CC4C Questions and Answers

In the document below, you will find questions related to the CC4C Training Web Page and the date the question was submitted. As we can, we will incorporate the questions from the January 20, 2011 webinar along with the questions received during the February 2011 regional trainings.

We were able to quickly post answers that could be developed from previously approved training materials. To ensure that these questions could be posted as quick as possible, we have not elaborated on the answer, but we have simply referenced the training materials. We understand that a tremendous amount of information has been shared with CC4C CMs in a short period of time, and that it is impossible to absorb all of the information. Therefore, we completely understand the submission of questions for which answers can be found in the training material.

There are 18 sections in this document. There are several questions that we have not yet been able to answer. We are consulting with our partners at DMA and CCNC to ensure that you receive consistent, accurate answers. When the answer has been approved and recorded in this document, we will indicate the date the answer was posted. We encourage you to review this document often. Please consider that this document will be updated often in deciding the most appropriate time to print the entire document.

Date Updated: May 22, 2011

#	Question Submitted	Answer Posted	Question	Answer
Assessments				
1.	2/24	4/18	CHA & LSP: Will we receive case scenarios and examples of completed CHA & LSP?	At this time, we do not have scenarios developed. We will consider your suggestion in the development of future trainings and handouts. However in your agency's copy of the book entitled "Life Skills Progression: An Outcome and Intervention Planning Instrument for Use with Families at Risk" by Linda Wollesen and Karen Peifer, Appendices F and G offer a case scenario or story along with the Scored LSP Instrument based on what was learned from the visit with that family.
2.	2/24	2/25	CHA: CHA forms are completed at enrollment and yearly. Is this correct?	The following information was shared related to Slide #18 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page: "For all children moved from CSCP to CC4C and all new referrals to CC4C on or after March 1, a hard copy of the (CHA) form will be filed in the child's record at the CC4C agency. CC4C Care Managers will be required to complete the assessment annually, but can note changes and updates as needed."
3.	3/8	3/25	CHA: Do we need to complete CHA at closure or just every 6 months?	The following verbal information was shared related to slide #18 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page: CC4C Care Managers will be required to complete the CHA annually, but can note changes and updates as needed.
4.	2/25	3/7	CHA: Can you do the CHA over the phone?	According to Slide #7 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page, the CHA can be completed in person or by phone.

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5.	2/24	2/25	CHA: Cheryl says there will be future revisions to CHA, i.e. removing CP (CP abbreviation included on the form along with Cerebral Palsy) from current copy. Will this be soon or should we go ahead and make copies of what we have?	Revisions of the CHA Form will be made, but not before Care Managers will begin to use the form on March 1.
6.	2/24	2/25	CHA: If both parents are Hispanic, what "Race" do we check? White?	The race and ethnicity information on the Referral Form should be completed based on local agency policies/procedures and HIS guidance.
7.	3/11	3/25	CHA: On the CHA form what does CP stand for under Disease/Medical Condition?	CP is the abbreviation used for Cerebral Palsy. See the answer to question #5 in this same section.
8.	2/24	5/23	CHA: Is CPS part of DSS Family Support Services on this form (Additional Support Services – bottom of page 3 of CHA)? It is separate in this county.	At the State DSS Level Child Protective Services and Child Placement Services (Foster Care) both fall under the "Family Support and Child Welfare" part of their organizational structure. At the local DSS level, the organizational charts can be quite different. For the time being, please consider CPS and Foster Care as a part of DSS Family Support Services on the CHA Form in the "Additional Support Services" Question.
9.	3/14	3/25	CHA: The questions on the CHA are they for the child only or both parent/guardian/caretaker and the child?	The verbal information shared with slide #13 in Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels presentation posted on the CC4C Training Web Page indicates that the CC4C completes this section by documenting the diagnoses/conditions that apply to the child. On slide #15 in this same presentation, I stated that this section allow for documentation of the child's health information. For slide #16, I stated that this section allows the CC4C to record information related to all health care providers involved with the child.
10.	2/24	2/25	CHA: On the CC4C CHA do we have to have written permission from the parent/parents to contact the child care provider??? If so how will that be documented in the CMIS system?	In the CC4C Program, you will continue to obtain written permission or authorization according to your agency HIPAA policy as you did in the CSC Program. The reminder to obtain permission from the childcare provider was added to the CHA based on a suggestion from the CCNC Pediatric Work Group. It does not preclude obtaining the needed written authorization according to your local HIPAA policy. Documentation of written authorization in CMIS will be addressed when we begin to document CM services in CMIS.
11.	2/24	2/25	CHA: Will there be boxes to mark Referral Source? Cannot circle on a computer.	The CHA will be adapted for electronic entry in CMIS.
12.	3/10	3/25	CHA: Demographic Section: Child Care Provider: Who is this? PCP or Day Care?	'Child care provider' refers to the person/organization that provides supervision of a child arranged by the child's guardian. 'Child care provider' does NOT refer to the primary care physician or medical home that provides preventive and acute medical care.

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13.	2/24	2/25	CHA: If immunizations are in NCIR will there be a place on CMIS to note that?	Options are being explored for documenting immunizations on the CHA in CMIS. Additional information will be shared during future trainings addressing documentation of CC4C services in CMIS.
14.	2/28	3/7	CHA: Is the 30 day period to complete the CHA work days or calendar days?	The reference to "30 days" in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page is found on slide #26. The information provided on this slide indicates that the "PENDING status should not be used more than 30 days." Thirty days would refer to calendar days.
15.	2/28	2/28	CHA: Do we make copies of the Comprehensive Health Assessments?	Yes.
16.	3/7	3/25	CHA: I see the new CC4C Comprehensive Health Assessment form has a place for SS numbers. Are we still supposed to be putting SS numbers on documents?	Social Security numbers were included on the CC4C CHA because this data field is included on the CHA found in CMIS. Please follow your local agency's policy on documenting social security numbers on hard copy forms until we begin electronic entry of CC4C services in CMIS.
17.	3/7	3/25	CHA: Can more lines be provided under the SPECIALISTS NAMES section in the CHA? Most of my children have multiple specialty providers.	We will refer these suggestions to the CCNC Pediatric Workgroup for consideration in revising and updating the CHA
18.	3/3	3/25	CHA: Dentist name and Ophthalmologist / Optometrist Name are listed on the CHA, but not Ear, Nose and Throat doctor, which is a much more common problem/specialist for children birth-5yr. Have you considered this?	We will refer these suggestions to the CCNC Pediatric Workgroup for consideration in revising and updating the CHA. Until that time, ENT specialists could be listed in Specialist section, which is found directly under the Well Check section on page 3 of the CHA.
19.	3/1	3/25	CHA: Can more lines be provided for OTHER AGENCIES under the Additional Support Services section of the CHA?	We appreciate all the insightful suggestions related to revision of the CHA form. We will refer these suggestions to the CCNC Pediatric Workgroup for consideration in revising and updating the CHA.
20.	3/1	3/25	CHA: On the Comprehensive Health Assessment, how will we obtain the Height, Weight and BMI under the Health Assessment?	The Height, Weight and BMI are found under Health Assessment on the top of page 2 of the CHA. Current information of the child's height, weight and BMI would be obtained, when possible, from the parent or from the primary care physician or medical home.
21.	3/2	3/25	CHA: Under health information there are several questions including height, weight and BMI. Is this birth information only, or is this information that must be addressed each six months. If it is for every six months is it the responsibility of the CC4C's to weight and measure children?	It is not the responsibility of the CC4C to weigh or measure the child. The information would be obtained by report – see the answer to question #20 in this section. The CHA is to be completed annually – see the answer to question #3 in this same section.

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22.	3/3	3/25	CHA: Obesity is not listed on the CHA as a medical condition, but it is a goal of NC to lower rates of childhood obesity. Have you considered this?	We appreciate all the insightful suggestions related to revision of the CHA form. We will refer these suggestions to the CCNC Pediatric Workgroup for consideration in revising and updating the CHA
23.	3/2	3/25	CHA: Can a list of CHA medical terms be provided in Spanish?	We will wait until all possible revisions are made to the CHA form. We will consider this request at that time.
24.	3/31	4/18	CHA: In the Additional Support Section, does Nutritional Services mean WIC or special nutritional needs?	At this point, we define "Nutritional Services" as any services received by the family that assists the family in meeting the child's nutritional needs. Therefore, WIC would fall into this definition. When we move to electronic entry of the CHA in CMIS, we will issue additional guidance regarding the CHA sections.
25.	3/3	3/25	CHA: Intensity Level training said that an example of a child who would be deferred would be if they are receiving Cap services, but CAP-C, CAP-DA, CAP-MR/DD and CAP choice are all listed as possible referral sources on the CHA. This doesn't make sense. Why would these CAP agencies refer to CC4C if the child would be deferred for receiving CAP?	You make an excellent point. The referral sources you mentioned were included because they are included on the CHA form that already exists in CMIS. We will research this point with CCNC staff.
26.	2/23	3/25	Intensity: Heavy Intensity - is the one action each week to be taken literally? Or would this be an average? Say you speak with a client on a Monday, then Friday of the same week, then the next week nothing, then the next two weeks once each. Would that count as "Heavy?" Are 4 contacts in a month the same as once weekly? What is the penalty for missing a week? What about vacations - does someone else have to make that contact?	Excellent question. We will clarify how CCNC care managers address this issue. Until that time, please consider the frequency of contacts needed by a family as an *estimate*. We will provide additional information when it is available.
27.	3/1	3/25	Intensity: Need more information on how to determine the appropriate levels.	Please review slides #21 -31 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page. If you have questions after reviewing the slide content and the verbal information shared with these slides, feel free to submit more specific questions.

