CC4C Orientation

Module One

Goals of Module One

- Identify all agencies involved in the CC4C Partnership
- Present a brief description of each partner
- Introduce an overview of CC4C services
- Share resources for CC4C Care Managers

Care Coordination for Children (CC4C)

Brings together:
- **State Partners**: DMA, DPH, & CCNC Central Office
- **Local Partners**: LHDs & CCNC networks
- CC4C & CCNC care managers

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

Community Care of North Carolina

Statewide Program for Managing Carolina Access Recipients

North Carolina Medicaid

*1.5 Million Medicaid Recipients*

- 1,233,000 enrolled in a CCNC Medical Home

- 1,542 Practices
- 4,500+ Providers
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CCNC Origins

Medical Home Capacity & Accountability

• Started with 9 pilot networks
• Single-disease initiatives
  - 1998 asthma (data-driven, evidence-based guidelines, population-management approach, rapid cycle QI)
  - Other initiatives followed (DM, HF, etc.)
• Achieved cost-savings & improved quality of care
• 9 pilot networks grew to 14 Sustained Networks in 100 counties

Community Care Networks

• Non-profit, Physician-led, Locally owned and operated organizations
• Receive a designated amount of $$$ per Medicaid recipient enrolled in a CCNC practice in their Network per month from the Medicaid (Division of Medical Assistance/DMA)
• Funds the Primary Care Management model
• Partner with other safety net providers
• Use existing resources to build better local systems of care
• Local flexibility to create local solutions to local issues
• Have Medical Management Committee oversight & Board of Directors
• Participating Practices receive an enhanced patient incentive to function as a medical home and participate in CCNC Initiatives (disease management and quality improvement)

CCNC Networks

Focus of CCNC

improved quality, utilization and cost effectiveness of chronic illness care
Managing Clinical Care (Spreading Best Practice)

Clinical Directors Group
- Select targeted disease care areas
- Monitor analytic trends and patterns
- Establish program measures

Local Medical Management Committee
- Implement state-wide initiatives
- Develop local improvement initiatives

Practice A, Practice B, Practice C
Care managers and CCNC quality improvement staff support clinical management initiatives

Chronic Care Model
Over time, visits/interactions (planned and acute) will meet patient needs and assure the delivery of proven clinical and behavioral elements of care.

INFORMED
ACTIVATED
PATIENT
IMPROVED OUTCOMES

IN PREPARED PROACTIVE TEAM

http://www.improvingchroniccare.org

CCNC Network Teams
Support the Medical Home

Local Network Team
- Provider Engagement
- Patient Engagement
- Evidence-Based Guidelines
- Education, Referrals, Follow-Up
- Process Improvement
- Outcome Improvement
- Improved Care
- Improved Utilization

Main Program Activities
- Management of Priority Populations
  *TREO Priority Population List (PPL)
  *Patients in the Hospital/Transitional Care
  *Real-Time Referrals
  *Other Data Reports
- Chronic Disease Management of Key Conditions (e.g. Asthma, Diabetes, Heart Failure, Hypertension, Ischemic Vascular Disease, Mental Health Conditions)
- Medical Home Quality Improvement Activities
- Emergency Department Utilization
- Integration of Physical and Mental Health
- Chronic Pain Initiative
- Prevention Initiatives
- Pharmacy Initiatives
- Palliative Care
- Informatics Center/Pharmacy Home/Provider Portal/CMIS

A few of the challenges…
- The General Assembly charged DHHS (and CCNC) to save $90 million in FY2012 (July 2011 thru June 2012).
- As of 8/11, enrolled ABD population ~ 205,400 (total ABDs >361,000; NC Medicaid population ~1.48 MM; those enrolled in Carolina Access II & III >1,082,000).
- With health reform, the NC Medicaid rolls may grow by more than 500,000 new recipients by 2014.
- Total ABD population represents less than 25% of NC’s Medicaid population, but consumes more than 70% of Medicaid dollars. 0% of Medicaid dollars.

Primary Goals of Community Care
- Improve the care of Medicaid population while controlling costs
- A “medical home” for patients, emphasizing primary care
- Community networks capable of managing recipient care
- Local systems that improve management of chronic illness in both rural and urban settings
Definition of Public Health:
Public health consists of the activities that society undertakes to assure the conditions in which people can be healthy, including organized efforts to prevent, identify and counter threats to the health of the public.

Mission of NC Public Health:
• To promote and contribute to this highest level of health possible for the people of NC.

From Introduction to Public Health
http://www.sph.unc.edu/nciph/introduction_to_public_health_in.nc_6386_7857.html

Ten Great Public Health Achievements in the United States, 1900-1999
1. Vaccination
2. Motor-vehicle safety
3. Safer workplaces
4. Control of infectious diseases
5. Decline in deaths from coronary heart disease and stroke
6. Safer and healthier foods
7. Healthier mothers and babies
8. Family planning
9. Fluoridation of drinking water
10. Recognition of tobacco use as a health hazard
Title V of the Social Security Act

- Is a block grant program
- Is administered by the Maternal and Child Health Bureau (MCHB) within the US Dept of Health & Human Services
- Combines Federal, State, and local funds to provide comprehensive services to low income women and children with limited access to health care services

Title V MCH Programs

1. Assure access to quality care, especially for those with low incomes or limited availability of care;
2. Reduce infant mortality;
3. Provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at risk pregnant women);
4. Increase the number of children receiving health assessments and follow-up diagnostic and treatment services;
5. Provide and ensure access to preventive and child care services as well as rehabilitative services for certain children;
6. Implement family-centered, community-based, systems of coordinated care for children with special healthcare needs; and
7. Provide toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

