

CC4C Overview

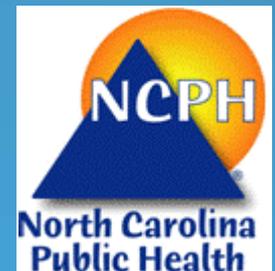
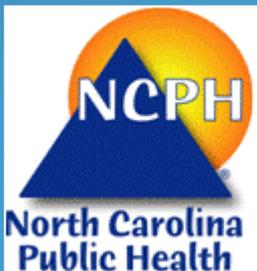
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Care Coordination for Children Program Manager

Children and Youth Branch

Women's and Children's Health Section

Division of Public Health



Care Coordination for Children (CC4C)

Brings together:

State Partners: DMA, DPH,
& CCNC Central Office

Local Partners: LHDs &
CCNC networks

CC4C & CCNC care
managers

to **1)** improve quality of
care for children &
families, **2)** increase
efficiency through
collaboration, and **3)**
decrease cost.



Mission of CC4C Partners

Medicaid	CCNC	DPH
Protect the health and safety of all North Carolinians and provide essential human services.	Improved quality, utilization and cost effectiveness of chronic illness care	Promote and contribute to this highest level of health possible for the people of NC.

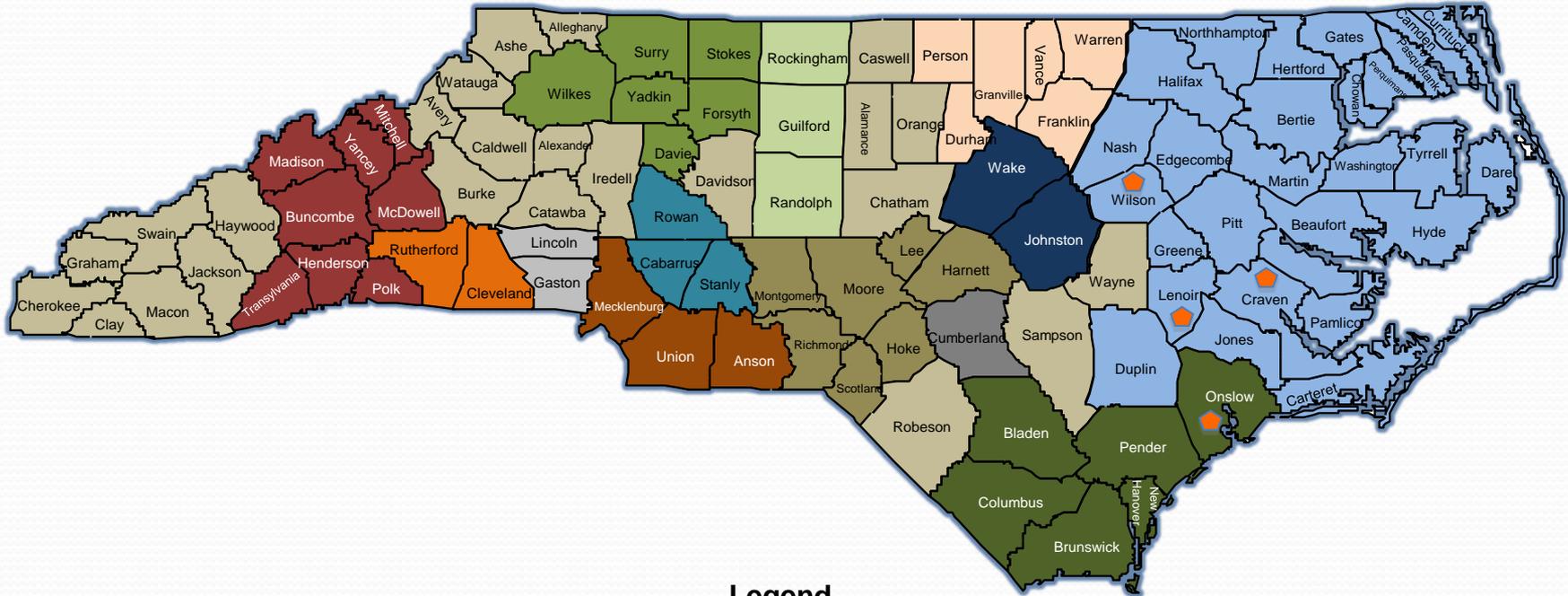
CC4C Goals:
improve quality of care for children & families,
increase efficiency through collaboration,
decrease cost