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28.	3/1	3/25	Intensity: Light Level review indicated the family would need services for a short period of time. What is a short period of time? Transition training defined light level as anticipated contact every other month. The CHA training defines it minimal of quarterly every three months? So families have to be contacted every other month or quarterly?	The details related to intensity levels have evolved as we moved forward with implementing this new program. On slide #62 in the CC4C Care Management presentation shared at the regional CC4C Transition Trainings, it states that LIGHT is less than once a month. On slide # 25 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page. LIGHT is defined as at least 1 documented action per quarter, but less than 1 per month. The latter is the current guidance.
29.	3/1	3/25	Intensity: Where will the level of intensity be documented? Now? and Later?	Verbal information shared with slide #31 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page included the following: "The intensity level will eventually be documented electronically in CMIS. Until electronic entry is available, the CC4C can choose where in the hard copy of the record to record the initial intensity determination and any changes in intensity status."
30.	3/2	3/25	Intensity: Which carries more weight when determining level of intensity: the LSP or CHA results?	Determination of Intensity Levels is covered slides # 21-31 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page. According to slides #23-25, the CC4C CM must consider several factors in determining HEAVY, MEDIUM and LIGHT, including the results of both the LSP and CHA. In considering these factors, the determination is made based on the estimated contact with the family.
31.	3/2	3/25	Intensity: Is there going to be a place to document level of intensity on respective forms or in CMIS? Will this be tracked to show variation over time?	In terms of documentation of the Intensity Level, please see the answer to question # 29 in this section. We will be assessing our ability to and the benefits of tracking variation in the Intensity Level over time. Thanks for the excellent suggestion.
32.	3/2	3/25	Intensity: Can someone be deferred indefinitely?	We will consult with our CCNC partners regarding this question, and will provide additional information when available.
33.	3/9	3/25	Intensity: In talking with CCNC, I asked her when would I know that my care managers are at "capacity" and to add another manager or reassign duties in either PMH or CC4C programs. She said she didn't know how health departments with CC4C would know that but that CCNC care mgrs were required to carry between 35-50 clients under medium or heavy intensity and then an unlimited number under light intensity. Are you going to address this?	At this point, we have not developed expectations for a specific number of different intensity levels to be handled by a CC4C CM. We will be collecting information from CC4C CMs as well as our CCNC partners on this expectation, and will provide additional information when available.

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34.	3/1	3/25	LSP & Intensity: How many levels are there? In this training it is said first there are three levels, then four levels, then five levels? From what I gathered from READING the fine print when scoring the LSP you divide a total by the number of levels, so how many levels are there?	There are 5 levels, as indicated in slide # 22 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page. Our thinking regarding the LSP Total Score is that it should be predictive of the family's resiliency and self-sufficiency and "one indicator" of family functioning that might influence a stratification intensity score. It was not intended that the LSP determine the stratification intensity. That is a professional decision based on the needs of the family and their ability to respond to those needs (slides # 23-25 in this same training). Unfortunately, in the taping of the Enhanced LSP Webinar Training, the scoring slides/content was lost by a gap in the recording. But, we also feel that introduction of this information was premature. We are going to postpone consideration of using the LSP Total Score until the CC4C Work Group has reviewed/discussed. Thank you for your comments which helped us to make this decision!
35.	3/1	3/25	LSP & Intensity: How are families stratified? LSP indicates a score that stratifies; however, this training indicates number of needs? Which is it?	See answer to question #34 above.
36.	2/23	3/7	LSP & Intensity: How does the total score impact the intensity level?	As indicated in slides 23-25 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page, the CC4C CM considers several things in determining the Intensity Level. The assessment (CHA & LSP) results are considered, as the Intensity Level is based on the number of types of needs identified. The numerical LSP results are not directly connected to the Intensity Level determination. See answer to question #34 above.
37.	3/1	4/18	LSP & Intensity: Scoring slides were not reviewed. How is the LSP scored? What is the mathematical equation and how does that correlate with the information in the CHA training which defined stratification as NOT a score, but a matter of having one component in certain sectors? This begins today and we have no CLEAR information about stratification.	See answer to question #34 above.

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38.	2/24	3/16	LSP: Discipline states under special circumstances that a 1 must be scored. How can we assess the abilities of the foster parent? If in foster care, there is a known/identified issue with biological parent.	In scoring the LSP Parent Scales, it is important to be clear about who you are scoring. According to Slide #15 in the Life Skills Progression (LSP): An Assessment Instrument for CC4C Managers PPT training on the CC4C Training Web Page, a special consideration is listed about use of the LSP Parent Scale which basically states that the Parent LSP Scale can be used "with fathers, grandmothers, foster parents or other family members/guardians." "Although the LSP was designed primarily for work with mothers, the parent LSP scale can be scored for the 'primary caregiver'. If the biological mother is not the primary caregiver, then some of the scales would be scored a "0" for not applicable and not used for analysis." So, in the case of the foster parent, if that is the child's primary caregiver currently, then the LSP Parent Scale would be scored for the foster parent.
39.	2/23	3/16	LSP: If a grandparent, FOB, or boyfriend comes in along with the primary care giver to the child, do we also fill out an LSP on them for their interaction with the child too?	The Parent LSP Scale is intended to be scored for the "primary care giver". If you feel that the "primary care giver" is more than one person, then you may choose to fill out a Parent LSP Scale separately for more than one person. See answer to question #38 in this section.
40.	3/1	5/23	LSP: What do we do when we have two LSP scores for primary caregivers as far as stratification? Do we combine the overall scores, get an average, and then stratify?	See answer to question #34 above.
41.	3/4		LSP: We are looking at a LSP for a foster child who has been out of the birth mother's home for 3 month's and in foster care 3 months now & has a medical home. Instructions for the LSP are to evaluate the child for the last 6 months and score. I told the CC4C CM to speak with DSS CM to get the 1st 3 months info. Then, look at the current family home and make a judgment call for where to mark the LSP, then score. Doesn't that seem logical, or should we do something totally different?	

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42.	2/23		LSP: A number of the items mentions split scores for differences between children. Are all these children to be under the age of 5 year, or are older children counted? E.g., a family has several "born in the USA" children who have Medicaid and get dental care, but one older child was born in Mexico, doesn't have any health insurance, and can't access dental care like her siblings do.	
43.	2/28	3/25	Can we carry more than one child in a family? Do we do two LSP's?	If you are serving more than one child through the CC4C program, then you would score the Parent LSP Tool taking into consideration both children (potentially leading to a "split score"). Remember that in LSP Scoring Instructions a "split score" happens when you have some of the parent's or child's characteristics circled in more than one column such that the resulting score includes a decimal. For example, if characteristics in Columns 2 and 3 are circled, then your "split score" will be 2.5. Eventually, when the Infant/Toddler Developmental Scale is implemented (page 5 of the LSP Tool), you would complete a separate copy of this "Infant/Toddler" form for each child being served through CC4C. According to Slide 7 in the Life Skills Progression (LSP): An Assessment Instrument for CC4C Managers PPT training on the CC4C Training Web Page, "CC4C will begin by using the Parent LSP Life Skills Scales only [1-35] until we determine how best to access the developmental screening results from the child's medical home."
44.	2/25	3/25	LSP: Regarding the LSP...I was under the impression that the scale was for each parent and child duo, however on several occasions during the PPT regarding the LSP it was stated that split scores were required if there are several children i.e. with varying dental care needs in the Child Dental Care (Scale 22)	See answer to question #43 above.
45.	2/23	3/7	LSP: Are we only to use numbers 1-35 at this time? In the discussion of the LSP, the final page (Infant/toddler development) was not even addressed. Is there anything we need to know about this section?	As stated on slide # 7 of the Life Skills Progression: An Assessment Instrument for CC4C Care Managers training found on the CC4C Training Web Page: "CC4C will begin by using the Parent LSP Life Skills Scales only [1-35] until we determine how best to access the developmental screening results from the child's medical home."

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46.	2/25	3/7	LSP: Can we do the LSP over the phone?	As stated on slide # 8 of the Life Skills Progression: An Assessment Instrument for CC4C Care Managers training found on the CC4C Training Web Page: "The LSP will be done every 6 months and at the time of deferral during a face to face visit".
47.	3/9		LSP: Does the LSP need to be completed during a face to face contact at deferral? (meaning, does the last contact with family needs to be face to face?)	
48.	3/1		LSP: The LSP should be done face to face; does the child need to be present?	
49.	2/24	5/23	LSP: Does anyone know about when we can expect to receive the LSP Score Sheet and LSP book order form? In the webinar, it was stated that these were posted already and I am unable to find them.	In an email sent out on March 23, 2011, DPH/Children & Youth Branch notified the CC4C Supervisor List Serve that the "Life Schools Progression" books had been ordered and that paper copies of copyrighted materials were being shipped with the permission of Brookes Publishing. LSP copyright rules forbid the sharing of their copyrighted materials electronically. Since then, the LSP books have been distributed to every health department in the state.
50.	2/25	5/23	LSP: Can we get a list of definitions for the abbreviations used throughout this section?	See the answer to question #49 above. "Appendix B: Abbreviations Used in the Life Skills Progression (LSP)" from the "Life Skills Progression" book was mailed out as a part of the packet mentioned in #49 above. Sharing of these copyrighted materials was not possible until the LSP book was ordered.

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51.	3/1	5/23	LSP: Header information was not reviewed. What information is required to be completed? What does ongoing mean? # attempted visits? Web ID? ... More information is needed.	Guidance regarding completion of the "LSP Header Information" was included in the LSP Packet of Materials mentioned in the answer to question #49. Sharing of this information was not possible, due to copyright issues, until the LSP book was ordered. In answer to your specific questions: (1) The only information in the Parent LSP Header that is not being completed right now (while we work on paper) is the Family Medical Record #; the Individual ID #; the Web ID # and the Medical Codes. All other "Header Information" should be filled out in accordance with the instructions included in the mailed packet. (2) The "Ongoing LSP Assessment" is asking you to note whether this is the 1st LSP performed or the 2nd, 3rd, 4th, etc. AND to list the date the LSP was performed (mm/dd/yyyy). Right now you are doing the first LSP on all of your clients because we have not used this tool prior to March 1 and the LSP is only repeated every 6 months & at deferral. (3) "# of Attempted Visits" is the # of times that a face-to-face visit was scheduled, but the parent was not home or a no show; if the visit was cancelled & rescheduled in advance you would not count this as an "Attempted Visit." (4) The Web ID # is not currently being used, as noted above.
52.	2/24	3/7	LSP: How often should the LSP be repeated for each family?	As mentioned in slides # 62 & 66 in the CC4C Care Management presentation shared at the regional CC4C Transition Trainings, the LSP will be completed with all families moving from CSCP to CC4C and with all new referrals received after March 1. According to slide # 3 in the Life Skills Progression: An Assessment Instrument for CC4C Care Managers training (available on the CC4C Training Web Page), the LSP is completed sequentially in 6-month increments and at deferral.

