NC InCK

NC INTEGRATED CARE FOR KIDS

Integrated Care Round: Supporting Children & Youth with Special Health Care Needs (CYSHCN)

September 12: 12:00-1:30 PM

This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $11,999,227 in 2024 with 0% percentage financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS, HHS or the U.S. Government.

Agenda

1. Why Children & Youth with Special Health Care Needs?
2. CYSHCN Overview: Dr. Brian Eichner
3. Reflections and Perspectives
4. Community Alternatives Program for Children (CAP/C): Shenita Ross
5. A Look Ahead

Grounding for All NC InCK ICRs & Echos

- **Respect for All:** *There will be topics, situations, or maybe even resources that you as a person have various feelings about. We ask that in these spaces, we all show respect for all, by being supportive, caring, and professional.*
- **Take 2 and Pause:** *Discussion and hearing from you is so powerful, and what we strive for in these spaces. We ask that if you have shared twice, take a pause, to encourage colleagues to take the floor and share as well.*
- **Questions Encouraged:** *If you have a questions please ask, in most cases someone has the same one. Be BOLD and PROUD, ask it! You are always welcome to private chat Josie Hatley as well!*
- **Play, Learn, Grow:** *Just like Fisher Price, we want you to enjoy this learning space, learn and grow from/with each topic!*



NC InCK NC INTEGRATED CARE FOR KIDS

Why Children and Youth with Special Health Care Needs?

Challenge: Accessing resources for this population, particularly, when someone has aged out of CDSA*



"CYSHCN include individuals with a wide range of health care needs including physical, mental and behavioral health conditions, and levels of limitations" (Source)

"Research shows that beneficiaries and their families often receive little to no transition assistance or planning when transitioning to adult coverage and care" (Source)

Challenge: Communication with healthcare providers *

NC InCK NC INTEGRATED CARE FOR KIDS

*Challenges identified by NC InCK Family Navigators in September 2024 ICR Pre-Survey

Overview of CYSHCN

NC InCK NC INTEGRATED CARE FOR KIDS

A Sea of C's: Care Coordination for Children with Medical Complexity

Brian Eichner, MD

Associate Professor of Pediatrics, Duke University Medical Center

Outpatient Medical Director, Duke Children's Complex Care Service

DukeHealth

Disclosures

- No relevant financial disclosures.
- I did NOT do any fellowships in care of medically fragile children. Nor do I have any formal training other than experience…
- At my core (and 50% of “me”) is a primary care physician.

Objectives

- Define core tenets of care coordination and separate this from case management;
- Explore ways that care coordination can help patient and family-centered outcomes;
- Develop more global understanding of the factors that influence patient and family well-being.
- Learn tools that can help foster successful relationships between patients, families, and their pediatricians.



Roadmap

- Discuss key tenets of care coordination and ways to think about medical complexity.
- Examples of cases with and without care coordination.
- Active learning (hopefully!) to learn where gaps are.



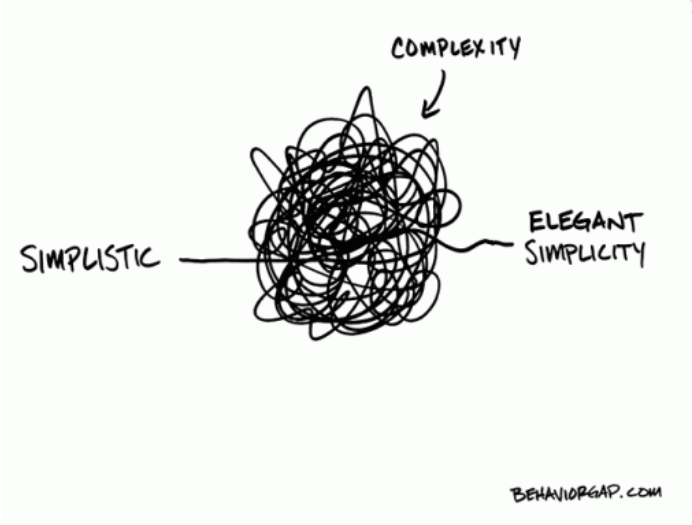
Tools, resources, data

- AAP with policy statements, clinical reports, toolkits.
- Some from >10 yrs ago, but with more recent “affirmations”.
- See references slide.
- Outline that care coordination is evidence-based AND generally cost-effective.
- Reviewing that data is beyond the scope of today’s session.



But First a Word on Complexity…

- We have always struggled to define “What is a medically complex patient?”
  - Is it the ex-24 week premie with seven items on their problem list?
  - Is it the child with diabetes and food insecurity?
  - Is it the 4 y/o with autism spectrum disorder?
  - Is it the teen with gender dysphoria?



Frameworks for Children with Medical Complexity

- How to ID?
  - Family-identified service needs
  - Chronic conditions
  - Functional limitations
  - High health care utilization
- Classifications of kids who may qualify?
  - Technology assistance
  - Neurologic impairment
  - Complex chronic conditions

Bottom Line

- In truth, a medically complex patient is a patient that YOU and your team think is medically complex.
- Practically speaking, not that simple, of course but if you come at it with this mindset, you'll do right by your patients.



Children with Medical Complexity

- AAP definition- CMC's "are a subset of children and youth with special health care needs (CYSHCN), have multiple significant chronic health problems, functional limitations, high health care and resource need and/or utilization. They may need medical technological devices to improve or sustain life and daily function."
- Make up less than 1% of children in the US.
- Account for more than 1/3 of pediatric healthcare costs.



Goal of pediatrics

- And raising children in general…
  - Help every child reach their potential while experiencing life and all of its joys as fully as possible.







The Current Landscape



- According to recent study:
- 53% of patients suffered from at least one chronic problem
- 25% had two or more chronic conditions
- 5.1% had four or more conditions.
  - A regression analysis showed a significant positive correlation between the number of chronic medical conditions and mental health diagnoses.

What Should Care Coordination Entail? (Schor 2019)

- Care coordination is a ***family-centered, team-based*** activity with well-defined goals, infrastructure, and responsibilities.
- Care coordination services are designed and allocated ***based on a comprehensive assessment of the patient's health and psychosocial needs.***
- The assessment of the patient's needs is used to create a ***written care plan jointly developed*** by the family and/or patient and key health care professionals.
- The provision of care coordination services and adherence to and modifications of the care plan are ***regularly monitored and modified*** as necessary.
- ***Face-to-face communication*** between the patient and/or family and clinicians should be ***augmented using synchronous and asynchronous electronic modalities*** to facilitate formation and enhancement of working relationships among all clinicians and family members participating in the patient's care.

What Should Care Coordination Entail?(Schor 2019)

- The patient and/or family ***are provided with information and other supports*** to assist them in the management of the patient's care.
- Care coordination services should include coordination between ***clinicians and other community service professionals*** from whom the patient and/or family receive services and support.
- Each patient has an ***identified care coordinator who has regular contact*** with the family and the principal clinician.
- ***An electronic health information system*** is used that allows relevant health information to be shared among the family and all the patient's health care professionals.
- ***Care coordination for transition between settings should be planned and proactive*** to ensure the patients' continuous access to the care necessary to maintain their health and safety.