History of DPH

Care/Case Management for Children ages 0-5 years

- Began the High Priority Infant Tracking program in 1978
- Expanded and name changed to Child Service Coordination Program (CSCP) in 1989
- Initially viewed CSCP as a care coordination service
- With HIPAA code conversion in 2002, CSCP became a targeted case management service (FFS)
- CSCP services ceased on February 28, 2011

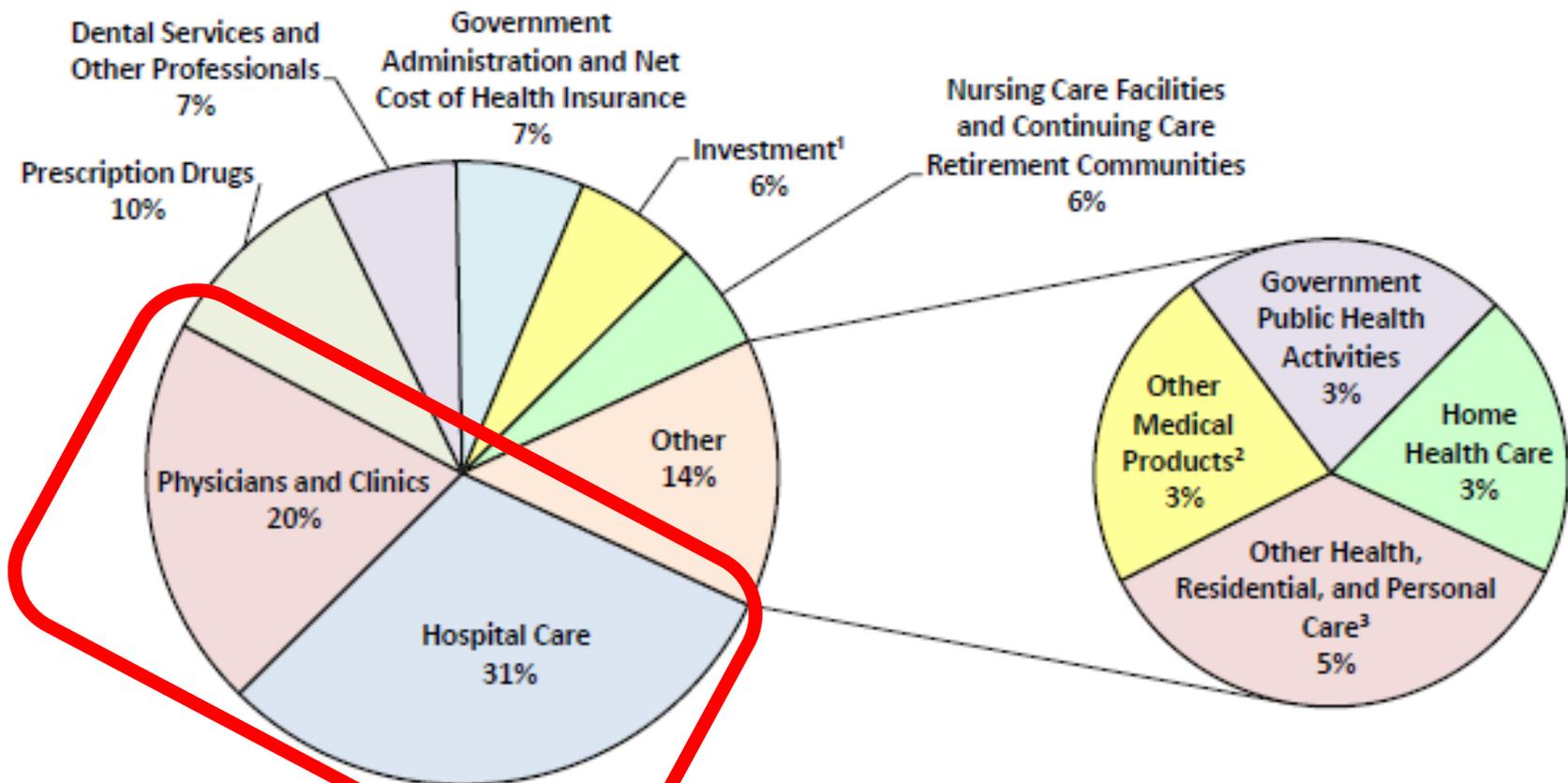
CCNC Networks



Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Community Care of Wake and Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Carolina Community Health Partnership
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care
- Partnership for Health Management
- Community Care of the Sandhills
- Community Care of Southern Piedmont

The Nation's Health Dollar (\$2.6 Trillion), Calendar Year 2010: Where It Went



¹ Includes Research (2%) and Structures and Equipment (4%).

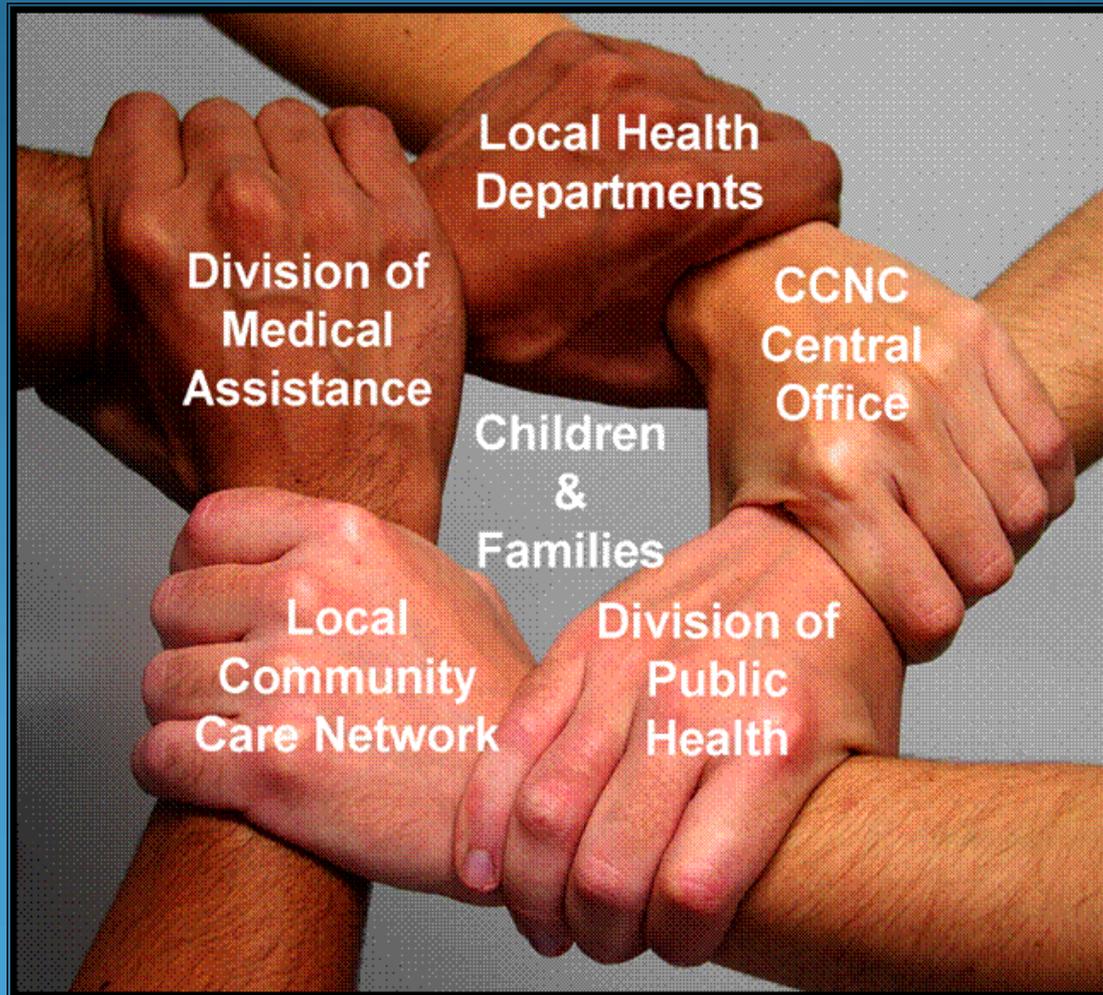
² Includes Durable (1%) and Non-durable (2%) goods.

