CareSouth Delivers Patient-Focused Care to South Carolina's Senior Underserved Population

South Carolina community health center employs chronic care model in care for medically underserved communities.

CareSouth Carolina is the only community health center in the nation that serves as an Area Agency on Aging, which allows the center to focus on the specific needs of the elderly. With more than 45 percent of patients who are uninsured, the private, South Carolina non-profit corporation relies on a system of care involving hospitals, nursing homes, private providers, and health and social agencies. The organization has offices in seven federally designated medically underserved communities.

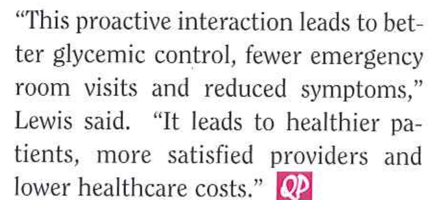
CareSouth Carolina began using the Chronic Care Model in 1999 to serve its patients, and is involved with health disparity collaboratives in diabetes, depression, and asthma. In 2002, CareSouth Carolina joined the Institute for Healthcare Improvement IMPACT Network to improve the clinical office practice. The model, which is now the driving strategy of the organization, relies on knowing which patients need the care, assuring that they receive knowledge-based, culturally competent care, and actively aiding them to participate in their own treatment. When informed patients take an active role in managing their own health and when medical providers are prepared and supported with time and resources, CareSouth Carolina has found the interaction between them becomes more productive.

"Our organization was founded on being responsive to community need," said Ann Lewis, chief executive officer of CareSouth Carolina. "By developing relationships that change the way care is being delivered, especially for seniors, we meet needs and improve the quality of care and the quality of life. In short, the chronic care model is a road map, a cultural shift in the way care is delivered: it's patient-focused instead of clinician-focused. It involves six components that include everything from the business plan of the organization and investment in technology to a team approach that makes every effort possible to involve patients in their own care."

Developing Relationships*—CareSouth's Outreach Coordinator Sherry Johnson, center, helps two consumers understand Medicare materials.*

Recognizing that chronic diseases account for 70 percent of all deaths in the United States, the center makes a point of encouraging chronic disease self-management by emphasizing the patient's central role, assessing the patient's beliefs, advising patients with personalized information, and collaboratively setting specific goals.

CareSouth Carolina has also established a registry of clinically useful information, and staff provide timely reminders and feedback to patients. In addition to these systems, the organization emphasizes the importance of being a "prepared, proactive practice team;" that is, at the time of the visit, the team has the patient information, decision support, people, equipment, and time required to deliver evidence-based clinical management and self-management support.



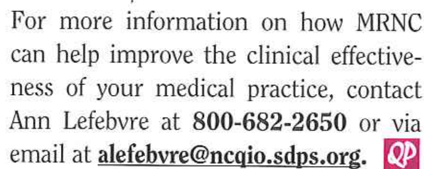
"This proactive interaction leads to better glycemic control, fewer emergency room visits and reduced symptoms," Lewis said. "It leads to healthier patients, more satisfied providers and lower healthcare costs." QP

—Contributed by Andrea Fuller
CMR Outreach Specialist

Disparities in Diabetes Care

(Continued from page 4)

project (**www.mrnc.org/mrnchcqip/changing.aspx**) that offers continuing medical education credit for quality improvement activities within medical practices. MRNC provides free assistance and resources to improve clinical effectiveness.



For more information on how MRNC can help improve the clinical effectiveness of your medical practice, contact Ann Lefebvre at **800-682-2650** or via email at **alefebvre@ncqio.sdps.org**. QP

—Contributed by Mark Massing, MD, PhD
MRNC Clinical Epidemiologist

1. **Massing MW, Henley N, Biggs D, Schenck A, Simpson RJ. Prevalence and Care of Diabetes Mellitus in the Medicare Population of North Carolina: Baseline findings from the Medicare Healthcare Quality Improvement Program. *NC Med J* 2003; 64(2): 51-57.**
2. **Massing MW, Henley NS, Carter-Edwards L, Schenck AP, Simpson RJ. Lipid testing among patients with diabetes who receive diabetes care from primary care physicians. *Diabetes Care* 2003; 26(5): 1369-73.**