Case Example- CYSHCN

- 19 y/o, h/o oculocutaneous albinism, ADHD, depression with history of suicide attempts, presents for evaluation of concussion symptoms.
- Occurred at college last week of classes in TN; mom went to pick her up.
- Since then, having significant headache, emotional lability, unable to focus on anything.
- Stopped ADHD meds mid-year- forgot to ask for refills.



Case, continued

- After consulting pharmacist, I added in amitriptyline, anticipating a prolonged course. Advised to follow up in 1-2 weeks.
- Did not schedule appointment.
- Referred to PT; went to one appt, per report, told not helpful.
- 3 ED visits subsequently for severe menstrual cramping and bleeding.
- Eventually seen by ob-gyn and IUD placed.
- Since then, intermittent menstrual bleeding/cramping, as well as continued headaches.

Finally has appt scheduled with me

- 2.5 months after it was intended. Switched to video.
- Hasn't really left bed other than bathroom for past 2-3 weeks due to pain, fatigue.
- Hasn't called OB-GYN to talk about bleeding.
- Med reconciliation:
  - Taking oxycodone daily
  - Taking butalbital-caffeine
  - Taking Zofran daily
  - Taking amitriptyline
  - Still taking fluoxetine as prescribed previously
- OF NOTE, NEEDING TO REALLY EXAMINE PILL BOTTLES CLOSE TO HER FACE.
- Not ready to go back to school for fall semester.

CLEARLY some gaps…

- Visual impairment- unsure about her meds
- Polypharmacy
- Inadequate receipt of mental health
- Follow-up with me not timely
- Not plugged in for timely follow-up with ob/gyn
- Falling behind in her education and quest for independence

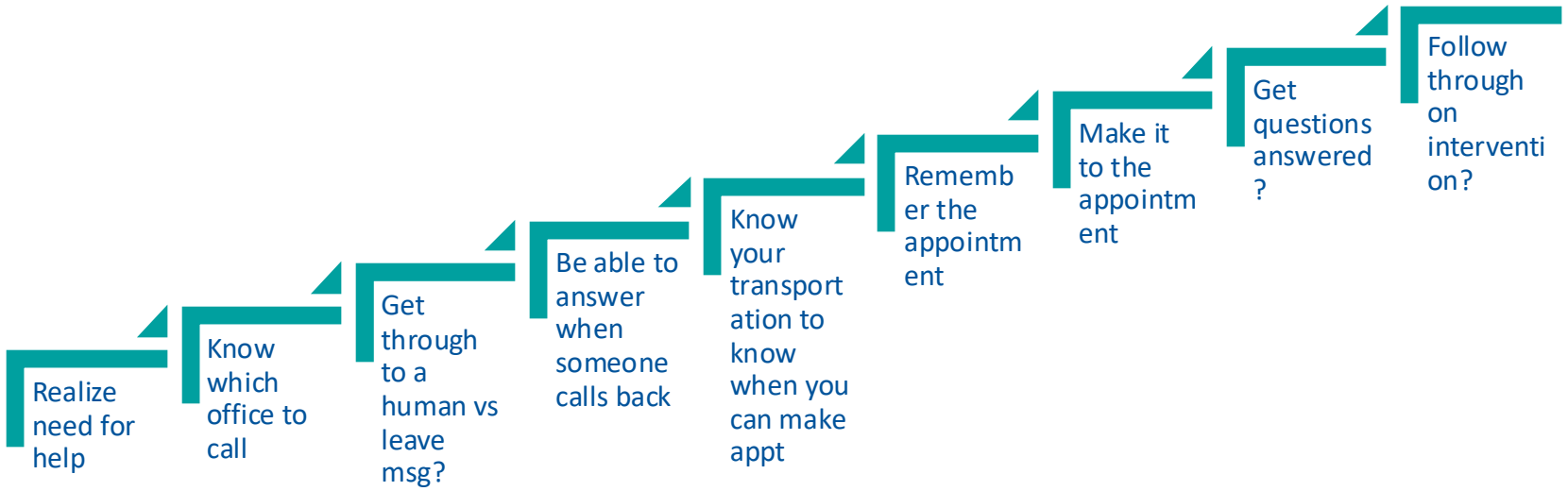


Barriers?

- Knowledge/understanding
- Physical disabilities (visual impairment)
- Complicated health care system
  - See next slide
- Multi-system symptoms



Health-care system complicated!