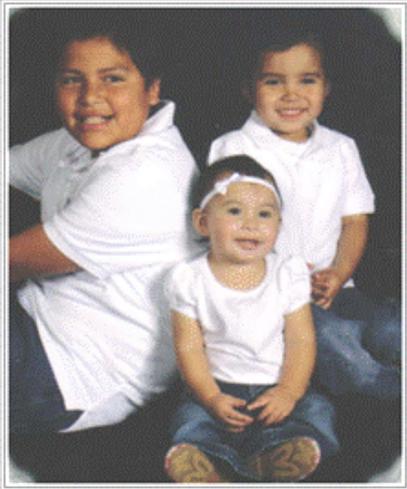
³ Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid.

Note: Sum of pieces may not equal 100% due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

Care Coordination for Children





Beginning March 1, 2011

- Local Health Departments began providing Care Coordination for Children (CC4C) services in partnership with local CCNC networks.
- The name of the CC4C service provided by LHDs is Population Care Management.
- The LHD staff providing CC4C services are referred to as CC4C Care Managers.

Performance Metrics

CC4C Contract Metrics [Reported to DMA]

PM #1:

Increase in NICU graduates who have their first PCP visit within one month of discharge.

PM #2:

Reduce the rate of hospital admissions for children birth to <5.

PM #3:

Decrease the rate of readmissions for children birth to <5.

PM #4:

Reduce the rate of ED visits for children birth to <5.

Performance Metrics

CC4C Contract Metrics [Continued]

PM #5:

Increase percent of comprehensive assessments completed for CC4C patients identified as having a priority (heavy/medium case status).

PM #6:

Increase the Life Skills Progression (LSP) Assessments for the targeted population of children ages birth to five (Toxic Stress) receiving care coordination through CC4C on entry into the system, every six (6) months thereafter and/or upon closing.

CC4C Program Measures

1. Increase the # (and rate) of infants < 1 year of age referred to Early Intervention (EI) Program.
2. Increase the percent of children with special health care needs enrolled in a medical home.
3. Increase the percent of children in foster care who are enrolled in a medical home.

MEASURES

Success = Meeting Performance Metrics and Program Measures

Meeting Measures depends on:

- 1. # of children touched**
- 2. Actions taken when touching**

CCNC has long history of meeting measures that demonstrate ↑ quality & ↓ cost.

CC4C Target Population

Children from birth to 5 years of age (both Medicaid & non-Medicaid) who are:

- Children with Special Health Care Needs
- NICU Babies
- In Foster Care & Not Linked to a Medical Home
- Exposed to Toxic Stress in Early Childhood
- Children Flagged on a Priority Population List Based on Above-Expected Potentially Preventable Hospital Costs
- Other children identified through claims data reports that could benefit from follow-up and/or transitional care services



Children with Special Health Care Needs

[Title V: Maternal Child Health Block Grant Definition]

Chronic physical, developmental, behavioral or emotional condition

Expected to last at least 12 months

Requires health and related services of a type & amount beyond that required by children generally

Children Exposed to Toxic Stress in Early Childhood

Toxic stress is caused by “extreme, prolonged stress in the absence of a supportive adults to help the child adapt.” It results in:

- Negative effects on a child’s development, and

- Hinders the child’s ability to thrive

All children experience normal or tolerable stress, which actually builds resilience & allows the development of a child’s stress-response system.

Toxic stress happens when the stress hormone levels (cortisol) go up, stay up and don’t come down. This is chemically toxic to the brain and damages the developing brain causing disrupted circuits & a weakened foundation for future learning and health.

Source: “Preventing Toxic Stress in Children”–Jack Shonkoff, Author, Researcher, & Harvard Professor

What contributes to toxic stress?

