Handouts for the Webinar

Monitoring and Oversight of Psychotropic Medications for Children in Foster Care in North Carolina

January 29, 2013

Presenters

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Child Welfare Services
NC Division of Social Services

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Community Care of North Carolina

Charlene Sampson
Outpatient Pharmacy Program
NC Division of Medical Assistance

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Supervisor, Therapeutic & Specialized Foster Care Services
Catawba County DSS

Produced by
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Jordan Institute for Families
UNC-Chapel Hill School of Social Work

Sponsored by
NC Division of Social Services

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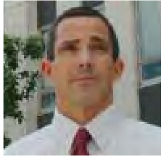
PRESENTER INFORMATION



KEVIN KELLEY has served as the Chief of the Child Welfare Section of the NC Division of Social Services since October 2011. Prior to that he served in the Child Welfare Section in numerous capacities over the past 13 years, including efforts to enhance the automation capacity of Child Welfare through what is now known as NC FAST. Kevin began his social work career in another state, but since 1995 North Carolina has been his adoptive home state. He worked at a county DSS for three years before moving to the Division. Kevin and his wife Toni have two children, a daughter who is a recent NC State graduate and a son who is a current NC State student.

JERRY MCKEE is currently the Associate Director of Behavioral Health Pharmacy Programs for North Carolina Community Care Networks, a clinical partner agency with the North Carolina Division of Medical Assistance. He is a psychiatric pharmacy specialist with over 29 years in the public mental health system in inpatient psychiatry, residential developmental disabilities, and correctional mental health services. He is Board Certified in Psychiatric and Neurologic Pharmacy, having received his undergraduate and graduate training at UNC. He serves as an active member of many professional organizations, including the American Society of Health-Systems Pharmacists, the North Carolina Association of Pharmacists, and serving as immediate past president of the College of Psychiatric and Neurologic Pharmacists. McKee also serves as the immediate past chair of the Board of Pharmaceutical Specialties Psychiatric Specialist Council.

Jerry received the North Carolina Department of Human Resources Secretary's Award for Excellence, the 2000 Eugene Hargrove Award for sustained excellence in mental health research, the Western Carolina Center Directors Award for Excellence, and was a finalist for the CPNP 2006 Best Practices Award.

CHARLENE SAMPSON is a 10-year employee of the North Carolina Department of Health and Human Services. Her current position is with the Division of Medical Assistance (DMA) Outpatient Pharmacy Program. She is the lead pharmacist for behavioral health policies and initiatives implemented by the Pharmacy Program. As a veteran pharmacist, her work experience includes retail, regulatory services and consultation

MATT HILLMAN has worked for Catawba County DSS for the past 5 years as a Therapeutic Foster Care Social Worker and Supervisor. Prior to working for Catawba County Matt worked for Support Incorporated as a Case Manager and Supervisor of a Day Treatment Program.

SOURCES FOR LEARNING MORE ABOUT SPECIFIC PSYCHOTROPIC MEDICATIONS

National Alliance on Mental Illness

- http://www.nami.org/template.cfm?section=About_Medications
- http://www.nami.org/Template.cfm?Section=Ask_the_Pharmacist&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=61&ContentID=28925
- http://www.nami.org/Template.cfm?Section=By_Illness

Texas Dept. of Family and Protective Services & University of Texas at Austin College of Pharmacy. (2010, December). *Psychotropic medication utilization parameters for foster children*. Accessed January 7, 2013 from http://www.dfps.state.tx.us/documents/about/pdf/TxFosterCareParameters-December2010.pdf

Second Generation Antipsychotic Agents (SGAs)	SSRI Antidepressants	Mood Stabilizing AEDs	Psychostimulants
Clozaril®--clozapine	Prozac®- fluoxetine	Depakote/Depakene®- divalproex/valproic acid	Adderall IR/XR®- mixed amphetamine salts
Risperdal®- - risperidone	Zoloft®- sertraline	Tegretol®- carbamazepine	Ritalin®- methylphenidate
Zyprexa®- -olanzapine	Celexa®- citalopram	Lamictal®-lamotrigine	Dexedrine®- dextroamphetamine
Seroquel®- - quetiapine	Paxil®- paroxetine	Topamax®-topiramate	Concerta®- methylphenidate
Geodon®- -ziprasidone	Luvox®- fluvoxamine	Trileptal®-oxcarbazepine	Vyvanse®- lisdexamfetamine
Abilify®- - aripiprazole	Lexapro®- escitalopram		Daytrana®- methylphenidate transdermal
Saphris®- - asenapine			Metadate®- methylphenidate
Fanapt®- -iloperidone			Focalin®- dexmethylphenidate
Latuda®- -lurasidone			