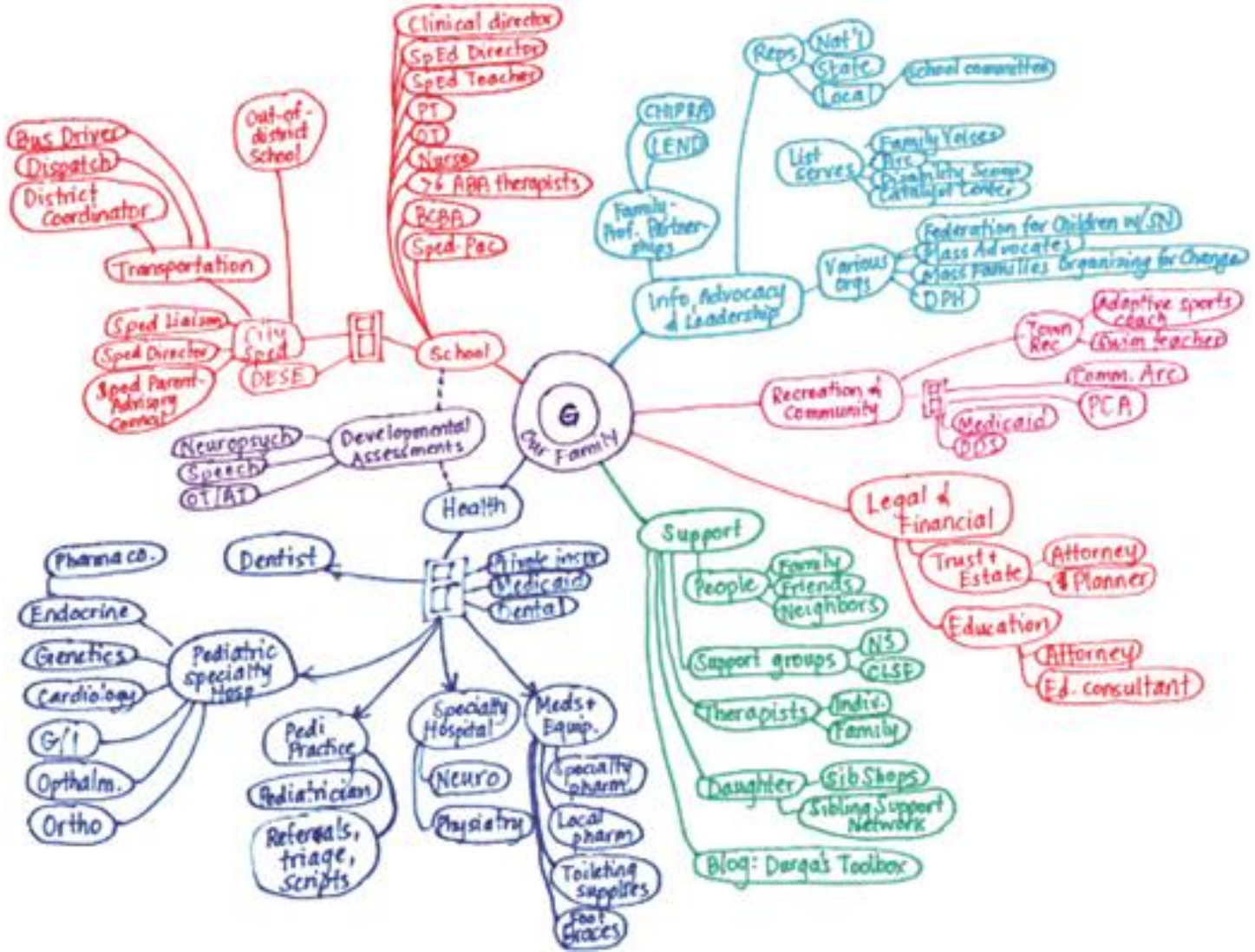


A more traditional CMC…



- Patient ,now 14 y/o:
  - Epilepsy
  - Global developmental disability
  - Feeding tube dependent
  - Noonan Syndrome as underlying cause
  - Incontinent
  - Recurrent pneumonias
  - Restrictive lung disease
- Parents married, she has 4 older sibs (3 now adults)
- 15 medications
- Followed by ent, neurology, GI, pulmonary, cardiology, genetics.

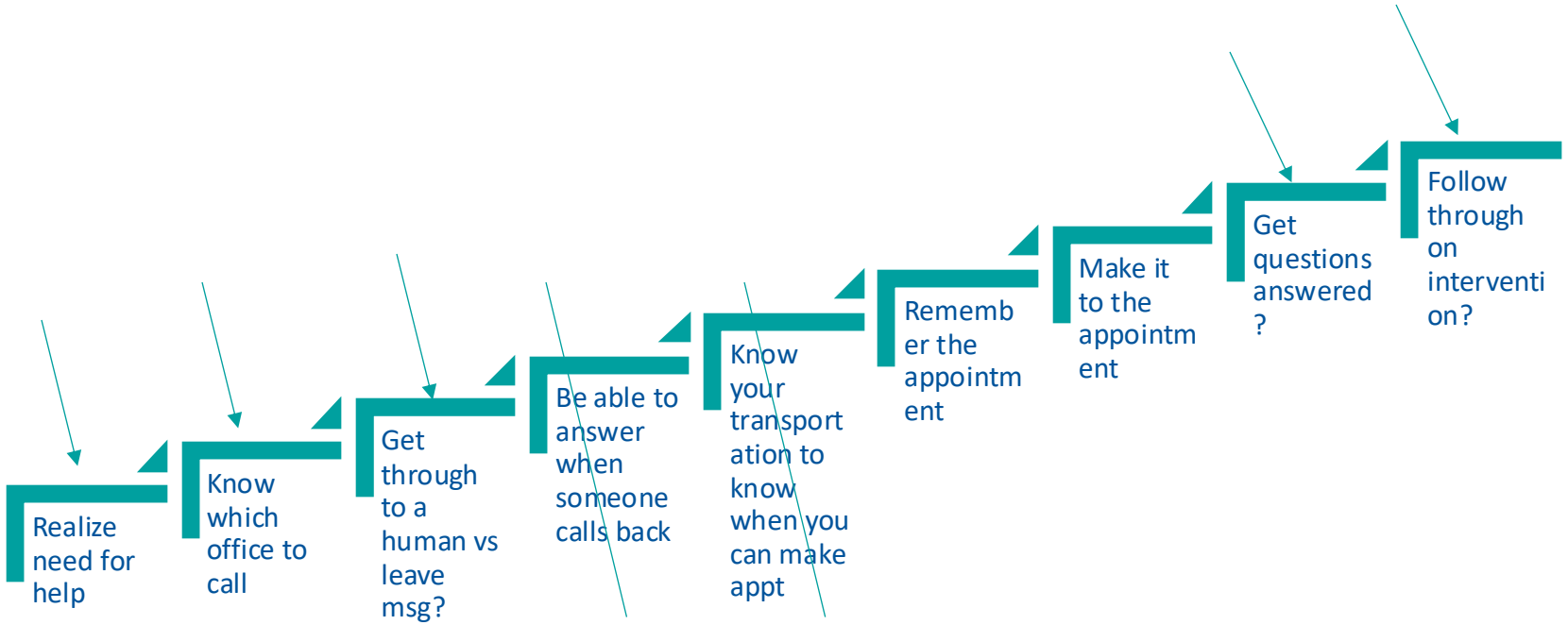
CMC Caremap


Our Family
School
Clinical director
SpEd Director
SpEd Teacher
PT
OT
Nurse
7& ABA therapists
BCBA
Sped Psc
Out-of-district school
Bus Driver
Dispatch
District Coordinator
Transportation
Sped Liaison
Sped Director
Sped Parent Advisory Council
City Sped
DESE
Info, Advocacy & Leadership
CHOPEA
LEND
Family-Prof. Partnerships
Reps
Nat'l
State
Local
School committee
List serves
Family Voices
Various orgs
Federation for Children w/ SN
Mass Advocates
Mass Families Organizing for Change
DPH
Recreation & Community
Town Rec
Adaptive sports coach
Swim teacher
Comm. Arc
PCA
Medicaid
DDS
Legal & Financial
Trust + Estate
Attorney
Planner
Education
Attorney
Ed. consultant
Support
People
Family
Friends
Neighbors
Support groups
NS
GLSF
Therapists
Indiv.
Family
Daughter
Sib Shops
Sibling Support Network
Blog: Dorga's Toolbox
Health
Dentist
Private insur
Medicaid
Dental
Pediatric specialty Hosp
Pharmaco.
Endocrine
Genetics
Cardiology
GI
Opthalm.
Ortho
Pedi Practice
Pediatrician
Referrals, triage, scripts
Specialty Hospital
Neuro
Physiatry
Meds + Equip.
Specialty pharm
Local pharm
Toileting supplies
Foot braces
Developmental Assessments
Neuropsych
Speech
OT/AT

Ways that care coordination has helped our patient:

- Scheduling assistance for subspecialty appointments.
  - Including rescheduling due to appointments missed for hospitalization!
- Help getting refills from subspecialists.
- Transition back home after discharges.
- Assistance with adapting technology and nursing services when temporarily in an RV, avoiding DSS involvement.
- Help with accommodations for school setting.
- Ways to be assessed by our team or in primary care instead of automatically going to ED.
- Attend subspecialty appointments with family to help communication.
- Helped provide support mom needed to finish a new degree which will help her own career satisfaction/stability, as well as financial resources.

Health-care system complicated!



So Many Fires to Put Out

- Makes it hard to focus/prioritize big picture goals and plans.

