Care/Case Management Model Cover Sheet

Program Name: Family Care: In-home, multi-disciplinary team led public health case management for young families

Population Focus:

At risk families, with a focus on pregnancy and early childhood, outside the scope of Part C Early Childhood Providers and Montana evidence based home visiting models. Montana has approximately 74,000 children under age 6. Of these children, 22 percent live below the Federal Poverty Guideline, while almost 50 percent live below 200 percent of the poverty guideline. Approximately 32,000 children ages 0-5 qualify for Medicaid and CHIP in Montana. Based on results from the National Survey of Children's Health, in 2015–2016, 26 percent of children in Montana under age 18 were identified as having two or more adverse experiences as children (below age 18), higher than the national average of 22 percent. Montana's children are "at risk" as determined by growing numbers of children in out of home placements from child abuse and neglect, increasing mental health concerns across the life span, and a growing substance abuse problem. Public Health is invested in diverse evidence-based strategies to create stability and honor families and assets in the communities in which they live, we invite others to join this strategy.

Program Objectives:

Implement a home-based case management model highlighting community-coordinated client-based goals paired with evidence-based model elements and flexible intervention length targeting pregnant women and children ages 0-5.

•Cultivate parents' ability to form strong, positive attachments with their children and to keep them safe.

•Promote children's healthy physical, cognitive, and social-emotional development by monitoring their progress, guiding parents in recognizing their children's and their own needs, and accessing appropriate services.

•Improve maternal and child health.

•Report on Medicaid and Children's Health Insurance Program Child Core Set measures. As public health agencies we have access to vital records, immunization registry, or EPSDT chart reviews for calculating Child Core Set measures to collect or validate quality measure data in addition to assisting families with identified needs addressed in care plans.

•Evaluate the costs and benefits of the program through quality of life (QOL) for patients and their families due to increased preventative healthcare visits, reduced

days of work lost, and family self-sufficiency.

Program Description:

Identify through a unified community platform eligible women and children, who will then gain greater access to social, medical, educational and other services via a home-based client-driven model. Frontline public health staff interact with providers and families on a regular basis to encourage compliance with and documentation of recommended care (such as well-child visits). The home-based case management would collect quality measure data and encourage health plan improvement. A number of the indicators focus on outcomes and activities that are under the direct and immediate control of family support and coaching through this program. With budget challenges it is vitally important to invest in what works.

Required Care/Case Management Staff:

This team offers an interdisciplinary approach in order to meet the clients where they are. It includes a social worker, nurse practitioner and dietitian. A community health worker or peer supporter may also be appropriate.

Program Demographics

Monthly member count: Montana has 73,242 children under age 6. Of these children, 22 percent live below the Federal Poverty Guideline, while almost 50 percent live below 200 percent of the poverty guideline. Approximately 32,000 children ages 0-5 qualify for Medicaid and CHIP in Montana. Based on results from the National Survey of Children's Health, in 2015–2016, 26 percent of children in Montana under age 18 were identified as having two or more adverse experiences as children (below age 18), higher than the national average of 22 percent.

Average monthly program cost per member: To be determined

Average monthly total benefit cost per population member: To be determined

Monthly provider count: Best practice caseloads = 25 to 50 families per month depending on the visit frequency and acuity.

Average # of members per provider: With less than 20% of the high-risk families being served by Evidence Based Home Visiting, this number could be large.

Average monthly provider program revenue: To be calculated

Program Measurements

We would recommend aligning measurements to the Montana Children's Data

Partnership agreed upon measures and the Medicaid and Children's Health Insurance Program Child Core Set measures. This is public investment worth making, given the current status of the measurements for the Child Core Set.