

CONVENING 2:
PATH TO BETTER HEALTH
FOR CCHN AT THE
INTERSECTION OF HOME
AND HEALTHCARE SYSTEMS

February 24th, 2021
2:00-5:00 p.m. on Zoom

Contact Carter Crew
at carter.crew@duke.edu
with any questions.



Our Approach

- A child's health is shaped by the environment in which they live, learn, and play
- In our convenings, we hope to take a broader approach that looks past just medical services
- We consider how children with complex needs and their families thrive at home, with support from healthcare systems, local communities, and neighborhoods.



Agenda

Opening Remarks

2:00 p.m.

Keynote Speaker - Dr. Charlene Wong

2:10 p.m.

Break

2:40 p.m.

Gallery Walk Activity

2:45 p.m.

Bite-size talk on Medicaid Transformation - Sabrena Lea (NC DHHS)

4:20 p.m.

Networking Session (Optional)

4:30 p.m.

Children w/ Complex Health Needs (CCHN) in North Carolina

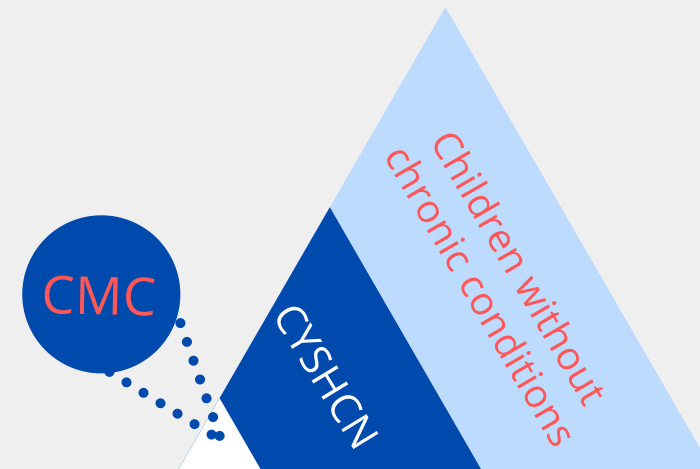
*includes both CYSHCN & CMC populations

Children and Youth with Special Healthcare Needs (CYSHCN)

↳ Children with or at risk for chronic physical, developmental, or behavioral conditions.

Children with Medical Complexity (CMC)

↳ Children with multiple chronic conditions, functional limitations, and high health service use.



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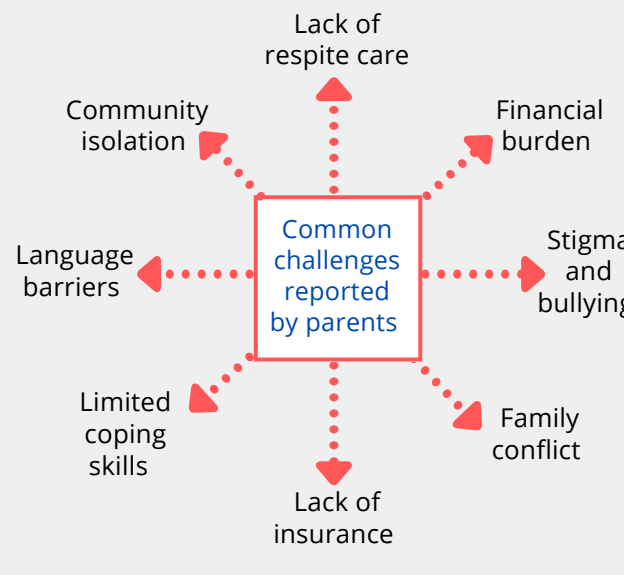
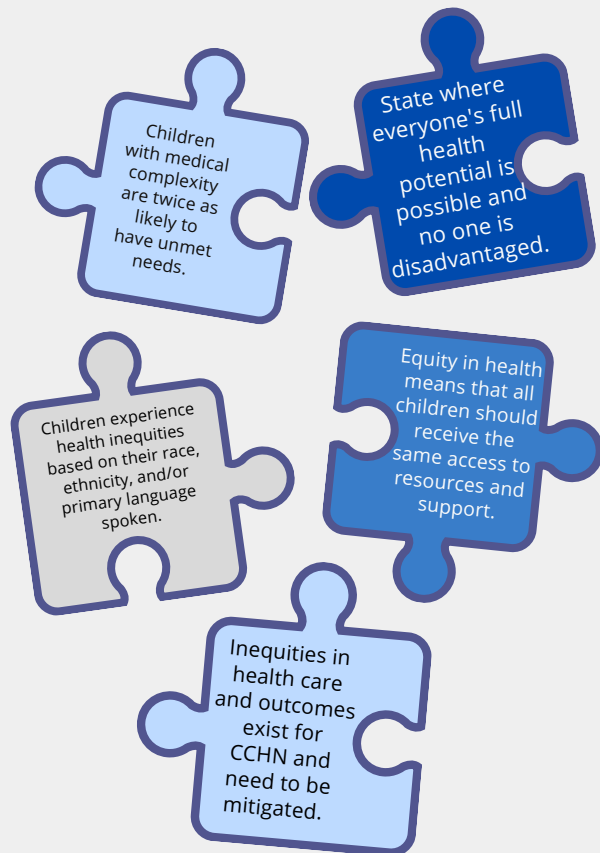
ADDITIONAL INFORMATION

