Welcome to CC4C Webinar for Care Managers & Supervisors

The sound is being broadcast via your computer. Please be sure that your computer sound is turned on. You should hear music, although the sound may come and go, which is NOT indicative of problems. The quality of the sound will improve once the webinar starts at 9:30 a.m.

If you are not able to hear via the computer, you can call the meet-me number at 919-233-4708. But, we only have a limited number of spaces available on that phone line. We do have speakers using the phone line today, so if you use the phone line, it is imperative that you MUTE your phone.

The Care Manager and Postpartum Depression Screening

Marian F. Earls, MD, MTS, FAAP
Director of Pediatric Programs
Community Care of North Carolina

American Academy of Pediatrics (AAP) Statement

- Postpartum Depression leads to
  - Adverse affects on infant brain development
  - Family dysfunction
  - Cessation of breastfeeding
  - Inappropriate medical treatment of the infant
  - Increased costs of medical care

- To have a positive impact on the health of the child and family, Medical Homes can be timely and proactive by
  - Implementing screening
  - Supporting the mother-child relationship
  - Identifying and using community resources for referral and treatment

AAP Statement

Advocate for and support
- Awareness of the need for screening in the obstetric and pediatric periodicity of care schedules.
- Use of evidence-based interventions focused on healthy attachment and parent-child relationships.
- Training for professionals who care for very young children.
- Appropriate payment.

Perinatal Depression

- Of all women, up to 12% may experience depression in a given year.
- If the woman has low income, the prevalence is doubled.
- If a woman experiences Post Partum Depression (PPD), she is likely to experience it with subsequent pregnancies.
- PPD can affect mothers with subsequent pregnancies even without a previous history with earlier births.
Compounding Factors

Age and Income
- 40%-60% of parenting teens and other mothers who have low income report depressive symptoms.
- 25% of parenting mothers who have low income have depression compared to 12% in all women.

Peak Occurrence
- 2-3 months postpartum is the peak for minor depression
- 6 weeks postpartum is the peak for major depression

Risk Factors for the Mother

The mother can be placed at risk for depression if the child has
- Difficult temperament
- Hard to read cues
- Difficulty managing stress
- Insecure attachment
- Prematurity, chronic health condition
- Birth trauma

Prenatal Risk Factors: Stressors

- Gestational diabetes
- Maternal poor nutrition
- Maternal chronic physical and mental health conditions
- Instability or disruptions in home life
- Lack of social supports
- Unsafe or violent neighborhood
- Low SES

Postnatal Risks for Infants and Children (ACEs)

- Emotional neglect
- Physical neglect
- Emotional abuse
- Physical abuse
- Sexual abuse
- Household substance abuse
- Household mental illness
- Parental separation or divorce
- Incarcerated household member
- Mother treated violently

Social-Emotional Development

Why concern?

Immediate impact
- Maternal depression compromises bonding.
- Babies often avoid interaction; attachment is at risk.
- The mother-child relationship creates an environment for the infant in which s/he withdraws from daily activities.
- Emotional and social development, as well as intellectual, language, and physical development is at risk.
Impact of Maternal Depression
Long Term

- Infants are at risk for insecure attachment. Children with insecure attachment are more likely to have behavior problems and conduct disorder.
- Maternal depression in infancy is predictive of cortisol levels in preschoolers, which is linked with anxiety, social wariness and withdrawal.
- When mothers experienced major depression, then attachment disorders, behavior problems, and depression and other mood disorders can occur in childhood and adolescence.