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#	Question Submitted	Answer Posted	Question	Answer
53.	3/1	3/25	LSP: If you receive information that the families circumstances have dramatically changed do you administer a new LSP to indicate those changes since their stratification may change?	The stratification of intensity score is a professional decision based on the needs of the family and their ability to respond to those needs (slides # 23-25 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page. The CC4C CM can change the level of service intensity, based on his/her professional judgment at any point they feel that is appropriate. So, in response to your question about administering a new LSP when the family's circumstances have dramatically changed, given that administration of the LSP Instrument requires a face-to-face contact and that it is recommended that this only be performed once every 6 months, it is our feeling that the CC4C CM should focus his or her time and energies on meeting the families needs, including work to help families move along the continuum on "life skills" during the 6 month interval between LSP Assessments. We have also decided to postpone use of the Total LSP Score for stratification purposes. See answer to question #34 for clarification of future plans.
54.	2/24		LSP: How should the Parent Scale be shared amongst families? Should we just make copies to be filed in each record (until CMIS is up and running)?	
55.	2/23	3/16	LSP: I am still unclear on how to score the form. There are two columns, one for score and one that says "O". I am not sure what goes where.	Good question! On the sample scoring sheet contained in the "Life Skills Progression: An Outcome and Intervention Planning Instrument for Use with Families at Risk" book, the column labeled with a "0" at the top is checked (√) and the "0" is noted in the "Score" Column. To visualize that, go to slide #9 in the Life Skills Progression: An Assessment Instrument for CC4C Care Managers PPT training (available on the CC4C Training Web Page).

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56.	2/25	3/16	LSP: I was a little disappointed in the presentation regarding the LSP scale. Very detailed info was provided regarding each scale, however no further clarification was provided on how to use this based upon a home visit conducted. If this tool is "not designed to be used as an interview form with a list of questions for the parent" then how do you know if there is drug use, or how involved the FOC is or if FP methods are being used?	We are sorry that the LSP training did not meet your needs in that regard. The guidance shared is that provided by the authors of the LSP Tool. In Chapter 5 – "Instructions for Using and Scoring the LSP" of the "Life Skills Progression" book (page 57), the authors state "Because the relationship between the family and home visitor is intimate, based on trust, and dedicated to building strengths, the LSP is not designed to be used in an interview form with a list of questions for a parent to answer. If used that way it could interfere with establishing a trust relationship. It is intended to help a visitor reflect on complex family issues in a way that facilitates a clear understanding of family needs, strengths, and issues and results in more effective visitation services." It is our perception that once you have become more familiar and experienced with the tool that gleaning this information from the visit through your conversation/questions and observations will become easier. What the authors are saying is that the "conversation" rather than the "interview" is the preferred method of gleaning this information. We are considering how best to address your concern.
57.	2/23	3/16	LSP: If someone is working under the table (cash only work-no benefits/taxes), how do we score this?	Assuming that you are referring to Scale 34 – "Income" – the authors' guidance is that "Income from illegal activities is not counted." This guidance can be found on slide #82 of the Life Skills Progression: An Assessment Instrument for CC4C Care Managers PPT training (available on the CC4C Training Web Page). Presumably, if the only income is from illegal activities, you would score Column 1 – "Parent has no source of income."
58.	2/23	3/16	LSP: Is the prenatal care category filled out on every mother no matter what age the child is now?	Thank you for this question. Although this question was addressed in the LSP PPT for the February CC4C Regional Trainings, it was not specifically addressed in the Online LSP Webinar. According to the "Life Skills Progression" book, page 62, "Scale 17, Prenatal Care, is not scored for fathers and for mothers if it has not been an issue within the past 6 months. " Because "Keeps postpartum appointments" is the measure at the high end of the continuum for that scale, it is our interpretation that you would not score this life skill as long as the entire prenatal care period, including the postpartum appointment, happened before the previous 6 months. That means you would enter a "0" in the Score Column for "Not applicable."
59.	2/22	3/16	LSP: On page 9 of the LSP, when scoring #7 all of number 2 and all of number 3 were circle but you scored it as a 2.5, why?	Good question. Because you are looking at what is true for the previous 6 month period in your scoring, you may have a young mother who at the beginning of the 6 month period had limited interest in development, but now is beginning to use some of the information and ideas that you have offered in relation to supporting her child's developmental progress. The split score, in this instance, is reflective of the progress this parent has made over the past 6 months.

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#	Question Submitted	Answer Posted	Question	Answer
60.	3/2	5/23`	LSP: Scale 12: Language – [For parent whose primary language is not English] Use a "0" & check NA if the parent's primary language is not English and he or she is not bilingual in any combination of English and another language. Should this say "Use a "0" & check NA if the parent's primary language is English and he or she is not bilingual in any combination of English and another language."?	You are correct! Good catch. We made an error in interpreting the information on pages 44-45, but your quote is the wording on pages 72-73 of the LSP book. So, to be clear, it should say… "Use a "0" & check NA if the parent's primary language is English and he or she is not bilingual in any combination of English and another language." Thank you for that catch!
61.	2/25		LSP: I understand the scale and how to score, but how do you obtain the answers if you do not question families, .i.e., if FP methods are being used, or if the FOC is involved.	
62.	2/25	3/16	LSP: During the discussion of the LSP, on scale 24 (slides 62 and 63), there seemed to be conflicting information. On slide 62, it said that the scale describes extent of use/abuse of alcohol and/or drugs during pregnancy and early parenting within the last 6 months. Slide 63 states that the scale is used for ongoing drug use-which is it?	After reviewing both slides, we are not seeing use of the word "ongoing" in Slide 63, but rather see "continuing history of drug addiction and/or alcohol abuse." The LSP, per slide 13 in the Life Skills Progression: An Assessment Instrument for CC4C Care Managers PPT training (available on the CC4C Training Web Page) cites that "scores should apply only to skills, behaviors or attitudes occurring currently or over the last 6 months. "
63.	2/28	5/23	LSP: Do we make copies of the Life Skills Progression?	Yes, now that the LSP book and has been ordered for your agency's use and shipped to you, you may make copies of the LSP tool for use in assessing the families you serve. Copyright laws prevented the use of the LSP tool until the book had been ordered. See the answer to question #49 for more detailed information.
64.	3/2	5/25	LSP: Will the LSP be available for completion in CMIS?	Once the CMIS system has been programmed for CC4C, the LSP scores will be electronically entered in CMIS. We do not yet know what that will look like and how it will work, but it will be capable of evaluating our progress longitudinally so that our outcomes are measurable.
65.	3/2	3/16	LSP: Page 5 states it is for use between the ages of 4mos to 3 years. What about the children less than 4 months and greater than 3 years?	According to slide #41 in the CC4C Care Management presentation shared at the regional CC4C Transition Trainings, CC4C will begin by using the Parent LSP Life Skills Scales only [scales 1-35]. Based on information found in the LSP Manual and provided by one of the developers of the tool, the Parent LSP Life Skills Scales can be used with families who have children 0-5 years.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
66.	3/9	5/23	LSP: Should we be going out to make home visits or attempt home visits when we don't have the LSP form to use as of yet?	The answer to this question should no longer be an issue as the "Life Skills Progression" books were ordered and shipped. We assume you are asking this from the perspective of administration of the LSP Instrument, which does require a face-to-face contact. However, the choice about whether or not to make a home visit, aside from the LSP Assessment, should be based on the needs of the family and how best to address those needs. We do appreciate your patience as we struggled with getting funding approval to purchase the books.
67.	3/9	5/23	LSP: I know some counties have said they were practicing using the LSP tool until they received their manual for actual LSP completion. My question is if the LSP is done now as "practice" without the manual then once we receive the manual could the "practice" LSP then be entered into the CMIS OR does it have to be repeated?	The LSP Enhanced Training closely follows the guidance provided in Chapter 5 of the "Life Skills Progression" book. Throughout the PPT, the source pages for the guidance have been cited. Knowing that there would be a gap between a book being ordered for your agency and the actual receipt of the book, we confirmed with Brookes Publishing that you can begin using the LSP Instrument, according to copyright restrictions, once the book has been ordered. So, if you are following the guidance, there is no need to consider the LSPs you have performed "practice LSPs". With regard to entering data retroactively, we will provide guidance once the CC4C CMIS Updates have been made. Either way, the LSP will not need to be repeated prior to 6 months from the initial LSP.
68.	3/16		LSP: There are still concerns about the "Life Skills Progression form use that have not been addressed specifically related to "documenting" the parent's current immigration status	
CC4C Providers				
1.				

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
			CCNC	
1.	3/14	4/18	Should CCNC provide services for those children 0-5 with particular chronic health needs and CC4C provide to those without chronic health needs but with more social/emotional/mental health needs?	As discussed in the February Regional Training Sessions, it is critical that local CCNC and CC4C staff discuss the best way to integrate services to serve the target populations at risk, building on the strengths and resources that each team brings to the table. Decisions re: the best way to collaborate and accomplish our joint objectives will vary from region to region based on the outcome of these assessments and discussions. Once the roles and responsibilities have been defined, then the "Care Management Medical Home Team" can be introduced to individual practices in the community to clarify roles/responsibilities, handling of referrals and how best to foster strong relationships and communication. This information will also need to be shared with other referral sources. Sources for this guidance include Slide 6 of the Care Coordination for Children slides PPT presented during the February regional CC4C Transition Trainings and posted on the CC4C Training Web Page.
			CMIS	
1.	3/15	3/16	Our county IT says that all of our current computers are 32 bit in our county health department. Is 64 bit a requirement (based on the computer specifications contained in the email sent to health directors regarding the computer survey)? Our current care managers run CMIS on our computers who do the Aged, Blind and Disabled program through Community Care.	The specifications contained in that email are more than is required to run CMIS, but it does establish a minimum for assuring that they purchase a quality laptop with sufficient speed and memory to be of value to the program for years to come. The specifications are not a requirement, but approximate a quality purchase.
2.	3/14		Where are we to put the signed releases of information for the CC4C participant if we are to eventually be "paperless"?	
3.	4/13		Will there be a place on CMIS to collect this data since CCNC does not see non insured? It is my understanding that CMIS does have somewhere that uninsured persons are data managed…maybe that's were the documentation completed by the CC4C CM will live?	