One Helpful Tool-Goal Cards



Communication Goals	Community, Social, and School Goals	Home & Family Goals	Independence Goals	Medical & Health Goals
• Have others listen and understand me • Improve my ability to communicate • Learn how to tell others what I need • Understand and express my feelings	• Be part of my school • Be safe in my environment • Experience my community • Feel like I belong in my community • Get help at school with _____ • Go to camp without my parents • Make new friends • Play more • Reduce behaviors that hurt others	• Find a care provider to help at home • Get support for my brother(s) and sister(s) • Have an accessible home • Have my parent(s) spend more time by themselves • Have someone help find and coordinate community services • Have transportation I can use with my family • Help get myself dressed • Improve my hygiene • Take vacations	• Accept my differences • Be more independent • Be treated with respect • Have a hobby • Make my own decisions • Use technology	• Access more therapy opportunities • Describe pain and other physical symptoms • Get better sleep • Have equipment that is made for me • Have fewer medical appointments • Learn about my medications • Learn healthy choices • Learn how to use my equipment / supplies • Make the switch to the adult health care system • Receive good dental care • Spend less time in the hospital

More on Goal Cards

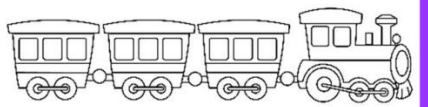
- Goals are grouped into 5 areas: communication;community, social and school; home and family;independence; and medical and health.
- Designed as a guide for the family for starting a conversation on identifying goals that are appropriate for their child and as a catalyst for conversations about goals in general.
- Previous and subsequent slides borrowed from:

https://healthtransitionwi.org/wp-content/uploads/sites/178/2020/05/Goal-Cards-for-Families_final.pdf

Play more





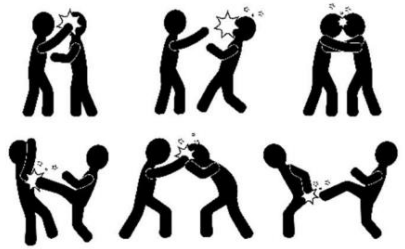


Community, Social, and School

Reduce behaviors that hurt others







Community, Social, and School

Find a care provider to help at home







Home and Family

Have an accessible home







Home and Family

Connection Interrupted
Citrix Receiver will try to reconnect for 5 minutes.
Click Citrix Receiver menu for more options.

Last Case

- 3 y/o, Syrian Refugee by way of Turkey (now 5)
- Hypoxic brain injury, apparently sustained during cleft repair in Turkey.
- Came to our medical center direct from RDU, brought by refugee organization.
- Tracheostomy and g-tube dependent; spastic quadriplegia; adrenal insufficiency; legal blindness; stage 3 chronic kidney disease.

Specific Challenges

- Gaining weight faster than healthy;
- Father being required to work a prescribed job that has too many hours, not enough pay; as such, they have been threatened to lose their support from agency for housing and almost evicted;
- Wondering how to get into school system;
- Wondering what realistic goals/expectations are for her;
- In previous country, parents didn’t provide the bedside care;
- Language-Arabic, but also a dialect that is specific to their home region.

Using Care Coordination Model, team able to:

- Gradually understand family's concerns about nutrition;
- Navigate other financial housing supports to avoid eviction (which would have mandated hospitalization);
- Support in enrollment in public school system and navigating paperwork for IEP, medical support at school; healthy older sibling now in school as well;
- Allowed ongoing skill development in the management of her illness/technology;
- Allowed ongoing goals of care discussions and setting realistic goals (while communicating nuance of what we DON'T know).

Last Topic

- Finding the “right” pediatrician and navigating that relationship.



Selecting the “right” pediatrician

- There are definitely some pediatricians that have more comfort (and skill) in this area than others.
- The one with the best “reputation” may not be the right fit.
  - They may have too high of a patient panel to be available enough.
  - They may have other roles and are in clinic less than needed.
- It’s not just the pediatrician that’s important.
  - Do they have a nurse clinician who can help with paperwork, navigating DME companies, giving relevant advice?
  - Do they have a social worker?
  - Do they have an office that’s truly accessible?

Selecting the “right” pediatrician

- Ideally one with good communication skills- with families, with subspecialists, and with other members of team.
  - Sometimes the family asking their cardiologist if they have recommendations, for instance, in someone they work well with.
- Ideally one who is willing to say “I don’t know, but I can do my best to find out”.
- Ideally no matter how accomplished they are, not one that’s on the cusp of retirement.
- Often best if they are within the same health care system that the subspecialty care is received in- the communication and logistics are much simpler.

We are VERY imperfect…Communication helps

- Realistic expectation setting is important.
  - Having a complex patient come once/year is not allowing us to provide good care.
    - We can't foresee/prevent problems this way.
    - Often the paperwork we fill out (hours per year per patient, in many cases) can't even be accepted if not having recent face-to-face appointments.
    - Thus,patients asking: "how often would it be helpful for us to see you"? (and vice versa). Okay to do some by telehealth, though!
- Not everything can/should be solved via MyChart/portal.
- Prioritize concerns/questions ahead of visit-What are the big 3?
- Be clear- let your physician know it's okay if they don't know the answers (and let them now when it's really important to get one)

What CAN pediatricians do?

- Follow growth trends, help adjust feeds.
- VACCINES!!!
- Understand/help family develop goals.
- Surveillance of development, referral for therapies.
- Navigation of school system, advocacy.
- Document medical necessity for things like wheelchairs, standers-patients should bring these up at visits.
- Contact subspecialists if interim concerns (inc'd spasticity,etc).
- Order things like incontinence products, feeding supplies.
- Be part of larger health care team discussions.
- See patients after discharge from hospitalizations.

Conclusions

- Health care and other relevant ecosystems are incredibly complex to navigate.
- So much of what affects a child's health is not a direct result of the plan the physician decides, but in how well it can be executed with the support of the family and the team members.
- Providing care to these children in a way that focuses on them and their families' goals is effective and extremely rewarding!
- Finding the right pediatrician is half the battle- utilizing them correctly is just as imporatnt.

References

- Antonelli R, McAllister J, Popp J. *Developing Care Coordination as a Critical Component of a High Performance Pediatric Health Care System: Forging a Multidisciplinary Framework for Pediatric Care Coordination*. Washington, DC: The Commonwealth Fund; 2009.)
- Cohen E Berry JG , Camacho X , Anderson G ,Wodchis W , Guttmann A (2012) Patterns and costs of health care use of children with medical complexity. *Pediatrics*. 130(6): e1463-70.
- COUNCIL ON CHILDREN WITH DISABILITIES and MEDICAL HOME IMPLEMENTATION PROJECT ADVISORY COMMITTEE, Renee M. Turchi, Richard C. Antonelli, Kenneth W. Norwood, Richard C. Adams, Timothy J. Brei, Robert T. Burke, Beth Ellen Davis, Sandra L. Friedman, Amy J. Houtrow, Dennis Z. Kuo, Susan E. Levy, Susan E. Wiley, Miriam A. Kalichman, Nancy A. Murphy, W. Carl Cooley, Joan Jeung, Beverly Johnson, Thomas S. Klitzner, Jennifer L. Lail, Linda L. Lindeke, Amy Mullins, Lee Partridge, William Schwab, Christopher Stille, Debra Waldron, Nora Wells, Calvin Sia; Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems. *Pediatrics* May 2014; 133 (5): e1451–e1460. 10.1542/peds.2014-0318
- Ellen Roy Elias, Nancy A. Murphy, the COUNCIL ON CHILDREN WITH DISABILITIES, Gregory S. Liptak, Richard C. Adams, Robert Burke, Sandra L. Friedman, Amy Houtrow, Miriam Kalichman, Dennis Kuo, Susan E. Levy, Kenneth W. Norwood, Renee M. Turchi, Susan E. Wiley; Home Care of Children and Youth With Complex Health Care Needs and Technology Dependencies. *Pediatrics* May 2012; 129 (5): 996–1005. 10.1542/peds.2012-0606
- Nasir A, Nasir L, Tarrell A, Finken D, Lacroix A, Pinninti S, Pitner S, McCarthy M. Complexity in pediatric primary care. Prim Health Care Res Dev. 2018 May 22;20:e59. doi: 10.1017/S146342361800035X. PMID: 29785895; PMCID: PMC8512535.
- Schor EL. Ten Essential Characteristics of Care Coordination. *JAMA Pediatr.* 2019;173(1):5. doi:10.1001/jamapediatrics.2018.3107
- Care Mapping | Integrated Care | Boston Children's Hospital (childrenshospital.org)
- https://healthtransitionwi.org/wp-content/uploads/sites/178/2020/05/Goal-Cards-for-Families_final.pdf