Dr. Charlene Wong



Dr. Wong specializes in adolescent and young adult medicine and health services research. She focuses on providing high quality medical care to youth through respect for each individual, support of their physical and emotional growth, and education to empower them to be thriving, independent adults. She serves as the Executive Director of the North Carolina Integrated Care for Kids (NC InCK) model. NC InCK is a CMS-funded pilot to develop and implement a local integrated service delivery and payment model for Medicaid/CHIP insured children.

Health Equity



Next Steps

Sustain Momentum

- ✓ Continue to engage with the coalition through the website, listserv, and additional opportunities for engagement.

Share Our Findings

- ✓ A summary white paper and additional publications.

Translate Ideas Into Action

- ✓ Issue-focused workgroups to advance policy, advocacy, quality improvement, and research efforts.

GLOSSARY

Care Coordination: Effective organization and use of resources to ensure access to comprehensive services for children with special health care needs and their families.

Transitions of Care (or Transition): The movement of patients between health care practitioners, settings, and home as their condition and care needs change.

Care Plans: Co-created with families and their care team to plan, document, and accomplish care goals and coordinate care across services.

Integrated Care Models: Providers (often led by a primary care team) work together with families to provide a full array of services.

Medicaid: A public benefits program jointly funded by state and federal dollars and administered by the state. Medicaid provides coverage for health-related services to low-income children and youth with disabilities.

Medicaid Transformation: In 2015, the NC enacted legislation directing the NC DHHS to transition Medicaid and NC Health Choice from fee-for-service to managed care; the state contracts with insurance companies, which are paid a predetermined set rate per enrolled person to provide all services.

Specialist: Focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types conditions.

Generalist: An internist, family physician, or pediatrician who performs general medicine; one who treats most diseases that do not require surgery, including those related to obstetrics.

Habilitative Providers: Providers who focus on physical movements and help patients restore and improve movement and functioning. Examples include physical and occupational therapy and speech-language pathology.

Behavioral Health Care: Provides services to diagnose, treat, and manage mental health conditions, substance use disorders, and intellectual/developmental disabilities.

Innovations Waiver: Designed to meet the needs of Individuals with Intellectual or Development Disabilities (I/DD) who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

Medical Home: Provides comprehensive primary care by facilitating partnerships between patients, clinicians, medical staff, and families; produces higher quality care with improved cost efficiency.

Links to Additional Resources

-Social Ecological Model

-The Catalyst Center Glossary