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
Collaboration with Care/Case Managers				
1.	2/24	5/23	If we get a referral on a child under 3 years of age and the child is potentially eligible for I-TP, should we do any assessments first or should we forward the referral on to the CDSA?	According the Bulletin 19 in NC Infant-Toddler Program (I-TP) Manual, a referral source must refer a child within 2 days of identifying a child who may be eligible for I-TP services. If the CC4C care manager (CM) is aware the child may be eligible at the time the CC4C referral is received, the CC4C CM should immediately make the referral at that point. Once the referral is made, the CDSA will assign an Early Intervention Service Coordinator (EISC) who will support the family during the evaluation process that will determine the child's eligibility. The CC4C CM should communicate with the EISC assigned to the child, as well as communicate with family, to determine if the family has any needs that cannot be addressed by the CDSA EISC. If CC4C services are needed to address some of the family needs, then the CC4C CM would proceed with the CC4C assessments (LSP & CHA) in order to appropriately provide CC4C services. If the family needs both the EISC and CC4C CM, then it is imperative that the CC4C communicate with the EISC in order to prevent duplication of services. Duplication of services could be frustrating and confusing to a family, and it is definitely not a good use of limited staff/program resources. But, if the family needs are being addressed by the EISC, it would be in the best interest of the family to only work with one case/care manager, as well as the best use of limited staff/program resources. The EISC and CC4C CM should communicate once the child's eligibility has been determined to discuss whether the child is eligible for EI services and whether CC4C services will be needed at that time to meet the family's needs.
2.	2/24	5/23	Can CC4C be involved if CDSA is also working with the child? They are not family centered.	CC4C is no longer considered a targeted case management program and both programs can technically serve families simultaneously **if** CC4C services are needed by the child/family and CC4C services would not be a duplication of EI services. If the child/family has needs that are not being addressed by EI and if it would be appropriate for CC4C to address these needs, then it would be in the best interest for the child/family to receive CC4C services. For example, EI case management could focus on the developmental disability and related services while CC4C CM may be working with the same family for medical or social/emotional issues. In these cases, the Early Intervention Service Coordinator and CC4C CM must collaborate to ensure a family-friendly service delivery system as well as the best use of limited programmatic resources.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
3.	3/9	5/23	I am still confused on what types of cases 0-5 CCNC opens and follows and what kinds of cases LHD opens and follows. One example is I received a SSI information sheet on a child that is autistic and is between 0-3 years old. In the past what I would do is call CDSA to see if they were open. If the child was not open at the CDSA, I would make a referral to CDSA. With the new program CC4C, do I still do it that way? It also looks like either LHD could open them or we could refer them to the CCNC case managers as this is the kind of referral they are used to handling. Can you give me some direction on it?	As the Title V agency for NC, the Children and Youth Branch is required to make sure that children with special needs are referred to public programs (under our oversight) for which they may qualify. Disability Determination and Transmittal forms for all children determined to be eligible for SSI, during the previous month, come to the Children and Youth Branch, and in turn are sent to local health departments. Because of their medical and/or mental health conditions, new SSI enrollees under age 5 qualify for CC4C. Some of these children 0-3 years of age may already be receiving Early Intervention Program (EI) services through the local Children's Development Services Agency (CDSA). If children who are not receiving EI services could be possibly eligible for EI, the CC4C CM should offer a referral – see answer to Question #1 above. If the family is in need of both EI and CC4C services, the CC4C CM should follow the guidance found in the answer to Question #2 above. If the CC4C care manager receives notification of SSI determination, he/she should also determine whether the child is currently receiving CCNC care management services. It will be important for CC4C care managers to work closely with the local CCNC network staff on how to determine the following: 1) whether CCNC is providing care management services to a child; and, if so, 2) which service would best meet the family's needs. Once CC4C care managers have access to CMIS, it will be very easy to determine if a child is receiving CCNC care management services.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
4.	3/7	5/23	One of our CC4C case managers asked the following question: "I have a patient that I'm following for PCM and her daughter for CC4C and I was wondering if I can do the CHA on the child and PCM Assessment on mom on the same day? Or will this conflict?"	Pregnancy Care Management (PCM) focuses on the needs of high risk pregnant and/or postpartum woman. CC4C Care Management (CM) will focus on the needs of children in the target population. It could be appropriate for PCM and CC4C CM services to be provided to the same family at the same time. For example, a postpartum woman may need PCM services, but her child is in the NICU and the family could benefit from CC4C CM services. In some agencies, the PCM and CC4C services could be provided by the same person. In other agencies, different staff will be providing PCM and CC4C services, and therefore if the woman and her child are receiving both services, she will be dealing with two different providers. If this is the case, then it is very important that the CC4C care manager communicate with the PCM, to determine whether both services are needed in order to prevent duplication of services. Duplication of services could be frustrating and confusing to a family, and it is definitely not a good use of limited staff/program resources. If the family <u>does</u> need both PCM and CC4C services, there are no longer any restrictions related to these services being provided on the same date of service, since the services are no longer billed fee-for-service, by date of service.
5.	3/14	4/18	In talking with our partners (CCNC and others), it seems that they think CC4C Care Manager would be able to be a referral for the family if they did not want to be a part of the CCNC program. I explained that our CC4C program was also voluntary and that the family would have the choice to participate. Hopefully I understand this correctly.	CSCP (in the past) and CC4C (now) are voluntary programs as indicated in the answer to question #2 in the Services section of this document.
6.	3/14	5/23	If we serve children in CC4C who have been referred to the CDSA and/or are enrolled in CDSA, would a CC4C nurse provide more medical services to these developmentally delayed children??	See the answer to Question #2 in this section.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
7.	4/12		If we receive a referral for CC4C and the primary care provider has an Access Care Manager connected with their practice and who works solely with their patients, are we to do an CHA and LSP prior to contacting the Access Care Manager or talk with her first to say we have a referral and is she working with the family and then complete the assessments or not complete the assessment if she says she will monitor? We have received several referrals with the practice as the primary care provider and when I have contacted the Access Care Manager, have been told she will flag the child's chart and monitor and if the doctor feels there is a problem (even when the referral is under toxic stress category), she will handle it or possibly refer back to CC4C if doctor wishes.	
Contracts				
1.				
Funding				
1.	2/24	3/16	Where the pregnancy care management gets paid for putting in the referrals, do we get paid for the referrals and the comprehensive forms to be filled out as well?	Both Pregnancy Care Management (PCM) and Care Coordination for Children (CC4C) will be paid a PMPM (per member per month) rather than a fee-for-service reimbursement. That reimbursement is for all of the services you provide as a CC4C Care Manager. The Pregnancy Medical Home is being paid a financial incentive on a fee-for-service basis to complete a CCNC Pregnancy Home Risk Screening Form. CC4C is not asking providers to complete a risk screening form. There is no fee-for-service payment for completion of a referral form.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
2.	3/1	3/16	If we are only receiving funding for Medicaid children, how are we to serve Non-Medicaid children? The impact of military communities was not taken into consideration. The military children have Tri-Care, but are still in need of services. The median age is 24 for their parents, most families have more than one child, they have no local support, are unfamiliar with child development, resources, etc. This population is in need. Many children in this community have Tri Care, but their mothers are not in relationships with the fathers, so the children are living in single parent, Medicaid situations. What about all these children? We are losing more than half our staff, the remaining staff will not be able to serve these families. It will have a huge negative impact on our community as a whole.	As indicated in slide #21 in the CC4C Overview for CSCP Supervisors slide handouts, it is anticipated that LHDs will continue to receive the CSCP AA allocation for service to the non-Medicaid population through SFY 2011-2012. Local health departments will provide CC4C services to Medicaid and non-Medicaid children.
3.	3/14	5/23	If we open a client under CC4C and they are also open under CCNC who gets the PMPM $?	The PMPM payment for CC4C is not based on services to an individual child, but rather it is based on services to a population of children from birth to 5. The PMPM is not a fee-for-service reimbursement system, so who is serving any given child is not relevant to the reimbursement your agency receives for CC4C.
4.	3/14	5/23	From what I understand, a pediatrician has to be hooked into the Access Care System Network in order for the CCNC case managers to manage a client. With that information, I wonder does CC4C program also have that stipulation. I did not think so, since we can follow non-Medicaid clients also. Would we be at a disadvantage on the per member /per month rate as we would see those patients 0-5 years of age that do not have Medicaid and are not hooked into the Access Care System? Would this cause the program to have financial limitations?	You are correct that CCNC care managers only manage Medicaid clients who are served by providers in the Access II Medicaid Network. Access II is the name given to practices that have chosen to affiliate with CCNC Networks who offer care management services. The same is not true for CC4C Care Managers, who may serve any child eligible for Medicaid, regardless of whether their primary care provider is linked to an Access II Medicaid Network or not. The PMPM for CC4C Medicaid patients is based on the total Medicaid-eligible population from birth to 5 years of age. As was the case in CSCP, the DPH will also provide funding to the local health department to provide CC4C services to the non-Medicaid population in the CC4C Target Population through the CC4C Agreement Addenda. See the answer to question #5 in this section for information about funding for non-Medicaid children.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
5.	3/14	3/16	In reviewing Deliverables 1 in Section III (Scope of Work) in Revision #1 of the FY 10-11 AA for CSCP/CC4C, it states that the contractor "shall for the number of non-Medicaid children…" Isn't the new CC4C supposed to target Medicaid children with high cost and high use?)	As indicated on the CC4C Referral Form, the CC4C target population includes children with special health care needs, children in foster care who need to be linked to a medical home, and children exposed to toxic stress. In addition, CC4C Care Managers will begin in May to identify children who are high cost/ high users of Medicaid services. Services to the Medicaid population are addressed in the PCM-CC4C Contract Agreement. As was the case in CSCP, the DPH will also provide funding to the local health department to provide CC4C services to the non-Medicaid population in the CC4C Target Population through the CC4C Agreement Addenda. Identification of high costs / high users of services would not apply to the non-Medicaid population, as we do not have access to a single database that will provide that information.
6.	3/14	3/16	In item 2.b of Section III (Scope of Work) in Revision #1 of the FY 10-11 AA for CSCP/CC4C, the first bullet states "Care coordinators will use data summaries to identify those at greatest risk where it is available for non-Medicaid children." We have not seen this data and our understanding was that CCNC has data only for Medicaid population.	We attempted to keep the language consistent for services to both the Medicaid and non-Medicaid populations. Thus, "data summaries" were included in the description of non-Medicaid services, but the phrase "where it is available for non-Medicaid children" was added. Entry for CC4C services will eventually be made in CMIS, but service payment information for the non-Medicaid clients will not be available.
7.	3/14	3/16	Item 2 in Section IV (Performance Measures) in Revision #1 of the FY 10-11 AA for CSCP / CC4C, it states that until CMIS is available, the CC4C program manager will issue a monthly report to document the current case load, number of clients that were deferred, number of new clients and total number of clients served. Who does this get reported to? What is the beginning reporting date-April 1?	We are trying to create the opportunity for online, electronic entry of the needed information. Further information will be provided as soon as possible.
8.	3/14	3/16	My question is in reference to item 1.b in Section V (Performance Monitoring and QA) in Revision #1 of the FY 10-11 AA for CSCP / CC4C. It states If the six-month review results in compliance below the required units of service based on the annual expenditure of state funds, then a CAP will be developed. What does this mean? I didn't think we were keeping up with units of service any longer.	The unit language remained in the monitoring section in the revision of the FY 10-11, because units did apply to 9 months of this contract (June 2009 through February 2010).