History of DPH

Care/Case Management for Children ages 0-5 years

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

Example of National Public Health Initiatives

http://medicalhomeinfo.org/

Example of NC Public Health Initiatives

http://www.ncpublichealthquality.org/ctr/
From Introduction to Public Health
http://www.sph.unc.edu/nciph/introduction_to_public_health_in_nc_6386_7857.html

Additional PH Resources

- This is Public Health campaign by Association of Schools of Public Health
  - View This is Public Health Video at: www.thisispublichealth.org/video_highres.html
  - Learn more about This is Public Health Campaign at: www.thisispublichealth.org/
- Introduction to Public Health – a free online, one hour course at:
  http://www.sph.unc.edu/nciph/introduction_to_public_health_in_nc_6386_7857.html

As of 1949, each NC county had established a local health department (LHD)
- Today, all 100 counties are served by an individual LHD, except for the following multi-county health departments:
  - Albemarle District (Bertie-Camden-Chowan-Currituck-Gates-Pasquotank-Perquimans)
  - Appalachian District (Alleghany-Ashe-Watauga)
  - Granville-Vance District
  - Martin-Tyrrell-Washington District
  - Rutherford-Polk-McDowell District
  - Toe River (Avery-Mitchell-Yancey) District
- Each LHD is governed by a local Board of Health
Local Health Departments began providing Care Coordination for Children (CC4C) services in partnership with local CCNC networks.

- The name of the CC4C service provided by LHDs is population Care Management.
- The LHD staff providing CC4C services are referred to as CC4C Care Managers.

**CC4C Target Population**

- Children from birth to 5 years of age (both Medicaid & non-Medicaid)
- Children with Special Health Care Needs
- NICU Babies
- In Foster Care & Not Linked to a Medical Home
- Exposed to Toxic Stress in Early Childhood
- Children Flagged on a Priority Population List Based on Above-Expected Potentially Preventable Hospital Costs
- Other children identified through claims data reports that could benefit from follow-up and/or transitional care services

**CC4C Responsibilities**

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

- level the service based on the family’s needs (e.g. heavy, medium, light)
- determine the length of time that services are provided depending on family’s need and evidence that progress is being made
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CC4C Medical Home Responsibilities

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

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

Note: Recruitment of CC4C MH is not a program focus, as most MHs serving children 0-5 years were already enrolled as CCNC providers. However, assuring that children we serve are linked to Medical Homes is a priority.

Performance Metrics

CC4C Contract Metrics [Reported to DMA]
PM #1:
Increase in NICU graduates who have their first PCP visit within one month of discharge.

PM #2:
Reduce the rate of hospital admissions for children birth to <5.

PM #3:
Decrease the rate of readmissions for children birth to <5.

PM #4:
Reduce the rate of ED visits for children birth to <5.

Performance Metrics

CC4C Contract Metrics [Continued]
PM #5:
Increase percent of comprehensive assessments completed for CC4C patients identified as having a priority (heavy/medium case status).

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

MEASURES

Success = Meeting Performance Metrics and Program Measures

Meeting Measures depends on:

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

CCNC has long history of meeting measures that demonstrate ↑ quality & ↓ cost.
CC4C Funding

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

- receive a Per Member Per Month (PMPM) allocation to serve Medicaid clients; amount of PMPM is based on the number of Medicaid children 0-5 years in each county.

- have the opportunity to draw down CC4C Agreement Addenda funding to serve non-Medicaid children; level of funding is consistent with past CSP AA funding.

Care Coordination for Children

Pulling it all together

CC4C Program Development

Cheryl Lowe
CC4C Program Manager
Division of Public Health
WCH Section / C & Y Branch
Work Cell: 336-813-2068
cheryl.lowe@dhhs.nc.gov

Carolyn Sexton
CC4C Project Manager
CCNC Central Office
Office: 919-745-2428
carolyn.sexton@dhhs.nc.gov

Care Coordination for Children (CC4C)

A critical component to the success of the CC4C Program is establishing a close relationship between the local CCNC & the LHD

- To achieve a fully integrated and collaborative system of care, decisions about how to manage the targeted populations must be decided at the community level - building on the strengths and resources that each partner offers.

- Together we will also need to determine how we can build strong, stable relationships and communications between CCNC Care Managers, CC4C Care Managers and the Medical Homes they serve.

- Together we will monitor progress and discuss strategies for achieving the outcome measures of the CC4C Program (many of which are objectives that we share).
Possible Responsibilities of Network Lead CC4C Contact
1. Responsible for CC4C and other network duties
2. Facilitates regular meetings of local CC4C staff
3. Provides CMIS support
4. Monitors CMIS activities
5. Knowledgeable of Medical Homes in each county
6. Works with local Medical Homes to ensure close working relationship with CC4C CMs
7. Discusses local network case load & face-to-face expectations

Possible Responsibilities of DPH Regional Child Health Nurse Consultants (CHNCs)
1. Provides technical assistance to a region of LHDs for CH Programs, including CC4C
2. Monitors the number of cases and staffing
3. If a need is identified, works with the agency using QI tools to develop a step-by-step plan to address the need, including timelines.
4. Provides support to regional meetings for CC4C staff and network staff (role varies from network to network).
5. Support CC4C CM orientation and training needs.
6. Provide training and support to local health department staff on using the Quality Improvement Model.

CC4C Webinar for Supervisors & Care Managers
- 1st Thursday of every month
- 2:00 p.m.
- Via the internet
- Announcement sent via the CC4C Email List