Extreme poverty in conjunction with continuous family chaos

Recurrent physical or emotional abuse

Chronic neglect

Severe and enduring maternal depression

Persistent parental substance abuse

Repeated exposure to violence in the community or within the family

Children in the Foster Care System

Defined in CFR as Children with Special Health Care Needs & have often been exposed to toxic stress.

Major emphasis for the CC4C program is linking these children to CA II Medical Homes & CCNC/CC4C CM Services.

Professional associations are interested in developing best practice models for medical homes who specialize in the care of children in foster care.

NICU Babies

To assist in their transition back to the community & with linkages to community resources including a quality CA II medical home.

This is clearly an area where partnering with CCNC to offer transitional care is the ultimate goal.

Treo Priority Population List

Children identified from Informatics Center Reports – especially the Treo Priority Population List.

Based on their above-expected potentially preventable hospital costs given the person's disease burden.

Referral Sources

- Medical Homes
- Hospitals
- Community Organizations
- CCNC Care Management Staff
- Families
- Children are also identified using Informatics Center Reports, in collaboration with CCNC. A priority for our f/u is children birth to <5 on the Treo Priority Population List

CC4C Responsibilities

CC4C CMs are responsible for all the children 0-5 in their county who are in the CC4C Target Population. In order to meet this responsibility, CC4C CMs will:

- level the service based on the family's needs (e.g. heavy, medium, light)
- determine the length of time that services are provided depending on family's need and evidence that progress is being made

CC4C Services

Assessments

- Comprehensive Health Assessment,
- Life Skills Progression* (for targeted populations)



- Identification of the child's needs
- Development of a plan of care with the parent/guardian;
- Determination of the frequency of contacts required to achieve these goals.

Contacts occur in a variety of settings including the child's home, medical home, hospital, community and by phone.

**The Life Skills Progression is an evidence-based tool that measures a parent's life skills (the abilities, behaviors and attitudes) that help a family achieve a healthy and self-sufficient level of functioning. The tool assesses 35 dimensions that look at relationships/support systems; education and employment; health and medical care, mental health and substance use/abuse and access to basic essentials. The LSP also assesses the child's developmental progress. When completed sequentially in 6-month increments & upon closure, the LSP makes progress visible and measurable.*

CC4C Medical Home Responsibilities

CC4C CMs are required to work with the Medical Homes (MH) by:

- Linking or embedding CC4C CMs with MH practices
- Communicating and collaborating with MH for children in CC4C Target Population in order to best meet child/family needs

Assuring that children receiving CC4C services are linked to Medical Homes is a priority.

CMIS (Care Management Information System)

All CC4C services are documented in CMIS, which:

- Is a user built, patient-centric, electronic record of care management activities used by CCNC care managers since 2001.
- Contains demographic data and claims data on over 2.8 million Medicaid recipients.
- Allows Medicaid and non-Medicaid patients to reap the benefits of the continuity of care provided by CMIS.
- Maintains a health record and care plan that stays with the patient as he or she moves from one area of the state to another or across eligibility programs.
- Contains standardized health assessments, care plans, screening tools, disease management, health coaching modules, and workflow management features.

Source: CCNC Web Site (<http://www.communitycarenc.com/informatics-center/cmis/>)

Informatics Center

All CC4C Care Managers have access to Informatics Center, which:

- Provides information & support for patient-centered care within a medical home environment. (Provider Portal)
- Supports a Population Care Management approach by allowing care managers to hone in on the highest risk / highest opportunity patients for targeted services. (IC Reports)

CC4C Funding

To assist in meeting the responsibilities of the CC4C Target Population, the LHDs:

- receive a Per Member Per Month (PMPM) allocation to serve Medicaid clients; amount of PMPM is based on the number of Medicaid children 0-5 years in each county.
- have the opportunity to draw down CC4C Agreement Addenda funding to serve non-Medicaid children; level of funding is consistent with past CSCP AA funding.



CC4C Program Development

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CC4C Workgroup

DPH, DMA, CCNC's Central
Office, Physician Community,
Local CCNC Networks, Local
HDs & the DPH C&Y Family
Council.