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
9.	3/14	5/23	In item 2 of Section V (Performance Monitoring and QA), it refers to appropriate documentation. What is the actual appropriate documentation we should be using?	"Appropriate documentation" would be based on the documentation addressed in CC4C trainings thus far: CC4C Referral Form, Comprehensive Health Assessment, Life Skills Progression (once it is made available), and Care Plans. Important information may also be found in the Narrative Notes. See answer to question #2 in the Oversight section of this document for additional information related to Narrative Notes.
10.	4/14		In CSC, we did not make contact with the family while the client was in the hospital nursery. Is this still the case for CC4C?	
Guidance Documents				
1.	4/14		I have been trying to locate the update CC4C Medicaid Bulletin and I cannot fine it. They have the up to date PCM. What about CC4C???	
Interventions				
1.	2/24	3/7	When will we be getting the new care plans to use?	As mentioned in slides # 68 in the CC4C Care Management presentation shared at the regional CC4C Transition Trainings, the plan is that CC4C Care Manager will use CC4C protocols to develop CARE PLANS by May 2011. This slide also indicates that " Online, on-demand training in developing care plans using CC4C protocols will be provided for CC4C managers beginning in April."
2.	2/28	3/7	For all current CSC cases, upon completing the CHA and LSP, does a new Care Plan have to be developed using the State Care Plan format or can the CC4C CM use the care plan developed at the LHD?	As mentioned in the CC4C Care Management presentation shared at the regional CC4C Transition Trainings, the CC4C CM will use the CSCP care plan format currently used at the agency to address newly identified needs for children moved from CSCP to CC4C (slide #64). The CC4C CM will also use the CSCP care plan format currently used at the agency to address identified needs for new referrals (slide #66). The current CSCP care plan format will be used during the transition period of March 1 – April 30. The hope is that CC4C will begin to use protocols to develop CARE PLANS by May 2011 (slide # 68). This slide also indicates "Online, on-demand training in developing care plans using CC4C protocols will be provided for CC4C managers beginning in April."
3.	2/28	2/28	What are the requirements for updating Care Plans? Do we update them at each contact?	As indicated in slides # 16 in the CC4C Care Management presentation shared at the regional CC4C Transition Trainings, the CC4C will be expected to use professional judgment in providing CC4C CM services. The CC4C will need to determine how often a particular care plan needs to be addressed in order to ensure that the family/program goals are met. When actions are taken to address a particular family/program goal, those actions should be documented on the care plan.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
4.	3/1	4/18	Is it possible to obtain a clear version of service components care plan that was in handout?	Yes. We have posted the care plan on the CC4C Training Web Page in the "Handouts from Previous Trainings" section. This care plan was displayed on Slide #59 in the CC4C Care Management presentation shared at the regional CC4C Transition Trainings. The entire presentation is also posted on the CC4C Training Web Page in the "Handouts from Previous Trainings" section.
5.	3/2	4/18	Someone who has a transportation need – We could refer them to DSS for Medicaid transportation and once they have done that then that concern/goal per say would be achieved or the need is now an "un-need," however with a child who is attending the EC Program and receiving ST and OT , ST and/or OT may not end in 6 Mo.(for example)-they may continue to receive ST and OT long past aging out of the CC4C Program. How do we develop a measurable goal for that child?	The CC4C assists the family in determining the identified need, which could be "the child needs ST". The CC4C should also work with the family to determine the goal or outcome the family would like to achieve. The goal/outcome could be that "the child's speech will be age appropriate" or "family will feel the child is consistently receiving effective ST". The CC4C CM will use family input as well as professional judgment to determine the frequency of contact needed to monitor this goal and when the goal has been met.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
6.	3/17	5/23	I have been told by our supervisor that anything scored/circled under a 5 had to have a care plan to go with it. I went back through all of my training information and I saw nothing that indicated this in the training materials. It is my understanding that the Care Manager is to identify the needs of the family based on the CHA and the LSP. The purpose of the care plan is to find a way to make a desired change (see slide 46 of the first training session) If the family feels they do not need to change or can not change circumstances, especially when the scores are fours, are these still considered needs that have to be care planned? For instance, how can one go from a learning disability (4) to average or above average (5), yet he or she is able to function well and raise a family. What if family doesn't want child care? What if care giver stays unemployed by choice? Do situations like this need a care plan if it is already an "un-need"?	At the back of the "Life Skills Progression" book, in Appendix J, there is a version of the LSP Instrument and LSP Cumulative Score Sheet with "target scores." The target scores vary for each dimension of family life skills being assessed. For example, on some dimensions the target scores are 4-5; on others the target scores range from 2-5 or 3-5. These target scores are based on the parent or primary caretaker having achieved a higher level of self-sufficiency and family functioning as a result of their progress along the continuum for that dimension. The purpose of the Care Plan, according to Slide 46 of the CC4C Care Management PPT from the February Regional Trainings and posted on the CC4C Training Web Page is to: ▪ Help families find ways to make desired changes. ▪ Demonstrate for families a process of setting goals and developing actions to meet the goals. ▪ Help families decide what they would like to change or address. ▪ Ensure program goals are met. Clearly, as a program, we want to show that the CC4C service helps families move along the continuum to self-sufficiency and family functioning, but it is important for families to decide what they would like to change or address and to identify ways that they can make the desired change. This is a core concept of motivational interviewing and, in the end, empowers the family to set and attain their own goals. A great reference book is "Motivational Interviewing in Health Care: Helping Patients Change Behavior" by Stephen Rollnick, William Miller and Christopher Butler.
Medical Home				
1.	2/25	4/18	Will a letter be sent to local MDs about the CC4C program letting them know who to contact for referrals to CC4C or should this be done on local level?	See answer to question #1 in the CCNC section of this document.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
Oversight				
1.	2/25	4/18	Do we have one case for each family, or if there are multiple children in each family that qualify, do we have separate charts and forms for each child?	If the CC4C CM is actually providing CC4C Care Management services to multiple children in one family age 0-5 years, the CC4C services for each child would need to be entered into CMIS so that all providers with access to CMIS would be aware that this child is receiving CC4C services. Until CC4C services can be entered in CMIS, a hard record of these services would be kept in individual charts for each child. If one care plan is developed to meet the family needs, then this care plan could simply be copied for one of the children's charts. Also, if one LSP assessment is implemented for the family, the LSP can be copied for one of the children's charts – see answer to question #43 in the Assessment section of this document.
2.	2/25	5/23	Will we have any narratives? How do we document attempted contacts, phone calls, referrals, or any other discussions had outside the LSP scales?	CC4C CMs should continue using their prior CSCP documentation process (care plans, narrative notes, etc.) to document their CC4C activities until CMIS is available for CC4C electronic documentation. The CC4C CM would also need to document the intensity level (see question #29 in the Assessment section of this document) somewhere in the record, and the Narrative Note may be the most appropriate place. We are anticipating that there will no longer be any hard copy documentation after everyone transitions to CMIS.
3.	2/24	4/18	Will we receive any guidance on how to write the transition plans that are due April 30?	Since the date that this question was submitted, the Women's Health and Children & Youth Branches have developed written guidance relatsd to the development of the Transition Plan. This guidance was distributed via the CC4C Email List on 3/31 at 12: 55 p.m. An overview of this guidance was shared during the 4/11 PCM Supervisor's Webinar, which included CC4C supervisors for the Transition Plan presentation. The webinar PowerPoint slides were distributed via the CC4C Email List on 4/11 at 8:56 p.m.
4.	2/11	4/18	If we get a referral on a client (child) and the mother informs the cm that she does not wish to have cm services at this time; then what will be the procedure? Right now, we do the referral, note, status report, info is entered into the system and the paper record is filed in medical records. After March 1, 2011, in the new format what will be the procedure? Will we just defer in the CMIS or will there be a need for some other documentation other than just a note to inform of the declination.	When a family refuses services, this should be briefly documented in the narrative note of the child's record. Once CC4C services can be documented in CMIS, we will provide guidance on documenting a deferral in CMIS. Reasons for deferral, including refusal of services, were addressed in Slides #29 and 30 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page. If a child is deferred for any of these reasons, the reason should be briefly documented in the narrative note of the child's record. Once we begin to document CC4C services in CMIS, we will provide guidance on documenting the deferral of services.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
5.	3/29		What is done in the event that a referral is made and contact is made with the parent, but the parent refuses services face to face? Does this mean that a CHA is not to be completed? What is the process?	
6.	3/8	4/18	I was reading through the quality assurance section (of the PCM-CC4C Contract Agreement) which states: the health department shall monitor local CC4C records either paper or electronic for quality assurance and appropriate documentation. The local health department will assure this service deliverable by conducting a random record review at twice a year. My question: We will be provided an audit tool?	You get a gold star for thoroughly reading the Contract Agreement! ☺ Similar language is also found in the CC4C Agreement Addenda. A small committee has drafted an audit tool to be used by supervisors and/or QI committees in reviewing hard copies of CC4C records. Once the audit tool is reviewed by a small group of Branch and local staff and finalized, we will distribute this audit tool via the CC4C Email List. When we move to electronic entry in CMIS, we will provide additional guidance on quality assurance expectations.
7.	3/8	4/18	What do the staff do about having the 60 clients on their case load already and needing to assess that, then adding in new referrals. I am not sure at what point I will know when my case managers are at capacity.	This is an excellent question. We will be gathering information from our CCNC partners, as well as the CC4C Workgroup, related to population management and supervisory expectations. We also plan to provide guidance/trainings for CC4C supervisors that will assist them in assessing performance and productivity of the CC4C staff. Until that time, it will be important for supervisors to ensure that CC4C CMs are making the switch from targeted case management to population care management in order to effectively and efficiently meet program expectations. Please consider the following information from the CC4C Care Management presentation shared during the February Transition Trainings, which is also posted on the CC4C Training Web Page under "Handouts from Previous Trainings": ▪ Slide #8: The neediest of the needy must be served in CC4C. ▪ Slide #9: We are moving from CSCP, where we substantiated risk indicators, to CC4C, where we prioritize children in the target population. ▪ Slide #13-14: CC4C CMs must ensure that the outcomes are met for children in the Target Population to ensure ongoing funding. ▪ Slide #16: CC4C CMs will be required to use professional judgment in meeting outcomes, to ensure ongoing funding. It will also be important for supervisors to ensure that CC4C CMs are following the guidance found in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page. This "leveling" of services is an essential step in assuring that the CC4C Care Managers are able to serve the CC4C children in each county.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
8.	3/8	5/23	Is there a point of advice you can give to say what kinds of cases need assignment by nurses vs social workers for follow up?	When possible, it is expected that Care Management teams will be developed and composed of members possessing an appropriate mix of skills needed to work effectively with at risk children and families. As was the case in CSCP, when there is more than one care manager who could serve a child, the determination of which team member (i.e nurses, social workers) would be most appropriate is dependent on the family's needs and the abilities of the different team members. We will look for feedback from CC4C supervisors, as well as experiences of CCNC supervisory staff, as we continue to address this question. Based on this feedback, we may be able to provide more specific guidance in the future.
9.	3/1	5/23	Will CC4C workers need to have participants complete an Authorization for Release of Information?	We are in the process of determining whether/how the relationship with CCNC will impact the need for CC4C CMs to obtained signed consent or authorization. Until we are able to provide specific guidance, you should continue to obtain written permission or authorization according to your agency HIPAA policy, as you did in the CSC Program.
10.	3/11	5/23	We have both nurses and social workers providing CC4C (and PCM) care management services. In the new CC4C model, will nurses and social workers be providing the same care management services to families or will nurses be expected to provide a different service, that might include more medical functions (e.g. reconciliation of medications, weighing babies, giving medical advice).	Thanks for asking this question. Yes, both nurses and social workers will provide the <u>same</u> care management service based on the roles and responsibilities found in two documents: 1) PCM-CC4C Contract Agreement, and 2) CC4C Agreement Addenda. CC4C CMs who are nurses would provide care management services based on the roles and responsibilities found in these two documents. CC4C CMs who are social workers would <u>not</u> provide services which go beyond the roles and responsibilities found in the two guidance documents (e.g. reconciliation of medications, weighing babies, giving medical advice).
11.	3/29		Do we still need to complete a Staff Change Notification Form when we have a staff change?	
Population Served				
1.	2/24		On the CC4C referral form, a priority referral is "The child is in foster care and does not have a medical home." If the child is in foster care but has a medical home, would the child still be eligible?	

