Step-by-Step Guide for CMARC Services

Items appearing below in green font involve VirtualHealth (VH), the CMARC CM documentation system. More details about the VH steps are provided in the CMARC Start to Finish in VirtualHealth document, which can be accessed in the CMARC Toolkit; VH steps are also covered in the CMARC VirtualHealth Start to Finish training found on the Phase One Training Page.

Outreach
Identify the CMARC target population by:

1. Developing strong relationships with medical homes in your county
2. Reaching out to possible referrals sources, such as hospitals, DSS & WIC
3. Using any reports made available for identifying the CMARC target population

Identification
Referrals are received by the LHD designated person using the LHD procedure for processing referrals: once a child is identified for CMARC services by receipt of a referral:

1. Establish the child’s record in VirtualHealth, the CMARC CM documentation system, by:
   a. Identifying the child’s existing record in VH or create a temporary record
   b. Creating or updating the Care Team in VH, including CMARC CM, primary CM, family, DSS & providers
   c. Creating a CMARC Episode and a Referral in VH
   d. Reviewing the Queue and Tasks in VH
   e. Adding the CMARC Referral Screening form in VH
2. Within 72 hours of receipt of the referral:
   a. Notify child’s medical home (MH) of referral, including the reason of the referral – document as Correspondence and/or Interaction
   b. If a referral form is received, acknowledge receipt of the referral to the referral source – document as Correspondence and/or Interaction
3. Review available info:
   a. If the child is clearly not eligible for CMARC services, close the Episode as Ineligible; an example would be a referral of a child who is 6 years old; if clearly ineligible, send the CC4C Not Eligible letter in VH to the family and MH per CMARC Letter Guidance
   b. Otherwise, you would attempt to engage the family to gain more info to determine eligibility and need for services

Engagement
1. Attempt to reach out to identified families following CMARC timeframe expectations in the CMARC Patient Engagement Policy, which indicates:
   a. Within 7 days of receipt of a CMARC referral, the CMARC CM must either:
      i. Have a contact with the family by phone or home visit
      OR
      ii. Make a minimum of 3 attempts on different days at different times and different ways – NOTE: to meet this requirement, you must begin attempts within 72 hours
Step-by-Step Guide for CMARC Services

2. CMs could make a total of 3-5 contacts within 14 days to engage a client as indicated in the CMARC Patient Engagement Policy – document as attempted Interaction.

4. If no contact after 14 days, the CM should close that child unless there is a specific, unusual concern; if closing, close the Episode as Unable to Reach as indicated in the CMARC Lost to Contact and Unable to Reach Policy; send the CC4C Unable to Reach letter in VH to the family and MH per CMARC Letter Guidance.

3. If contacted with the family is made:
   a. Use a family-centered approach along with motivational interviewing (MI) skills
   b. Explain CMARC services and benefits of participation using materials in the CMARC Toolkit
   c. Document the contact with the family as an Interaction.
   d. If family refuses services, close the Episode as Declined; send the CC4C Declined letter in VH to the family and MH per CMARC Letter Guidance.
   e. If family agrees to services:
      i. Provide more details on how CMARC services will be provided
      ii. Change CMARC Episode to Managed
      iii. Send the CMARC Welcome letter as stated in the CMARC Letter Guidance document – it contains important info about the family’s rights
      iv. Begin the CMARC care management process below
   f. Be sure the child’s medical home has been notified of the outcome of the engagement attempt; document the notification as an Interaction &/or Correspondence.