Screening Process

- Edinburgh Postpartum Depression Scale, PHQ-2 followed by the Edinburgh or PHQ-9
  - Massachusetts version of SWYC (Survey of Well-Being of Young Children) contains the Edinburgh
- Screen at the 1, 2, 4, and 6 month well visits
- When positive, follow-up screen to assess attachment between the mother and infant within the next month.
  - ASQ, SE-2, BPSC

Edinburgh Postpartum Depression Scale

- Completed by the mother
- At 1 month, 2 month, 4 month, 6 month visits
- Simple 10 multiple choice questions
- Score of 10 or greater indicates possible depression
- English and Spanish
  - Sensitivity – 86%; Specificity – 78%
  - Available on line

Immediate Action

If the Edinburgh Score is 20 or greater, or
If the mother expresses concern about her or her baby’s safety, or
If the CM suspects the mother is suicidal, homicidal, severely depressed/manic or psychotic...
  • Refer for emergency mental health services
  • Be sure she leaves with a support person (not alone) and has a safety plan

When Screening Shows a Concern

- Communication
- Demystification
- Support Resources – family, community
- Referrals:
  - Integrated/Co-located Mental Health Provider at PCC
  - For mom
  - For dyad
  - For child for targeted prevention and early intervention
**Brief Intervention**

- Strengthen the mother-child relationship.
- Understand and respond to baby’s cues.
- Encourage routines for predictability and security.
- Focus on wellness: sleep, diet, exercise, stress relief.
- Acknowledge, accept and heal personal experiences.
- Encourage realistic expectations; prioritize important things.
- Encourage social connections.

**Intervention**

- For Mom – Ranges from: support, to therapy, to therapy plus medication, to emergency mental health services/hospitalization.
- For Dyad Relationship – Includes: therapy with child mental health professional re: attachment and bonding; follow-up social-emotional screen, and if Attachment Disorder of Infancy, referral to Part C.

**Referral for Mom**

- Who?
  - Mother’s PCC
  - Mother’s obstetrician
  - Mental health provider
- For
  - Individual and/or family therapy
  - Medication management

**Referral for the Dyad**

- The mother and child need to be referred to a professional with expertise in the treatment of very young children.
- Evidence-based treatments
  - Circle of Security (www.circleofsecurity.org)
  - Child-Parent Psychotherapy (Child First)
  - ABC (Attachment & Biobehavioral Catch up)
- Part C services can provide modeling for interaction and play with the infant to promote healthy development

**Important Linkages**

- CC4C
- Nurse Family Partnership
- Part C – Early Intervention
- Child First (eastern NC)
- Lactation Specialists
- Family Support Groups
- Mother’s morning out
- Early Head Start
- Child Care Health Consultants
- Home visiting and home visiting programs
- Mental Health Paraprofessionals
- Part C and other early intervention programs
- Community mental health providers

**References**

Linking Families to Services to Meet Identified Needs

November 3, 2016 CC4C Webinar

Health Check Program in NC

- 55 Health Check Coordinators (HCC)
- Health Check helps children under the age of 21 receive regular preventive medical care, and the diagnosis and treatment of a health problem found during screening.
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) ensures that children under the age of 21 must be provided all medically necessary health care services. This is a benefit for NC children who are eligible for Medicaid. Includes Vision and Hearing Screens, Dental screening, Immunizations, and laboratory procedures (i.e. hemoglobin, lead)

Role of the Health Check Coordinator

Preventive Health Services/Periodic Screening
- Key Responsibilities:
  - Outreach and Awareness
  - Member Enrollment, Education and Participation
  - Practice and Network Enrollment and Participation
  - Data Tracking, Reporting and Accountability
- Collaboration w/ CC4C CM:
  - Joint visits with CC4C CM to patient’s home
  - Participate in 3-way calls with practice for rescheduling delinquent visits

November 3, 2016 CC4C Webinar

November 2016 CC4C Webinar

Roles, priorities, and collaboration with CC4C care managers

Kern Eason
Pediatric EHR Consultant / Acting Pediatric Program Manager
Community Care of North Carolina

November 2016 CC4C Webinar

Resources for Linking Families to Needed Support

This document is provided as a webinar handout AND is located in the CC4C Toolkit using the following path: Home > CC4C Tool Kit File Share > CC4C Toolkit Jan 2015 > Section 16 - Linking Families to Resources
Health Check Program Priorities

- Improving Well-child Visit rates for 3-6 year olds and adolescents are CCNC clinical goals.
- Need Care Alerts restored for accurate list of children who are delinquent on well visits. Currently rely on practice no-show lists.