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
2.	3/4	5/23	For the children that are in Foster Care that consistently go to the same Medical Provider would they still qualify for the program. Most children in Foster Care do have a Medical Provider that they go to. It's just that because the placement could change at any given time no Medical Home is listed on the Medicaid Card yet those children always have a Medical Provider that the placement takes them to. So how is this going to be addressed?	Based on Federal legislation referred to as "Fostering Connections", the importance of being linked to a "Medical Home", especially for the vulnerable population of children in foster care, is receiving renewed attention. The American Academy of Pediatrics and the Child Welfare League of America have published standards for health care for children and teens in foster care. These standards are designed to help professionals understand the complexity of health problems for these children. The standards specify the parameters for high-quality health care. By "linking" foster children to a specific practice or medical home in Medicaid's eligibility information system, we are enhancing the health care system's capacity to coordinate and manage the care of these high risk children.
3.	2/24	2/25	I have several children who are on CSC because they have been diagnosed with a speech delay. Will those children qualify for CC4C?	The CC4C Referral Form (Priority Referral section) indicates that children with special health care needs (CSHCN) are part of the CC4C target population. The definition of CSHCN is included on the Referral Form: "Those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition that has lasted or is expected to last at least 12 months and who also require health and related services for a type or amount beyond that required by children generally." Children who meet this definition would be in the CC4C target population. Completion of CC4C assessments (CHA & LSP) would identify needs, which will be used to determine the intensity of services needed.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer

4.	2/4	5/23	Will we be able to serve families who need basic non-medical assistance including help with social services paperwork, who need assistance accessing services such as More at Four, Head Start, preschool and referrals for food, assistance with utilities? If these services are not provided by CC4C will there be any other agencies we can refer them to after closure.	Thanks for asking this important question. The CC4C Care Management presentation shared at February regional CC4C Transition Trainings (and posted on the CC4C Training Web Page) contains several points that address this question:
				• Slide #9: Move from CSCP, where we substantiated risk indicators, to CC4C, where we prioritize children in the target population.
				• Slide #12 : Review of the target population criteria, which are children birth to 5 years who:
				  ◦ are high cost/high users of services
				  ◦ have special health care needs
				  ◦ in foster care
				  ◦ are exposed to toxic stress in early childhood
				• Slide #8: Necessity to serve the neediest of the needy in CC4C.
				• Slide #13-14: Need to ensure that the CC4C outcomes measures are met for children in the target population to ensure ongoing funding.
				Also, in Slide #23 of the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page, it states that the CC4C CM should consider the potential to impact quality, cost and/or utilization with child/family's engagement in determining the intensity level. Therefore, the CC4C CMs must focus on the neediest of the needy within the CC4C target population where we can have the greatest impact in order to ensure ongoing funding. We recognize that there will be families in need of services who unfortunately cannot receive CC4C services. The availability of other services to meet the needs of these families will vary dependent on the community.

5.	2/4	5/23	One of the goals for CSC was making sure children who were enrolled from 3-5 were school ready. Will this be part of the new program?	The goals of the CSCP were: 1) improved access to services, pursuant to federal Child Find initiatives; 2) the opportunity to reach their maximum potential; and 3) the opportunity to identify concerns and develop or enhance self-reliance skills. The goals of the CC4C program are 1) improve health outcomes while 2) containing costs in a managed care setting. For children in the CC4C target population determined to be in need of services, ensuring that the child has optimal health for school entry would be consistent with the CC4C goals.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
6.	3/1	5/23	What is the definition of homeless (Toxic Stress Population?	The Federal definition of "homeless" includes: 1) An individual who lacks a fixed, regular, and adequate nighttime residence; or 2) An individual who has a primary nighttime residence that is: a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); b) an institution that provides a temporary residence for individuals intended to be institutionalized; or c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.
7.	3/1	5/23	Will the CC4C outreach materials be made available in Spanish?	Our goal is to provide bilingual (English/Spanish) CC4C outreach materials as soon as they are appropriately reviewed and vetted. Unfortunately, we do not have funding to produce the materials at this time, but we plan to make them available through a CC4C web site.
8.	3/3	5/23	In reviewing the forms, we also noticed the Referral Form does not include the mother being less than 14 years old under “Priority Referrals”. A young mother raising a baby could be a “toxic stress” situation without any other factors. We wondered if that could be listed under Toxic Stress: Other.	Thank you for the suggestion. The criteria for Toxic Stress found on the Referral Form are based on the research conducted by Dr. Jack Shonkoff. Although being a very young mom may put that mom at higher risk for the listed criteria, being a very young mom alone was not one of the criteria identified in Dr. Shonkoff’s research. Therefore, we will not be adding to the list of criteria on the Referral Form at this time. CC4C CMs should identify all children/families who meet the toxic stress criteria for CC4C services, including very young moms.
9.	3/3	5/23	As a supervisor in the CC4C program, I want to clarify that I do not defer any referrals that might come my way from a non- medical provider that have listed mother of newborn is 15 years old as the concern?	If the only identified need is that a new mom is 15 years old, this need does not meet the CC4C target population criteria. If a referral is received from a non-medical provider for this reason, a CC4C staff person could contact the referral source to see if there are any additional needs/concerns. If not, the child/family would not be a priority referral for CC4C services. While CC4C services are being documented in the hard copy format, the Referral Form and resulting actions, should be recorded and filed according to the local agency’s policies. Some agencies create a record for every referral that results in immediate closure (deferral). Other agencies create a secure file for open and deferred referrals. Once we move to electronic entry, guidance will be provided on documenting this situation in CMIS. We are developing an answer for referrals received from medical providers when it is not readily apparent that the child is part of the target population. Check out Question #8 in the Referral section of this document.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
10.	3/3	5/23	At any point, do I defer a referral before it is assigned to a CC4C CM to actually do the assessment? For example, there is not any toxic stress and the referral is made to us by the current MCC case worker as a potential high risk - the mom is a single mom but able to provide for child, no categories that can be checked on the toxic stress list, but non-specific info is given for a concern.	See answer to question #9 in this section.
11.	3/4	5/23	I understand that Title V type of referrals are a priority. CSHCN have most of the time been referred out to local CDSA's when they had a diagnosed condition. It looks like now that for most, if not all of those Title V children LHD CC4C workers would assess and follow? IS that correct?	CSHCN may be referred to EI and/or CC4C. Please see the answers to questions #1 and 2 in the Collaboration with Care/Case Management section of this document.
12.	3/10	5/23	On the CC4C referral form special health care needs is defined as "those who have or at risk for a chronic physical, developmental, behavioral, or emotional condition that..." BUT... from the webinar and on the printout for this-the definition of CSHCN- does NOT include "developmental".	Excellent point. Unfortunately, there is a slight discrepancy between the CSHCN definition found on the CC4C Referral Form and the one used in slide #8 in the How to Use the CC4C Referral Form training found on the CC4C Training Web Page. In the PowerPoint presentation, I did not include two important components of the CSHCN definition: 1) "developmental" as one of the conditions listed in the definition, and 2) the criteria indicating the conditions "has lasted or is expected to last at least 12 months". The CSHCN definition on the CC4C Referral Form is correct. I apologize for this error and any resulting confusion.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
13.	3/3		Can you explain how you chose what examples of Toxic Stress are listed as examples on the referral form? I question why there are 3 listed that have to do with housing when this could be condensed into 1 or possibly 2. Also, it uses the example that parental rights have been terminated in the past, but we are only supposed to be looking at the last 6 months. If the parent's rights were terminated in the last 6 months, they would not have the current child. I think that a better range of toxic stress examples could have been chosen to reflect our largest referral concerns. Different examples of toxic stress were listed on our handouts from the all day CC4C training that were more appropriate/common. Can you explain this?	
14.	3/4	5/23	Mothers that received no prenatal care, are those children eligible for the program?	Although not receiving prenatal care may put that mom at higher risk for Toxic Stress, not receiving prenatal care alone was not one of the criteria identified in Dr. Jack Shonkoff's research. CC4C CMs should identify all children/families who meet the toxic stress criteria for CC4C services. The CC4C CMs must focus on the neediest of the needy within the CC4C target population where we can have the greatest impact in order to ensure ongoing funding. Mothers who do not receive prenatal care would not qualify unless the situation met the criteria for Toxic Stress. We recognize that there will be families in need of services who unfortunately cannot receive CC4C services.
15.	3/29		Is there sample dialogue with CC4C and clients, CCNC, medical providers, co-workers? Can you help me with some more information with this one so I can be better prepared? What is the 'selling point" of this CC4C before we had child's development but what now?	
Referral				
1.	2/24	3/7	If agencies with CSC waiting lists are experiencing difficulties in addressing I&Rs, will the deadline date of 4/30/11 be extended?	Guidance related to Waiting Lists is included on slides #27-28 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
2.	2/24	3/7	Will the local doctor offices and local hospitals have the referral form for review and access to refer to the CC4C Program effective March 1, 2011 or will the CC4C staff have to go out and review the referral forms with the local doctor offices and hospitals.	As stated on slide # 6 of the How to Use the CC4C Referral Form training found on the CC4C Training Web Page: " CC4C staff will be responsible for: ▪ educating referral sources in each county on the benefits of program services, and ▪ establishing pathways by which referral sources can make referrals, as well as pathways by which the referral source and CM can communicate about the referral."
3.	2/24	2/25	Is there going to be a place added to the referral form that allows the inclusion of the child's medical home name (since not all referrals will come from the medical home)?	The amount of information needed to complete the CC4C Referral Form was limited to benefit both referral sources and Care Managers. Children in the CC4C target population will receive a CHA, which would require the Care Manager to assess Medical Home information. We will consider this suggestion in future revisions of the CC4C Referral Form.
4.	2/24	3/7	If we still have to open children in HIS, will the referral form (I&R) in change in HIS?	As indicated in slides # 17 in the CC4C Care Management presentation shared at the regional CC4C Transition Trainings, the CSCP I & R Form will no longer be used beginning March 1. Therefore, status of the I & R Form in HIS will be irrelevant. Information was also shared related to slide # 9 in this same presentation indicating that CC4C services provided on or after March 1st would not be entered into HIS. Therefore, there is no need to change the I & R form in HIS.
5.	2/23	3/7	With the high cost/high user information, do we receive the referral from CMIS or the medical home?	As indicated in slides # 70 in the CC4C Care Management presentation shared at the regional CC4C Transition Trainings, CMs will "begin to review CMIS Medicaid claims data to identify high cost/high users of services for CC4C care management" by June 2011. Information on how high cost/high uses of services will be identified will be shared prior to June 2011.
6.	2/22	3/7	Do we transfer the information on a current referral form to the new cc4c referral form, if the current referral is not opened prior to Mar 1st ?	As stated on slide #22 of the How to Use the CC4C Referral Form training found on the CC4C Training Web Page: "Children who were enrolled in CSCP on February 28 and moved to the new CC4C Program will not need a CC4C Referral Form completed. A completed CC4C Referral Form will only be needed for new referrals received on or after March 1st."
7.	3/1		What if a child is in foster care and has a medical home, which do you check?	

