease, we are now taking a chronic care approach, focusing on the general needs of all complex patients. Specifically, we are focusing attention on helping patients to make a successful transition from hospital to home so that they are not readmitted for a hospitalization for complications in their recovery that could have been avoided.


Our efforts have led us to even closer relationships with our hospital systems. We receive a daily list of our admitted patients. We then screen their conditions to identify patients who may be unstable and likely to relapse. For those screened unstable, a case manager visits them in the hospital to introduce our program and to indicate that one of our case managers will be visiting them within three days of their discharge. During the home visit, the case manager determines if they have filled their prescriptions, if necessary services such as home health care have been ordered and are in place, if follow-up doctor's appointments have been made, and if they understand their treatment/recovery plan. Case managers also make a list of all the medications they are taking and they submit that information and the provider's discharge instructions to our PharmD on staff to review for any discrepancies. Between January and June 16, 2009, we have reconciled medications on

238 patients and found 852 discrepancies, an average of 3.5 per patient. The most common discrepancies are continuation of prior medications (not on discharge instructions, but found on home assessment), medication compliance, medication dose/frequency issues, and therapeutic duplications. We inform the provider of these discrepancies so that they can make any necessary changes directly with patient and pharmacy. Clearly this is a very high rate of medication discrepancies, and we are certain that many unnecessary complications will be avoided through that intervention alone.

Although we do not yet have any concrete data about the results of our recent switch to a chronic care focus, anecdotally we know we have solved many problems, particularly with medication errors, and have most likely prevented some severe complications. These are very complex patients who

need a lot of help in following up on their medical appointments, linking with appropriate community resources, and following through on their treatment plans. In addition, our providers seem to welcome our attention to this group of patients who are often the most difficult to manage. Our quality improvement coordinator offers the list of ABD patients at his meetings with practices, and the providers immediately want to look through it and discuss strategies for working with their case manager on patients. We are excited about our new direction and feel as though this focused approach on the sickest patients will definitely improve the care they receive, prevent unnecessary complications, improve care quality and quality of life, and ultimately save tax dollars—a true win-win for all. **NCMJ**

Eat Smart, Move More Health Tip



Tame the Tube— and Get Moving

Many of us say we don't have time for physical activity, yet we spend 3 to 4 hours in front of the TV. Not only are we inactive while watching television, we often snack on high-calorie foods at the same time. Trade TV time for physical activity. Walk or bike with your family after dinner. By planning TV time, you'll have more time for physical activity.

For more tips on how to tame the tube where you live, learn, play and pray, visit

www.EatSmartMoveMoreNC.com