Value of this Project

Improves collaboration and integration of services between CCNC, CC4C and the Medical Home.

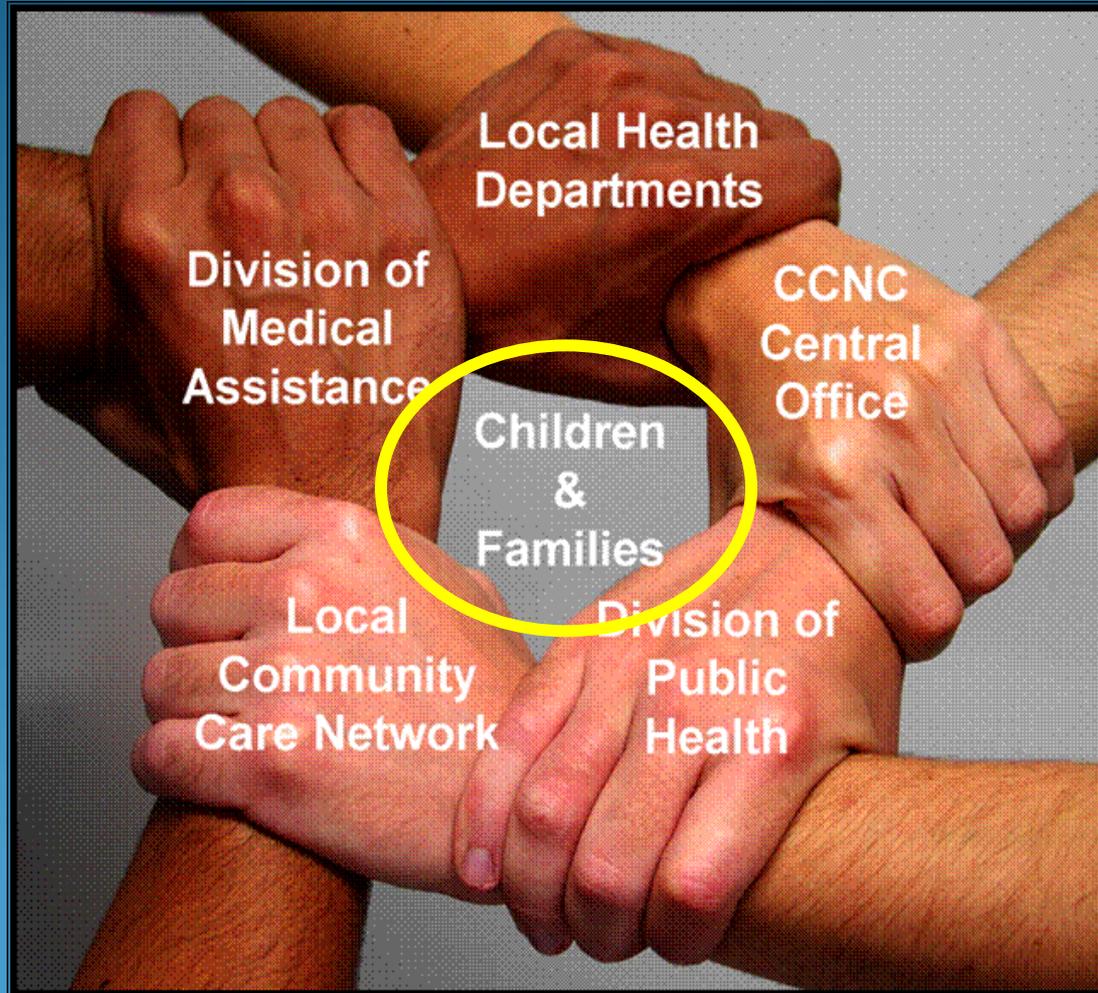
Stratifies the population to assure we serve those at highest risk first.

Implements evidence-based or evidence-informed practices that have a positive impact on health outcomes.

Measures outcomes to demonstrate program impact.

Strengthens the program by being able to demonstrate outcomes, cost savings and effectiveness.

Care Coordination for Children



Strong Partnership = Success