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
8.	3/1	5/23	What if a referral is sent without any referral priority section checked?	Thank you for asking the question. We are working on guidance that will provide specific steps for CC4C CMs to follow in this situation. We will distribute this guidance as soon as possible. Until that time, the CC4C CM should use their professional judgment to determine the actions needed to meet the needs of a child/family referred by the medical home, when the medical home did not indicate that the child/family may be part of the CC4C target population.
9.	3/1	5/23	In the demographic section, what if a primary caregiver does not want to give you information or the answer is other, NA? How do you indicate that on the form.	Thanks for raising this possibility. While we are using the hard copy of the CC4C Referral Form, instead of documenting "NA" in this situation, it would be more appropriate to document "info not provided". One possible area of information that the family may not choose to provide is the Race and Ethnicity information. Once we move to electronic entry in CMIS, this may not be an issue, as this information is automatically loaded in CMIS from the Medicaid database. When we move to electronic entry, we will give guidance on how to deal with other areas of information that the family may not wish to provide.
10.	3/8	5/23	As I receive and assign CC4C referrals, I have attempted to follow programmatic guidance to link care managers with providers. I have found this challenging since the CC4C Referral Form doesn't ask for Medical Home information unless they happen to be the provider. Historically, most of our referrals are faxed to us from outside referral sources. Will this be easier info to find in the new CMIS system or does it need to be added to the Referral Form?	Information about the child's medical home will be accessible through the CMIS System as well as the Informatics Center Provider Portal. So, you are correct, that access to this information will be easier once we have access to these electronic databases.
11.	3/14	5/23	If the primary providers check the reason for the referral is "caregiver not able to meet infant's health and safety needs/neglect", hopefully the provider would go ahead and call CPS/DSS for a social worker to go out and evaluate the home if there is a suspect abuse and/or neglect . Is that a clear assumption? I just would not want that referral to be referred to the health department and then not be evaluated in the manner CPS would evaluate this home for abuse/neglect.	Whether the referral source would make a referral to CPS in this situation is dependent on how the referral source defines "caregiver not able to meet infant's health and safety needs/neglect". There could be some situations where the health and safety needs are being met enough to not involve CPS, but not to the degree the referral source feels is needed, and therefore the referral is being made to CC4C. If the situation could be defined as neglect, we definitely expect the referral source to make a CPS referral. In this situation, the referral source may also make a referral to CC4C. If this occurs, the CPS worker and the CC4C worker should attempt to communicate in order to prevent duplication of services. If the CC4C CM is involved in a situation that could meet the criteria for abuse/neglect, the CC4C CM should follow the local agency's policy in making the CSP referral.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
			Services	
1.	2/24	2/25	Deferred status: What type of attempts before closing? In the past it was TC, HV, letter w/no response. What does CCNC use?	The number and types of attempted contacts required before closing a child to CSCP services was guided by local agency policies. The same will be true in CC4C – the number and types of attempted contacts required before "deferral" will be based on local agency policy.
2.	2/22	2/25	CSCP was considered a voluntary program is CC4C also considered voluntary and regardless of the family's score can they decline services?	Care managers must prioritize children where costs and health outcomes can be impacted. Families must desire and value CC4C services in order to obtain the desired goals. Therefore, CC4C services will be voluntary as has been the case with CSCP services.
3.	2/22	3/7	How many face to face visits are expected and how often?	As indicated in slides # 16 in the CC4C Care Management presentation shared at the regional CC4C Transition Trainings, the care manager will be expected to use professional judgment in providing CM services. Also in this same presentation, slide #10 compares contacts in CSCP to CC4C. In CSCP contacts were required at least every 3 months and face-to-face contacts were required at least every 6 months. In CC4C, contacts will be individualized based on the family/program goals. The CM will use professional judgment to determine the intensity and type of contact needed to meet the family/program needs
4.	2/24	3/16	During the PCM Transition Training meetings, they were told they did not have to see the patients face to face for the initial contact. Could you explain the difference to me?	As a part of the initial assessment process, you will be performing both a Comprehensive Health Assessment (CHA) and a Life Skills Progression (LSP) assessment. According to slide # 8 in the Life Skills Progression: An Assessment Instrument for CC4C Care Managers training (available on the CC4C Training Web Page), the LSP is completed sequentially in 6-month increments and at deferral during a face to face visit. The initial LSP assessment provides a baseline by which progress can be measured.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
5.	2/4	5/23	Is there an expected time frame for the length of time families are served? Once families crisis such as stable housing, current domestic violence or maternal depression is over do we close immediately? What about families who consistently over time face the same situations?	There is not a set time frame. Once a crisis such as housing, domestic violence or maternal depression is over, the CC4C CM will use their professional judgment and their knowledge of the situation to choose the appropriate intensity level, which may include choosing the intensity level of "deferred". According to slide #21 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page , the CC4C CM should use the following information in determining the appropriate intensity level: 1) family and program needs, 2) need for the CM to effectively and efficiently use time to meet goals, and 3) agency capacity to address needs of the entire target population. In terms of families who consistently face the same situation over time, slide #30 in this presentation indicates that it is appropriate to defer when a child/family is not progressing in meeting desired goals despite re-assessments and revision to care plans. The CC4C CMs would reach this determination of "deferred" using their professional judgment and knowledge of the situation.
6.	3/1	5/23	Do we still use the V codes and risk indicator forms? Do we still use the Preventative Health Services form(DHHS T1518)?	As indicated in slide #17 in the CC4C Care Management presentation shared at February regional CC4C Transition Trainings (and posted on the CC4C Training Web Page), there are several elements of the CSC Program that can now "Rest in Peace". The CSCP elements that were buried on February 28 include: Risk Indicator (RI) Forms, Preventive Health Services (PHS) Form, and Fee For Service (FFS) billing, which includes the selection of appropriate V Codes. We no longer use any of the CSCP components mentioned in your question in CC4C service provision.
7.	3/1	3/16	Can you provide a list of all forms that we will be using in CC4C?	In addition to the Life Skills Progression tool, CC4C Providers will also use the CC4C Referral Form and the CC4C Comprehensive Health Assessment Form. Training related to each of these forms is available on the CC4C Training Web Page. As indicated in the slides #64 & 66 of the CC4C Care Management presentation shared at the regional CC4C Transition Trainings, CC4C care managers will continue to use the CSCP Care Plan format used at their agency until the new CC4C Care Plan format is rolled out.
8.	3/1	5/23	My CC4Cs care managers are concerned about the forms they are to use. Is there any way you all can send a complete record (example) based on an example of a complicated case with care plan included for them to go by?	The forms that CC4C CMs are using are found in answer to question #7 in this same section. We are not able to provide an example of a complete record at this time. We will be transitioning to electronic entry in CMIS in the near future. Further guidance will be forthcoming about Care Plans and documentation in CMIS.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
9.	3/1	5/23	How do we close cases once a family has refused services or are deferred, both for those children who were transitioned from CSCP or for new referrals?	Children whose parents have refused services, whose current needs have been met, or who are not progressing in meeting desired goals despite reassessments and care plan revisions; etc. are considered "deferred" in CMIS. That is the CMIS equivalent of "closed", but has the advantage of being able to be reopened if the circumstances change, for whatever reason. Until we get to electronic entry, please review the answer to question #4 in the Oversight section of this document for guidance on documentation of deferral,
10.	3/11	5/23	Any suggestions on letters to be sent to the client on being non compliant with the program and CM needs to close?	We do not have any suggestion on client letters at this time. One possible resource could be to confer with the local CCNC care managers in your area to determine if they have standard letters to send to clients who are being deferred for CCNC care management. See the answer to question #5 in this same section for more information on choosing the deferral intensity level when progress in not being made.
11.	3/2	3/16	Are we to continue to do developmental screens on all of our children? If so how will that be documented? If not, how are we going to identify children who may need developmental services?	Routine developmental screening is the responsibility of the Medical Home. We are still determining if/how the care manager will obtain the results of the routine developmental screening and if it would be appropriate for CC4C care managers to provide developmental screening in specific situations. We are working closely with CCNC staff, as well as Medical Homes involved in the Assuring Better Child Health and Development (ABCD) project, in addressing this issue. Additional information will be provided as soon as possible.
12.	3/8	3/16	We will be working with Medical Home providers who routinely use the PEDS to screen development. Will CC4C providers be allowed/encouraged to complete ASQ or ASQ/SE as the next step in the developmental screening process to clarify what referrals beyond CC4C are indicated?	Routine developmental screening is the responsibility of the Medical Home. We are still determining if/how the care manager will obtain the results of the routine developmental screening and if it would be appropriate for CC4C care managers to provide developmental screening in specific situations. We are working closely with CCNC staff, as well as Medical Homes involved in the Assuring Better Child Health and Development (ABCD) project, in addressing this issue. Additional information will be provided as soon as possible.
13.	3/1	5/23	If a family is deferred because reassessments and revisions to care plans show no progress, how many times are these items revised...before deferred?	The CC4C must exercise professional judgment and knowledge of the family's individual circumstances in choosing the appropriate intensity levels, including "Deferred" status. Please see the answer to question #5 in the Service section of this document for additional information related to the decision to defer.
14.	3/8		How would you like for CC4C Care Managers to refer to themselves in SPANISH? We would like to be consistent with other Care Managers across the state.	