Reflections and Perspectives

NC InCK NC INTEGRATED CARE FOR KIDS

Discussion Questions

- What has been your experience connecting members with a provider?
- How are you engaging families when discussing this topic?
- What was your biggest takeaway from this morning's presentation?

NC InCK
NC INTEGRATED CARE FOR KIDS

Community Alternatives Program for Children (CAP/C)

NC InCK NC INTEGRATED CARE FOR KIDS

NC Integrated Care for Children Program Presentation:

Overview of CAP/C Services

September 12, 2024

Presented by: Shenita Ross, DHA

© CNSI/Kepro. All Rights Reserved.

Today’s Agenda

- Intro to NCLIFTSS
- Acentra Health’s Role in CAP/C
- What is CAP/C?
- Who is eligible for CAP/C
- How to Make a CAP/C Referral
- Completing the Consent Packet
  - Example of Beneficiary Consent Form
  - Example of Physician LOC Worksheet
  - Example of Freedom of Choice Form
  - Common Mistakes/Reasons for Delays
- CAP/C Assessments
  - Common reasons for denials
- Questions & Answers

Intro to NCLIFTSS

- June 2023: Kepro was selected by NCDHHS to complete comprehensive assessments/evaluations and facilitate transitional services for Medicaid beneficiaries needing LTSS. Kepro is now doing business as Acentra Health.

- As a result of this award, NC Medicaid implemented NCLIFTSS to provide beneficiaries a long-requested single point of entry for accessing Medicaid LTSS and streamline processes between initial contact and service provision. This single point of entry is now branded as NCLIFTSS.

- NCLIFTSS (**L**inking **I**ndividuals & **F**amilies to Long **T**erm **S**ervices & **S**upport)

NCLIFTSS Contract Implementation Timeline

AUGUST 3, 2023

PASRR Level II Scheduling Began

AUGUST 9, 2023

PASRR Level II Assessments Began

AUGUST 17, 2023

TOC Disenrollment Forms Processed Started

AUGUST 31, 2023

CAP/DA Receive/Process Referrals

CAP/C Receive/Process Referrals

SEPTEMBER 25, 2023

PCS Receive/Process Referrals

OCTOBER 2, 2023

PCS Scheduling Began

CAP/DA SRF Scheduling Began

CAP/C SRFs Scheduling Began

OCTOBER 23, 2023

CAP/DA Assessments Began

CAP/C Assessments Began

PCS Assessments Began

NOVEMBER 6, 2023

LCA Program Implemented

- All Programs Implements

NCLIFTSS Team

LYNEKA JUDKINS | EXECUTIVE DIRECTOR

GENEVIEVE MERRITT | DIRECTOR OF CLINICAL SERVICES

SHENITA ROSS | PROGRAM MANAGER, CAP/C

CINDEE DAUGHERTY | LEAD, CLINICALASSESSOR

JACQUETTA DOUGLAS | STAKEHOLDER ENGAGEMENT & EDUCATION COORDINATOR

RENEE WHITE | MANAGER, CONTACT SUPPORT CENTER

The Role of Acentra Health

- Acentra Health operates NCLIFTSS to ensure:
  - Streamline access to LTSS
  - Reduction in wait time between initial contact and service provision
  - Enhancement in quality through increased provider training and technical support
  - Outreach to underserved areas to promote health equity
  - Improvement in coordination between LTSS and benefit plans

- As the state contractor for NCLIFTSS, Acentra Health is responsible for processing referrals, completing LOC decisions through Service Request Forms, and conducting assessments to determine eligibility for CAP/C enrollment.

What is CAP/C?

- The Community Alternatives Program for Children (CAP/C) is a Medicaid Direct home and community-based service waiver under the 1915 (c) Social Security Act. This waiver targets medically fragile children from birth through age 20 who met an institutional level of care with a primary diagnosis that is physical or medical rather than cognitive or behavioral and are at risk of institutional care. This waiver allows medically fragile children to be cared for and remain in (or return to) their homes and community using wraparound services to offer support in home care, accessing their home and vehicles through modifications and other needed services that may not be covered by insurance/Medicaid Direct.

- The CAP/C Waiver provides additional supportive services to supplement services already received from regular Medicaid Direct/Insurance such as private duty nursing, durable medical equipment and supplies, therapy services, and home health.

CAP/C Home and Community-Based Services:

- Assistive technology
- In-home aide
- Case management/Care advisor
- Community integration service
- Community transition service
- Home accessibility and adaptation
- Specialized medical equipment and supplies
- Respite care
- Pediatric nurse aide
- Vehicle modifications
- Goods and services, such as nutritional services, and non-medical transportation

CAP/C Eligibility

- CAP/C is available to children from birth through 20 years of age who meet a LOC, is determined to be medically fragile, and has a reasonable need for at least one CAP/C home and community-based service. In addition, the child must:
  - Live in a private residence
  - Can be cared for safely at home
  - Has a primary caregiver willing to participate in the care and care planning for their child
  - Abide by the rights and responsibilities of participating in the CAP/C waiver

- It is important to note if CAP/C is not approved, due process is provided, promoting the right to appeal that decision.

How to Make a CAP/C Referral

- A referral can be made by calling NCLIFTSS customer call center at (833) 522-5429 (toll free) or by faxing a completed referral form to (833) 470-0597.
  - Additional information and the referral form can be found on the NCLIFTSS/Acentra Health website (CAP/C - NCLIFTSS)
  - To go directly to the form, click here: CAP/C Referral Form

- A referral can also be made by contacting a local CAP/C case management entity (CME), an In-Home/Health agency, Department of Social Services, or a hospital in the county of residence of the applicant. (CAP/C CME List)

