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The political economy of a public health case management program's transition into medical homes

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ABSTRACT

Throughout the United States, public health leaders are experimenting with how best to integrate services for individuals with complex needs. To that end, North Carolina implemented a policy incorporating both local public health departments and other providers into medical homes for low income pregnant women and young children at risk of developmental delays. To understand how this transition occurred within local communities, a pre-post comparative case study was conducted. A total of 42 people in four local health departments across the state were interviewed immediately before the 2011 policy change and six months later: 32 professionals (24 twice) and 10 pregnant women receiving case management at the time of the policy implementation. We used constant comparative analysis of interview and supplemental data to identify three key consequences of the policy implementation. One, having medical homes increased the centrality of other providers relative to local health departments. Two, a shift from focusing on personal relationships toward medical efficiency diverged in some respects from both case managers' and mothers' goals. Three, health department staff re-interpreted state policies to fit their public health values. Using a political economy perspective, these changes are interpreted as reflecting shifts in public health's broader ideological environment. To a large extent, the state successfully induced more connection between health department-based case managers and external providers. However, limited provider engagement may constrain the implementation of the envisioned medical homes. The increased focus on medical risk may also undermine health departments' role in supporting health over time by attenuating staff relationships with mothers. This study helps clarify how state public health policy innovations unfold at local levels, and why front line practice may in some respects diverge from policy intent.

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1. Introduction

Health care managers and policy makers in the United States are experimenting with how to better connect patients with health and social services needed to optimize well-being. Historically, a key means of facilitating effective use of health and social services has been case management, also called care coordination or care management, to assess individuals' needs and facilitate access to an individually tailored range of services (Issel, 2000). The Patient Protection and Affordable Care Act of 2009 (ACA) increases emphasis on patient-centered care and prevention, leading to more US health care systems implementing variants of case management for vulnerable patients with complex medical conditions.

A more encompassing strategy for improving patient-centeredness is the medical home. Given that Medicaid is the primary US public health insurance for people with low incomes, this study uses the Medicaid definition of medical homes, i.e., managing health care in order to improve the quality of care, health outcomes, and care continuity (North Carolina DMA, 2011). Practices commonly associated with medical homes include 24/7 access to medical advice, team-based care, and data used to improve both individual and aggregate patient care quality (NCQA, 2014). Medical homes started in the US in the 1960s primarily in treating chronically ill children, as pediatricians sought to improve coordination with specialists and maintain a common medical record (Sia et al., 2004). Managed care provided further impetus for medical homes

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(Institute of Medicine, 2001), as did endorsements of such coordination by national physician associations in 2004 (Future Committee, 2004) and operationalization of medical homes practices in 2005 (Carrier et al., 2009).

The purpose of the current study is to understand the implementation of a recent state-wide policy requiring integration of maternal and child case management within a medical home model. The intention of the state policy was to focus a previously broad maternal and child health program more on physical health needs. The policy reflected an ideological change at the state level toward more focused investments of public dollars in improving outcomes for vulnerable populations, and requiring public and private organizations to work together more closely.

Local health departments are public, typically county-level agencies. In North Carolina as in many other US states, health departments are responsible not only for safety inspections, epidemiologic surveillance, and crisis response, but also for assuring maternal and child health services to low income residents (CDC, 2011). Traditionally, local health departments have also provided a range of related health and social services such as income and nutritional assistance, and worked closely with other public providers, as well as with a limited number of private providers. Despite substantial accumulating evidence about the nature of health care change (AHRQ, 2014; Damschroder et al., 2009; Greenhalgh, 2004), the authors of comprehensive reviews of this literature have called for more research on how these implementations unfold. Our study addresses this gap in implementation research by examining the specific activities of each local health department in which implementation of a new medical homes-based case management program occurred.

1.1. North Carolina public health case management for pregnant women and young children: 1987–early 2011

To improve birth outcomes among low income women and to support healthy development among young children at risk of developmental delay, the North Carolina Department of Health and Human Services began a program called Baby Love in 1987. Baby Love consisted of one case management program focused on mothers and another on infants and young children. All 85 local health departments offered Baby Love. Through Baby Love's maternal case management, any pregnant woman enrolled in Medicaid could receive health education from case managers based in local health departments. Case management also included referrals to additional health and human services such as breast feeding education, primary care, public housing, food pantries, and child care (North Carolina DMA, 2010a,b). Through pediatric case management, local health department case managers helped parents of children ages 0–5 with or at risk of developmental delays to access needed medical and social services, including parent support programs and other family-oriented resources (North Carolina DMA, 2010a,b). Many of these women and children also received medical care at clinics within the local health departments.

Early program evaluations suggested that pre-medical home maternal case management reduced the proportion of newborns with very low birth weights (Buescher et al., 1991). The state's infant mortality rate steadily declined, which many policy makers attributed in part to this program, despite no subsequent rigorous research findings demonstrating the program's impact. Except for a relatively high dosage variant, empirical support for prenatal case management nationally remained modest (Issel et al., 2011).

1.2. 2011 Structural changes to case management programs

Sparse evidence of Baby Love's effectiveness and severe economic pressures from the 2007–2009 recession prompted North Carolina's Division of Public Health to collaborate with the state Medicaid agency and a state-wide network of Medicaid providers to refocus the program. The goal remained to improve infant and young children's health outcomes, but to do so more cost effectively than through Baby Love. In March 2011, a separate medical homes model was initiated, comprised of Pregnancy Care Management and Care Coordination for Children. The primary source of referrals for services became the clinical risk assessments conducted by providers within medical homes, a designation the state had not awarded any local health departments.

Centering case management around medical care was a major change from Baby Love, in which referrals had originated primarily from programs within local health departments, including family planning, prenatal clinics, food supplemental assistance, pediatric case management, social services, and school nurses and social workers. Case managers continued to be employed by and physically based in local health departments, but were now for the first time explicitly charged with supporting providers in ensuring positive pregnancy outcomes, including visiting clinicians' offices to communicate with staff and mothers. Instead of tracking their services in local health department information systems, in the context of the medical home, case managers were required to enter case management data in the information system already used by medical home providers (Steiner et al., 2008). Case management was evaluated on the basis of both processes relating to assessments and referrals and outcomes measures (Table 1).

1.3. Financial changes in the new medical homes models

Medical homes included new financial and clinical incentives. Providers in medical homes received $50 for every patient screened for potential referral to maternal or pediatric case management, and a per member per month payment for using quality indicators, such as eliminating elective deliveries prior to 39 weeks, providing a drug when needed for the prevention of preterm birth, and decreasing Caesarean section rates. An additional $150 was paid for every woman seen for a postpartum checkup. Local health departments received separate per member per month payments for providing case management to women and children enrolled in either program.

1.4. Eligibility changes in the new models

In medical homes, case management was intended only for women and young children at high risk of poor medical outcomes. The frequency of case manager interactions with clients varied according to results of the state's risk screening form. Eligibility also changed de facto. In theory, Baby Love had been intended to serve only women and children enrolled in Medicaid. In practice, however, many local health departments offered case management to all those with relevant needs, regardless of insurance status. In the medical homes, because case management data were managed through the Medicaid managed care network's information system, case managers needed to enter each woman or child's Medicaid ID as part of enrollment. Enrolling an individual who did not have a Medicaid ID now required a cumbersome work-around. Also, in Baby Love, case managers served families as long as they saw a need. In the new medical homes model, case management was to end when Medicaid eligibility ended (Table 1).

North Carolina's requirement that local health department case managers and providers work more closely together supporting low income pregnant women and young children at risk represented a major policy experiment. In this study, we use a political