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
15.	3/8	5/23	Is it acceptable to have the first contact of the client to be in the form of a letter, explaining the program and then do a hv.?	It is up to the CC4C CM to determine the most effective and efficient method to use in contacting families in your community. The CC4C CM should weigh the benefits of the letter as a communication tool with families compared to the expense and time needed to send the letter.
16.	3/1	5/23	Will there be a service charge for families as CSC was free of charge?	As was the case in CSCP, families will not be charged for CC4C services. Local Health Departments receive a Per Member Per Month (PMPM) allocation to provide CC4C services to the Medicaid population. Local Health Departments also receive Agreement Addenda funds to provide CC4C services to the non-Medicaid population. Therefore, families can not be charged for CC4C services.
17.	3/1	5/23	When will we receive the fact sheet to provide to families?	CC4C outreach materials are under development and will be available as soon as they have been appropriately reviewed and vetted.
18.	3/1		How often does the child have to be present for CC4C home visits/ contacts?	
19.	3/1		Does the child need to present for initial enrollment?	
20.	3/10	5/23	Case: A telephone call was attempted x 2 prior to CC4C on March 1. The CSC was unable to reach the family. A letter was mailed out with no response. Do I have to do an attempted HV prior to closing? What is the mandate concerning contacting client?	See the answer to question #1 in this same section for information regarding the number/type of attempt contacts.
21.	3/10		I have a question about county lines. In the PCM training, they stated that the Care Managers will only follow clients that reside in their county. Is this the case for CC4C as well? (Nash CC4C CMs only follow Nash residents; Edgecombe only follows Edgecombe residents...) This is something that I need to get clarified because it seems to come up every day.	
22.	4/13		If a child is in DSS custody in our county but resides with a foster parent in another county who should serve the child, the county where the child resides or the county where the child is in DSS custody?	

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
23.	4/13		If a child goes to a rehab facility with their mom and it is in another county who should serve the child? Should it be the county where the child receives Medicaid?	
24.	3/29		Are we to transport a client in a emergency situation, such as a child having a doctor appt and the parent says they have no way possible to get child to the appt or them selves on occasional basis?	
Stratification				
1.				
Training				
1.	2/24	3/7	Will a second training be scheduled?	Additional trainings will be provided. The content and date of future trainings has not been determined.
Transition				
1.	2/24	3/7	How do we transition current CSC referrals that are on a waiting list to CC4C referrals beginning March 1st?	Guidance related to Waiting Lists is included on slides #27-28 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page.
2.	3/8	5/23	Addressing CSC referrals on the waiting list -- should information be transferred to new CC4C form? If CSC referral is not appropriate for CC4C do we defer/document in chart or close old CSC way?	According to slide #27 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page, clients on the CSCP Waiting List on February 28 became possible CC4C referrals on March 1. Slide #12 in the CC4C Care Management presentation shared at February regional CC4C Transition Trainings (and posted on the CC4C Training Web Page) lists the target population criteria, which are children birth to 5 years who: • are high cost/high users of services • have special health care needs • in foster care • are exposed to toxic stress in early childhood Guidance on documenting the deferral of a CC4C referral when the child is not part of the CC4C target population is found in the answer to question #9 in the Population Served section of this document.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
3.	3/2	5/23	If we received an I&R at the end of February, but did not enroll the child until March, do we need to enter the I&R for billing and do a status form when they are no longer enrolled in the program, or should we fill out a new referral form and handle it that way?	If the child did not begin to receive services until after March 1, you would not enter the I & R form or the status report form. As indicated in slide #17 in the CC4C Care Management presentation shared at February regional CC4C Transition Trainings (and posted on the CC4C Training Web Page), there are several elements of the CSCP that can now "Rest in Peace". Both the I&R Form and the Status Report Form were buried as of February 28. For children who began to receive CC4C services after March 1, a CC4C Referral Form would be completed using the information found on the CSCP I & R form received prior to March 1.
4.	2/23	3/7	This is a question concerning the existing CSC clients and their eligibility for CC4C. Most of my clients have been on my caseload for a long time and are doing well. There are just a few remaining clients on my caseload who may need monitoring. Is there a need to re-assess these clients for CC4C when they have been stable and goals have been met? Why keep them if the families no longer need services?	As indicated on slide # 62 in the CC4C Care Management presentation shared at the regional CC4C Transition Trainings, all children who were enrolled in CSCP on February 28 will be moved to CC4C on March 1. The assessments (LSP and CHA) must be completed on all children and the Intensity Level determined. One of the intensity level choices is "no longer needs services", or defer. It is important the staff who were a provider of CSCP services make the paradigm shift to a provider of CC4C services, which was covered in slides # 6-17 of this same presentation. A few points from those slides that address this issue are: ▪ Slide #8: The neediest of the needy must be served in CC4C. ▪ Slide #9: We are moving from CSCP, where we substantiated risk indicators, to CC4C, where we prioritize children in the target population. ▪ Slide #10: We are moving from a Fee For Service (FFS) funding system to a Per Member Per Month (PMPM), so monthly billing will no longer generate revenue. ▪ Slide #12: CC4C CMs must focus on children in the Target Population. ▪ Slide #13-14: CC4C CMs must ensure that the outcomes are met for children in the Target Population to ensure ongoing funding. ▪ Slide #16: CC4C CMs will be required to use professional judgment in meeting outcomes, to ensure ongoing funding.
5.	2/24	3/7	All children currently enrolled in CSCP will be transferred to CC4C automatically and will need a LSP and CHA done correct?	According to information shared with slide #62 in the CC4C Care Management presentation shared at the regional CC4C Transition Trainings, all children enrolled in CSCP as of February 28 will be moved to CC4C on March 1. The assessments (LSP and CHA) must be completed on all children who are moved from CSCP to CC4C and the Intensity Level determined some time between March 1 and April 30.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
6.	2/25	5/23	My biggest question is what do I do about FMLA? How will I transition all my patients if I will only be here a couple of weeks in the transition period? What will my patients do while I am gone? Will they need to be contacted by another CC4C during that period?	By this time, we bet this staff member is already out on FMLA due to her pregnancy. We apologize that we were not able to respond to this question earlier. An important distinction between CSCP and CC4C is that the CSC and family actually entered into an individual agreement, and the family only received services from that one CSC. This is not the case for CC4C. For those children/families that received CSCP services from this particular staff member prior to March 1st, and were not transitioned to CC4C before the staff member's leave began, the remaining CC4C staff should assist these families in transitioning to CC4C. Due to the limited staff resources, children/families should be prioritized in this transition based on the needs of the child/family. For those children/families that were transitioned by the staff member before starting her leave, they should continue to receive CC4C services from the remaining CC4C staff while the CC4C is out on FMLA. For guidance on prioritizing children for services, please see the answer to question #7 in the Oversight section of this document.
7.	2/25	5/23	And how do we transition patients from CSC to CC4C if we are currently carrying multiple children in a family in CSC?	According to information shared with slide #62 in the CC4C Care Management presentation shared at the regional CC4C Transition Trainings, all children enrolled in CSCP as of February 28 will be moved to CC4C on March 1. The assessments (LSP and CHA) must be completed on all children who are moved from CSCP to CC4C and the Intensity Level determined some time between March 1 and April 30. For children who are members of the same family, the CHA would be completed for each child and the Parent LSP would be completed for the parent or primary caretaker. The Care Plans for each child should be updated, as appropriate.
8.	2/24	5/23	For the clients that receive CSC currently and they don't meet the guidelines for CC4C, are they to be terminated or do we carry them until original problems are resolved?	According to slide #60 in the CC4C Care Management presentation shared at February regional CC4C Transition Trainings (and posted on the CC4C Training Web Page), from March 1 thru April 30, the CC4C CM must access all children who were enrolled in CSCP services on February 28. Using the results of the CC4C assessments (CHA & LSP), the CC4C CM would determine the most appropriate intensity level. If the assessments indicate that the child is not part of the CC4C target population, then the appropriate intensity level would be "deferred". Information regarding the deferred intensity level is found on slides #29 & 30 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page.

CC4C Questions and Answers

#	Question Submitted	Answer Posted	Question	Answer
9.	3/1	5/23	During transition or at enrollment, if a family's LSP score is very high and above the light range are they not eligible if a new referral? Do we close them if being transitioned? If it is a family being transitioned and we have to close them--can we just call them or do we have to return to tell them face to face since the LSP is not done in the home/visit.	Please see the answer to question #34 under the "Assessments" section re: the decision related to the Total LSP Score. The stratification of intensity score is a professional decision based on the needs of the family and their ability to respond to those needs (slides # 23-25 in the Using the CC4C Comprehensive Health Assessment and Determining the CC4C CM Intensity Levels training on the CC4C Training Web Page. The CC4C CM can change the level of service intensity, based on his/her professional judgment at any point they feel that is appropriate. The CC4C Care Manager may communicate the decision about intensity of service, including "deferral", by phone or in a face to face contact. That is the decision of the care manager.
10.	3/4		Will the 4/30/11 deadline for completing the LSP and CHA for previous CSC cases be extended since the LSP is not ready for use yet?	
Other				
1.				