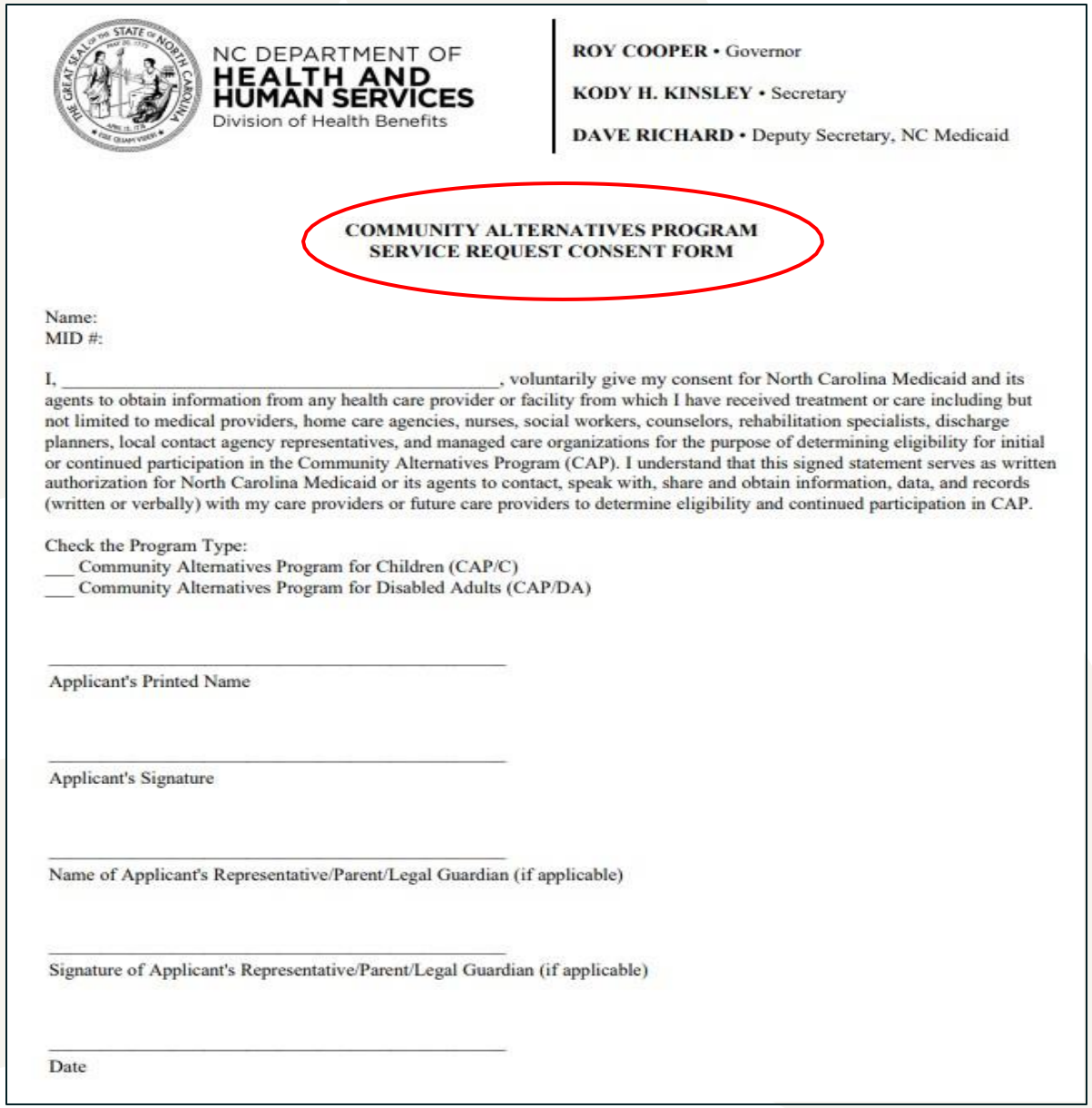
Completing the Consent Packet

- Once a referral has been made and validated, NCLIFTSS will mail out a consent packet within one business day.
- The consent packet includes three (3) documents that are critical for timely processing of the request for services:
  - **Beneficiary Consent Form**: This form allows NCLIFTSS to process the request by exchanging information with other professionals. This form is to be completed by the beneficiary or primary responsible person and must be received to complete the assessment.
  - **Physician LOC Worksheet**: This form is used to obtain clinical information from the physician and their opinion of the level of need. This form is to be completed by the primary physician and must be received to complete the assessment.
  - **Freedom of Choice (CME selection):** This form is used to link to a case management entity to offer additional support while the enrollment decision is being made. This document is to be completed by the beneficiary or the primary responsible person and must be received for services to be approved.

- It is important these documents are returned within the indicated timeframe, or it can delay the assessment and access to services if approved.

Beneficiary Consent Form

- This form is to be completed by the beneficiary or primary responsible person.
- This form **must** be received to complete the assessment.



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
DAVE RICHARD • Deputy Secretary, NC Medicaid

COMMUNITY ALTERNATIVES PROGRAM
SERVICE REQUEST CONSENT FORM

Name:
MID #:

I, _____, voluntarily give my consent for North Carolina Medicaid and its agents to obtain information from any health care provider or facility from which I have received treatment or care including but not limited to medical providers, home care agencies, nurses, social workers, counselors, rehabilitation specialists, discharge planners, local contact agency representatives, and managed care organizations for the purpose of determining eligibility for initial or continued participation in the Community Alternatives Program (CAP). I understand that this signed statement serves as written authorization for North Carolina Medicaid or its agents to contact, speak with, share and obtain information, data, and records (written or verbally) with my care providers or future care providers to determine eligibility and continued participation in CAP.

Check the Program Type:
___ Community Alternatives Program for Children (CAP/C)
___ Community Alternatives Program for Disabled Adults (CAP/DA)

_____
Applicant's Printed Name

_____
Applicant's Signature

_____
Name of Applicant's Representative/Parent/Legal Guardian (if applicable)

_____
Signature of Applicant's Representative/Parent/Legal Guardian (if applicable)

_____
Date

Physician LOC Worksheet

This 2-page document is to be completed by the Beneficiaries **Primary Physician**

Applicant Information
Beneficiary Name:
DOB:
Primary Caregiver:
Address:

Program Type the applicant is requesting:
☐ Community Alternatives Program for Children (CAP/C)
☐ Community Alternatives Program for Disabled Adults (CAP/DA)

Check all clinical indicators the applicant is currently experiencing or has a history of:
Has a primary physical diagnosis: ☐ Yes If yes, what is the ICD-10: _____ ☐ No

Provide a list of all diagnoses that includes ICD-10, date of onset, and primary or secondary diagnosis.

Prescribed medication: ☐ Yes ☐ No

Provide a list of all prescribed medications and its routing that are dispensed and over the counter (OTC) with the completed form.