CMARC Care Management Process

1. Assessment:
   a. Complete the following CMARC assessments according to the CMARC CM Assessment & Screening Policy and the CM Process, SWYC & LSP Phase One Trainings:
      i. CMARC Referral Screening, if not previously entered as part of Engagement
      ii. Comprehensive Needs Assessment – CMARC (CNA): complete within 30 days of engagement and update no less than every 90 days
      iii. The Survey of Well-being of Young Children (SWYC); complete within 30 days of engagement and then based on periodicity schedule
      iv. Life Skills Progression (LSP): complete within 60 days of a child being identified as potentially exposed to TS if viewed in a long-term caregiver-child relationship; then every six months
      v. Claims/Case Review: review claims data at engagement and then at least every 90 days; review case data initially and then as necessary
   b. Assessment that are completed should be documented in VirtualHealth as indicated in the Phase One VirtualHealth Training.
   c. Use the assessment results to:
      i. Confirm the child is in the CMARC target population; if not, close the Episode as Ineligible
      ii. Identify the family’s strengths and assets
      iii. Identify the family’s needs
2. Care Planning
   a. Discuss the needs identified via the CMARC assessments with the family as well as the reason for referral or identification, then determine the family’s priorities using motivational interviewing techniques.
   b. Jointly develop the care plan with the family based on their prioritized needs.
   c. If a Need is identified and the family does not want to work on that Need even after receiving info on the benefits of working on the Need, then enter the Need into the VH CP; also enter that the info provided as an Intervention and then close the Need by selecting the Problem Status as Declined.
   d. Ensure the need for preventive care is identified and addressed in the care plan (CP) according the CMARC Pathway of Care – Preventive Health document.
   e. If the child is less the 12 months of age, make sure there is a need identified and addressed in the CP related to safe sleep based on expectations found in the CMARC CM Assessment & Screening Policy.
   f. In addition to the Preventive Health need (item c. above) and possibly Safe Sleep (item d. above), ensure there is at least one additional need identified and addressed in the CP as indicated in the CMARC Care Planning Policy.
   g. Complete the VH CP according to the guidance provided in the CMARC Care Planning Policy and the Phase One VirtualHealth Training, which involves creating or choosing the Need, Problem, Problem Status, Start Date, End Date, Episode and the Component of the Care Goal.
   h. Within 30 days of the child being placed in a CMARC Episode of Managed, review the VH CP with the family, then sign as the CM, indicate the family’s agreement & save the CP.
   i. Be sure that the actions included in the CP include other providers who may be addressing that need and are not duplicative.
   j. Knowing the impact of social determinants of health (SDOH) as indicated in the SDOH training, be sure identified needs related to SDOH are addressed in CP if a priority for the family.
   k. With each contact that occurs with the child’s family, review the CP as indicated in the CMARC Care Planning Policy and update the CP as needed.
   l. Once the CP has been developed to meet the identified needs, choose an Engagement Status Level consistent with the level of engagement with the family needed to implement the CP:
      i. High: Daily to weekly engagement = > 4x/month
      ii. Medium: Weekly to bi-weekly engagement = 3-4x/month
      iii. Low: Bi-weekly to monthly engagement = 1-2x/month
      iv. Intermittent: Monthly to quarterly engagement = < 3x/90 days

3. Implementation
   a. Ensure actions in the VH CP are implemented to meet identified needs, including these commonly-implemented actions:
      i. Patient Education: CMs are to follow the CMARC Patient Education Standard providing:
         - Core Content to all families at specific age intervals and
Step-by-Step Guide for CMARC Services

- Condition or Age-Specific Content to families to meet individual needs

ii. Linkage to Community Referrals:
- Link families to resources to meet identified needs using these resources: LHD Resource List, CMARC Resource Directory and NCCARE360, if available in your county; more info available in the Social Determinant of Health Training
- Remember that informing families of resources is not enough – you must Close the Loop by ensuring the family was able to link with the resource and confirm that the resource met the identified need; see the Social Determinant of Health Training for more info

b. Document the implementation of actions as an Intervention in the VH Care Plan

c. Also document any Interactions &/or Correspondence made to meet the identified needs; if letter is used to communicate with the family, follow the CMARC Letter Guidance

4. Evaluation

a. Must review and update the CP with each contact; if you are unable to contact the family to review or update an existing CP, then you would close the CMARC Episode as Lost Contact according to the following guidance provided in the Lost to Contact – Unable to Reach Policy and the VirtualHealth Phase One Training; record 3-5 attempts to contact over 14 days in different ways and at different times; send the CC4C Lost Contact letter in VH to the family and MH per CMARC Letter Guidance

b. If it is determined that the identified Need has been met, close the Need as Graduated as indicated in the CMARC Care Planning Policy; if all the identified needs are met, close the CMARC Episode as Graduated; send the CC4C Closure letter in VH to the family and MH per CMARC Letter Guidance

c. After implementing the planned CP Interventions, if progress is not being made to meet the identified Need:
   i. Start the CM process over by assessing if:
      - The intervention needs to be revised or re-developed
      - The intensity of CMARC service needs to be revised to meet family’s needs, possibly changing the CMARC Engagement Status Level
      - Barriers exists that need to be address
      - The family is invested in the goal – if the family does not wants to continue work on a Need, then close the Need as Declined as indicated in the CMARC Care Planning Policy; if the family no longer wants to work on any of the identified Needs, then close the CMARC Episode as Declined; send the CC4C Declined letter in VH to the family and MH per CMARC Letter Guidance
   
   ii. If additional cycles of the CM process is implement and progress is still not made after, discuss the benefit of continuing services with the family; if the family no longer wants to participate in CMARC services, close the CMARC Episode as Declined; send the CC4C Declined letter in VH to the family and MH per CMARC Letter Guidance
Step-by-Step Guide for CMARC Services

d. Collaboration with the child’s medical home
   i. Notify the medical home if:
      • Significant changes are made to CP
      • If CMARC services stop, including why the services stopped
   ii. To communicate in writing with the MH, CMs can:
      • Choose and adapt one of the standardized letters available in VirtualHealth, such as the **CC4C Cover Letter Provider**
      • Create your own letters for mailing if none of the existing VirtualHealth letters meet your needs using the following guidance:
         a. Any letters sent that are created locally must be reviewed by the CMARC supervisor at your agency prior to sending
         b. Agencies may choose to create their own versions of letters for use by agency staff, but should obtain agency approval
   iii. Contact with the medical home should be documented:
      • In the **VH CP**, if contact is part of the planned interventions
      • As a **VH Interaction &/or Correspondence**, depending on the circumstances