HCC and CC4C

How they could interact with each other

- When child ages out or there are no more concerns, CC4C CMs can refer back to HCC for ongoing follow-up.
- HCC advised to look at tasks in CMIS and do not attempt to call patient if CM already working with patient.
- A regular huddle between HCC, CC4C CM (possibly include BH team member) around difficult cases
  - For internal support and morale
  - For promoting cross-training
  - For reviewing “lessons learned”
- CC4C CM reaching out to HCC regarding:
  - NC Tracks issues
  - Working with patients who’s impactability score is below 200, thus helping network over the 2% care management hurdle.

HCC Program Highlights

Patient Lists Used for Mailings to Members:
- Care Alerts
- AINS Data
- Practice Lists
- EPSDT Practice Profile
- Other “Informatics Center” Reports

HCC Program Highlights

<table>
<thead>
<tr>
<th>CCNC's Aggregate EPSDT Profile</th>
<th>Dec-14</th>
<th>Dec-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 month WCV - six or more</td>
<td>67%</td>
<td>69%</td>
</tr>
<tr>
<td>3 to 6 WCV</td>
<td>67%</td>
<td>68%</td>
</tr>
<tr>
<td>7-11 WCV</td>
<td>48%</td>
<td>46%</td>
</tr>
<tr>
<td>Adolescent WCV - Annual Visit</td>
<td>39%</td>
<td>38%</td>
</tr>
</tbody>
</table>

HCC Program Highlights

Types of automated calls include Welcome Calls, Delinquent Lists, EPSDT Practice Profile, Other Informatics Center Reports.
HCC Program Highlights

<table>
<thead>
<tr>
<th>Specific Population Contacted</th>
<th>ED utilization ages 5-18</th>
<th>Non-Emergent ED visits</th>
<th>School Age &amp; Adolescent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smart Start ages 0-5</td>
<td>Rising Kindergartners</td>
<td>Newborns/Pilot</td>
<td></td>
</tr>
<tr>
<td>Foster Care</td>
<td>Rising 6th Graders</td>
<td>Flu campaign</td>
<td></td>
</tr>
<tr>
<td>Spanish speaking children</td>
<td>Provider change requests</td>
<td>Re-enrollment</td>
<td></td>
</tr>
<tr>
<td>Deficient WCC</td>
<td>Transition age</td>
<td>Rising 7th Graders</td>
<td></td>
</tr>
</tbody>
</table>

Ideas...

- To improve awareness - Host a poster session at network where each department can showcase their areas of focus (similar to poster sessions at a health fair)
- To improve CM – PCP communication and coordination, a practice case study might be helpful.

CC4C Updates

The Standards Report can be used to assess the following requirements that are NOT flagged with yellow highlighting in the report:

- **CHA**: View only the cases in heavy & medium case status using the CC4C Case Status Column and then look at CHA Update (Most Recent) Column – the CHA must be updated every 30 days
- **Goals**: View only the cases in heavy & medium case status in the CC4C Case Status Column and then look at the Goal Date (Most Recent) Column - the goal must be updated every 30 days
- **Goals**: View only the cases in light case status in the CC4C Case Status Column and then look at the Goal Date (Most Recent) Column - all patients in light case status must have a goal, and the goal must be updated every 90 days

CC4C Data Dashboard Results
Measure 1 indicates the unduplicated number of children identified and contacted from Jan-Jun 2016:

- **29,263** children

Measure 2 indicates the unduplicated number of children engaged in heavy, medium or light case status from Jan-Jun 2016:

- **22,260** children

76% of the children identified and contacted were engaged in heavy, medium or light case status from Jan-Jun 2016.

Measure 3 indicates that only 1,245 were deferred for unable to contact out of the 33,713 children with a completed or attempted task from Jan-Jun 2016.