Specialized treatments: ☐ Yes ☐ No

Include an attachment of specialized treatments (such as MACE, in and out catheters, regularly prescribed enemas or digital stimulation, Vagus Nerve stimulation swipe, oropharyngeal suctioning) **with the completed form, or describe the specialized treatment in the text box below.**

Describe specialized treatment here:

To be determined to meet a level of care, the above-named applicant requires a need for any one of the following:

☐ Receiving physical therapy	☐ Receiving occupational therapy
☐ Receiving speech therapy	☐ Dialysis
☐ Specialized therapeutic diet	☐ IV drug administration
☐ Controlled medication	☐ Frequent drug injections
☐ Requiring respiratory therapy	☐ Nasogastric feeding

☐ Need or uses life-sustaining devices (endotracheal tube, ventilator, suction machine, oxygen therapy, cough assist device, high-frequency chest wall oscillation vest)

☐ Gastrostomy feeding	☐ Wound care
☐ Alzheimer's Disease	☐ Bowel and bladder program

In your clinical judgment, are the health care conditions (diagnosis, medication, specialized treatments, and medical regiment) chronic and severe enough to meet an institutional level of care?
☐ Yes ☐ No

Select one: ☐ Applicant's primary care Practitioner ☐ Outpatient Specialty Practitioner

Practitioner's Name: _____

Practitioner Signature and Credentials: _____

Date: _____/_____/_____

Practice Name: _____

NPI #: _____ Phone: _____

Address or Physician Practice Stamp: _____

_____

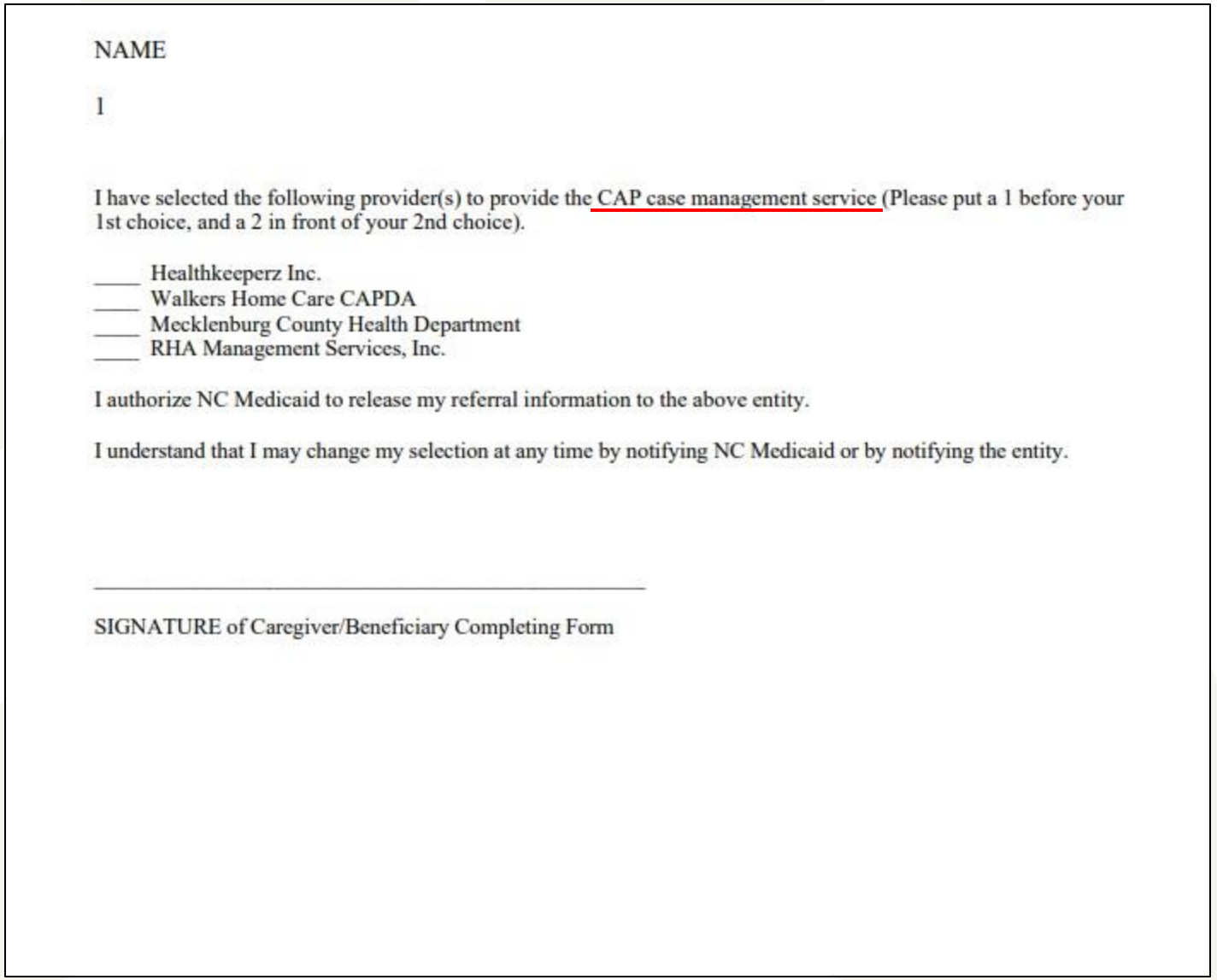
Practice Stamp

Thank you in advance for your assistance in completing pages 2 and 3. Upon completion, please fax back to (919) 715-0052 within 15 business days from the date of this letter. **Also include with the fax the medication and diagnosis lists.** If you have any questions or need additional assistance, you may contact the CAP unit at NC Medicaid at 919-855-4340.

Check the items enclosed:
☐ Meds list
☐ Dx list
☐ Specialized treatments

Freedom of Choice (CME selection)

- This document is to be completed by the beneficiary or the primary responsible person.
- This form **must** be received so that the POC can be initiated if enrollment is approved.



NAME

1

I have selected the following provider(s) to provide the CAP case management service (Please put a 1 before your 1st choice, and a 2 in front of your 2nd choice).

____ Healthkeeperz Inc.
____ Walkers Home Care CAPDA
____ Mecklenburg County Health Department
____ RHA Management Services, Inc.

I authorize NC Medicaid to release my referral information to the above entity.

I understand that I may change my selection at any time by notifying NC Medicaid or by notifying the entity.

_____

SIGNATURE of Caregiver/Beneficiary Completing Form

Common Mistakes/Reasons for Delays

- Not returning the consent form
- Dates and signatures missing from the beneficiary and/or physician
- Incorrect address/county listed
- LOC incomplete – Clinical judgement question left unanswered
- LOC not recommended
- Not checking the preferred case management entity or selecting an alternative CME

Common Reasons for an SRF Denial

- Inappropriate referrals
  - Primary Diagnosis **must** be chronic, physical, or medical rather than cognitive, developmental, psychological, or behavioral.
  - Misinterpretation or lack of knowledge of qualifying conditions for HCBS Nursing Facility LOC Criteria or and Medical Fragility criteria.
- Does not meet HCBS Nursing Facility LOC Criteria
- Does not meet Medical Fragility Criteria
  - All 3 Criterions must be met: A, B, & C

CAP/C Medical Fragility

A. A medically fragile child has a primary chronic medical condition or diagnosis (physical rather than psychological, behavioral, cognitive, or developmental) that has lasted, or is anticipated to last, more than 12 calendar months; and

B. The child's chronic medical condition:
- i. Requires medically necessary, ongoing, specialized treatment or interventions (treatments or interventions that are supervised or delegated by a physician or registered nurse) without which would likely result in a hospitalization; or
- ii. Resulted in at least four exacerbations of the chronic medical condition requiring urgent or emergent physician-provided care within the previous 12 calendar months; or
- iii. Required at least one inpatient hospitalization of more than 10 calendar-days within the previous 12 calendar months: or iv. Required at least three inpatient hospitalizations within the previous 12 calendar months; and

C. The child's chronic medical condition requires one of the following:
- i. the use of life-sustaining device(s); or
- ii. life-sustaining hands-on assistance to compensate for the loss of bodily function; or
- iii. non-age appropriate hands-on assistance to prevent deterioration of the chronic medical condition that may result in the likelihood of an in patient hospitalization.

