



Children & Youth Branch



Care Coordination for Children:

An At-Risk Population Management Program for Children Birth to 5 Years of Age

Brief Description:

Care Coordination for Children (CC4C) is a new program that began March 1, 2011 that transitions Child Service Coordination, a public health targeted case management program, into an at-risk population management model. The CC4C Program is administered as a partnership between Community Care of North Carolina (CCNC), the NC Division of Public Health (DPH) and the NC Division of Medical Assistance (DMA).

Referral Criteria:

Referrals originate from the medical homes, hospitals, community organizations, CCNC care management staff or families and can be submitted on paper or taken by phone. CC4C staff serve children birth to 5 years of age, who meet the following priority risk factors:

- **Children with Special Health Care Needs [Title V - Maternal Child Health Block Grant Definition]**
 - Chronic physical, developmental, behavioral or emotional condition
 - Expected to last at least 12 months
 - Requires health & related services of a type & amount beyond that required by children generally
- **Children Exposed to Toxic Stress in Early Childhood [Per Dr. Jack Shonkoff Research at Harvard University]**

Including, but not limited to:

- Extreme poverty in conjunction with continuous family chaos
 - Recurrent physical or emotional abuse
 - Chronic neglect
 - Severe and enduring maternal depression
 - Persistent parental substance abuse
 - Repeated exposure to violence in the community or within the family
- **Children in the Foster Care System who Need to be Linked to a Medical Home**
 - **Children in the Neonatal Intensive Care Unit who Need Assistance as they Transition Back to the Community and Link to a Medical Home**
 - **Children Flagged on a Priority Population List Based on Above-Expected Potentially Preventable Hospital Costs Given the Person's Disease Burden**
 - Identified through TREO methodology.

CC4C Services:

CC4C services are being provided based on patient-need and according to risk stratification guidelines. A comprehensive health assessment, including the Life Skills Progression*, assists the care manager in identifying the child's needs, plan of care and frequency of contacts required to effectively meet desired outcomes. Contacts occur in multiple settings including the medical home, hospital, community, child's home, and by phone. All documentation for CC4C services will be completed online in the CCNC Case Management Information System (CMIS). CC4C care managers work in close collaboration with CCNC care managers to meet the needs of the population.

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

Medical Home Relationships:

Each Medical Home serving children birth to 5 years of age will have a specific CC4C Care Manager(s) assigned to work with their clients. This stable relationship will support effective and complete communication between the Medical Home and CC4C Care Manager. Decisions regarding the best way to introduce the "CCNC/CC4C Care Management Medical Home Team" are being made locally. Ideally, a meeting with the practice is being scheduled to introduce the team and discuss the roles/responsibilities (division of labor) and handling of referrals that has been agreed upon.

CCNC Network Relationship:

Each CC4C agency will work in close collaboration with their local CCNC network. The network will use reports based on data from CMIS, Medicaid claims, vital records and other administrative sources for quality improvement purposes and to identify the extent to which the program is achieving its goals.

Goals and Outcome Measures:

The main goals of the program are to improve health outcomes and reduce costs for enrolled children. These goals will be monitored based on the following CC4C outcome measures:

DMA Performance Metrics:

1. Increase in NICU graduates who have their first PCP/medical home visit within one month of discharge.
2. Reduce the rate of hospital admissions for Medicaid children birth to <5 years of age.
3. Reduce the rate of readmissions for Medicaid children birth to <5 years of age.
4. Reduce the rate of ED visits for Medicaid children birth to <5 years of age.
5. Increase the percent of comprehensive (health) assessments (CHAs) completed for CC4C patients identified as having a "priority."
6. Increase the Life Skills Progression (LSP) Assessments on children receiving care coordination through CC4C on entry into the system, every six (6) months thereafter and/or upon closing.

CC4C Program Measures:

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

CC4C Workgroup:

A CC4C Workgroup has been convened to advise and guide our work. They are actively involved in CC4C program development and meet monthly. The group includes representatives from DPH (CC4C and Early Intervention), DMA, CCNC's Central Office, Physician Community; Local CCNC Networks, Local Health Departments and members of the DPH, Children and Youth Family Council.