- **3.7%** deferred d/t unable to contact
- **96.3%** NOT deferred d/t unable to contact

AMAZING!

Measure 4 indicates that only 255 were deferred for refused services out of the 33,713 children with a completed or attempted task from Jan-Jun 2016.

- **0.8%** deferred d/t refused services
- **99.2%** NOT deferred d/t refused services

AMAZING!

How many new children do you need to contact to be in the target range? Measure 1 example appears below in GREEN:

Total population X percentage desired to reach = number of unique patients that should be contacted (M1) or care managed (M2) per 6 months:

14,039 X 5% = 701.3 unique patients per 6 months

Number of unique patients per six months / number of unique patients that should be contacted (M1) or care managed (M2) per month:

701 / 6 months = 116.8 or 117 unique patients per month

Number of patients that should be contacted/care managed / number of unique patients that should be contacted/care managed per month per care manager:

117 patients / 11.48 Care Managers = 10 new, unique patients per care manager per month
New CMIS Intervention

Screen shot of CMIS screen where tasks are entered

Collaborating with WIC

Are you collaborating with your local WIC office?

If you are willing to share you WIC experiences and strategies, we would love to hear from you:


Please provide feedback by November 30

The more responses we receive, the more valuable the information we will be able to provide in January

Plans are to compile the information submitted and share during the January 2017 CC4C webinar.

Revised Case Review Tool Training

An email was sent on October 31, 2016 regarding the revised Case Review Tool, which included:

- The revised CRT
- Information on how to access a 30-minute recorded training providing an overview of the revised CRT, along with the training handouts.

The email also included the expectation that all supervisors and care managers view this training by November 30, 2016

Priority Report Filtering

Suggestions:

- Run the report with “Select all” in all filters
- Once the report is exported in Excel, manipulate the report to find the highest priority children – refer to the Using the CCNC TC Priority Report document in the Priority Report folder in the Section 04-Best Practice folder in the toolkit
- For larger counties, try running and exporting the report early or late in the day

CC4C Training Plan

The CC4C Training Plan posted on the CC4C Web Page at http://childrenyouth.CC4C.sgizmo.com/s3/ now consists of 3 phases:

Phase One – Basic Care Management (orientation), consists of 15 trainings that must be completed by new staff before engaging clients; latest changes made in July 2016

Phase Two – Priority Population: contains information related to the CC4C Priority Population: all six topics must be completed by new staff within 3-6 months of engaging clients; latest changes in July 2016

Phase Three – Supervision Expectation: Contains these brand new trainings:

- CC4C Supervision Expectations
- Revised Case Review Tool

As of November 1, 2016, new supervisors must complete Phase Three trainings within one month of assuming CC4C supervision.

CC4C Toolkit

The following downloadable chapters, found in Section 14 of the CC4C Toolkit, have been effective September 1, 2016:

- Section 2-Contracts and Agreements: CC4C Agreement Addenda Revision #1 has been added
- Section 06-Supervision: Updated Case Review Tool, CRT Instructions, Supervision Guidance document, along with the handouts of all Phase Three trainings.
CC4C Toolkit

The following downloadable chapters, found in Section 14 of the CC4C Toolkit, have been effective September 1, 2016:

• Section 15 - Patient Education - Healthwise: Updated Healthwise materials have been added, along with updated Patient Education policy
• Section 16 - Linking Families to Resources: the resources spreadsheet has been updated

The CC4C TP documents for CMs & supervisors have been updated in Section 13.

Questions?

• If you insert questions in the webinar evaluations, we are not able to follow up with you directly
• Reach out to your:
  • Supervisor,
  • Regional child health nurse consultant, and/or
  • Local CC4C network lead

Tiered System to Gain & Apply CC4C Information

**Goal:**
Ensure info is understood & applied in order to improve health outcomes & decrease cost, thus meeting Performance Measures

**Next Webinar:**
Thursday, January 5, 2017 at 9:30 a.m.