NC Medicaid Community Alternatives Program for Children (CAP/C) Clinical Coverage Policy No: 3K-1

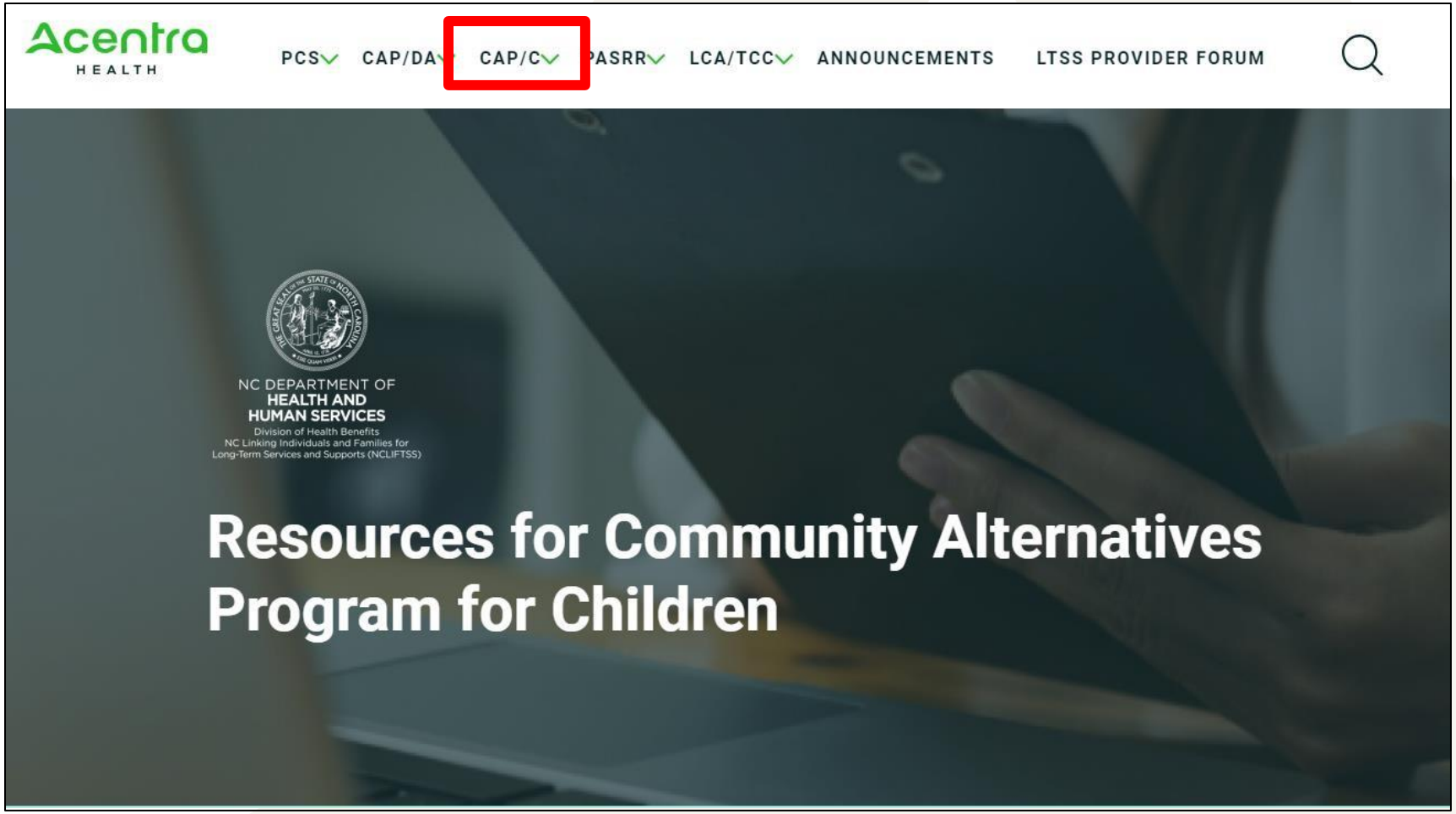
CAP/C Assessments

- Once the Service Request Form (SRF) determines level of care is met a full assessment is scheduled to evaluate risks and reasonable need for CAP/C services
- Assessments are conducted face-to-face
- When NCLIFTSS calls to schedule the assessment, they will ask the beneficiary or caregiver their preference for date and time
- The Assessor will ask questions about various functional activities and the beneficiary's ability to perform these activities or the caregiver process of performing those activities
- The Assessor requires the beneficiary/primary caregiver to demonstrate these activities to determine level of ability
- The Assessor will review provided medical records or other information that is helpful for them to understand the needs of the beneficiary/family

Common Reasons for an Assessment Denial

- Individual no longer meet Medical Fragility criteria (MF) at the assessment stage.
- Level of Care (LOC) changed at the assessment stage.
- An individual can meet Medical Fragility, but there's not a reasonable indication of need for at least 1 CAP Waiver service within 30 Calendar days that would avert institutionalization into a skilled nursing facility.

NCLIFTSS Website



NCLIFTSS.ACENTRA.COM

CAP/C - NCLIFTSS

Additional Resources on NCLIFTSS Website



Website Link: CAP/C Resources - NCLIFTSS

- For questions, contact NCLIFTSS at: 833-522-5429 (toll free) or 919-568-1717
- Call Center Hours: Monday - Friday 8:00am to 5:00pm
- CAP/C Fax Number: 833-470-0597
- Email Address: NCLIFTSS@acentra.com
- CAP/C Website: CAP/C - NCLIFTSS
- CAP/C Frequently Asked Questions: CAP/C FAQ's
- CAP Program Referral Request Form: CAP Program Referral Request Form

Questions & Answers





© CNSI/Kepro. All Rights Reserved.

A Look Ahead

For more events in the 5 NC InCK Counties, check out our NC InCK Webpage and Facebook. Also, explore our new NC InCK training page for archived ICRs, takeaways, and shared resources.

Upcoming NC InCK Events:

ECHO Series: Integrated Care Teams
Thursday, October 10th:
12:00 pm – 1:30 pm

Integrated Care Rounds: Behavioral health
Thursday, November 14th:
12:00 pm – 1:30 pm

Reach out to Josie Hatley (anna.hatley@duke.edu) if you need the invitation for the ICR/Echo series.

Upcoming Community and Learning Events:

Friday, September 13 | 12 PM - 2 PM
The Helpers Behind the Scene (Three Oaks Behavioral Health & Wellness)
Discussion about the challenging task of navigating a client's mental health crisis.

Monday, September 16 | 6 PM - 7 PM
Support Group for Stress and Anxiety (National Alliance on Mental Health)
Support group open to both peers and family members and focuses primarily on stress, anxiety, and depression.

Tuesday, September 24 | 12 PM - 12:30 PM
What is ECAC? (Exceptional Children's Assistance Center)
Learn about ECAC, who we are, what we believe, what we do, and what we do not do."

Saturday, October 5 | 11 AM - 1 PM
Walk for Mental Health (NC Cooperative Extension)
Open to all ages, this youth-led event is a powerful opportunity to support mental health awareness and foster meaningful dialogue.
Hosted by: NC Cooperative Extension