"RED FLAGS" FROM TEXAS

Criteria Indicating Need for Further Review of a Child's Clinical Status

The following situations indicate a need for further review of a patient's case. These parameters do not necessarily indicate that treatment is inappropriate, but they do indicate a need for further review.

For a child being prescribed a psychotropic medication, any of the following suggests the need for additional review of a patient's clinical status:

1. Absence of a thorough assessment of DSM-IV diagnosis in the child's medical record
2. Five (5) or more psychotropic medications prescribed concomitantly (side effect medications are not included in this count)
3. Prescribing of:

   (a) Two (2) or more concomitant antidepressants (if an additional one is used, may be reviewed but will be allowed if reasonable for the indications.

   (b) Two (2) or more concomitant antipsychotic medications

   (c) Two (2) or more concomitant stimulant medications[1]

   (d) Three (3) or more concomitant mood stabilizer medications

   NOTE: For the purpose of this document, polypharmacy is defined as the use of two or more medications for the same indication (i.e., specific mental disorder).

   [1] The prescription of a long-acting stimulant and an immediate release stimulant of the same chemical entity (e.g., methylphenidate) does not constitute concomitant prescribing.

   [2] When switching psychotropics, medication overlap and cross-titration may be utilized before discontinuing the first medication

4. The prescribed psychotropic medication is not consistent with appropriate care for the patient's diagnosed mental disorder or with documented target symptoms usually associated with a therapeutic response to the medication prescribed.
5. Psychotropic polypharmacy for a given mental disorder is prescribed before utilizing psychotropic monotherapy.
6. The psychotropic medication dose exceeds usual recommended doses.
7. Psychotropic medications are prescribed for children of very young age, including children receiving the following medications with an age of:

   - Antidepressants: Less than four (4) years of age
   - Antipsychotics: Less than four (4) years of age
   - Psychostimulants: Less than three (3) years of age

8. Prescribing by a primary care provider who has not documented previous specialty training for a diagnosis **other** than the following (unless recommended by a psychiatrist consultant):

   - Attention Deficit Hyperactive Disorder (ADHD)
   - Uncomplicated anxiety disorders
   - Uncomplicated depression

Reprinted from: Texas Dept. of Family and Protective Services & University of Texas at Austin College of Pharmacy. (2010, December). *Psychotropic medication utilization parameters for foster children*. Accessed January 7, 2013 from http://www.dfps.state.tx.us/documents/about/pdf/TxFosterCareParameters-December2010.pdf

For additional information about "Red Flags" in other states, see p. 7 in Leslie, et al. (2010). *Multi-State Study on Psychotropic Medication Oversight in Foster Care* (http://160.109.101.132/icrhps/prodserv/docs/Executive_Report_09-07-10_348.pdf)

38826

NORTH CAROLINA MEDICAID

Off Label Antipsychotic Safety Monitoring In Recipients Less than Age 18 Years

Please consider online registration at documentforsafety.org

Request Date ___ / ___ / _____

RECIPIENT INFORMATION

Recipient's Medicaid ID Number

Recipient's Date of Birth ___ / ___ / _____

Recipient's Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Phone: ___ - ___ - ____

Prescriber Fax: ___ - ___ - ____

Prescriber NPI #

Prescriber DEA # __ - _______

Drug Requested:

Strength ______________ Quantity ______________ Length of Therapy on Prescription ______________ Dosing Instructions ______________

A) **Primary Diagnosis**: (circle one only) Attention Deficit-Hyperactivity Disorder, Bipolar disorder, Disruptive behavior disorder, Mood Disorder-NOS, any Pervasive Developmental Disorder, PTSD, Schizoaffective Disorder, Schizophrenia, Tourette 's syndrome,
Other ____

B) **Primary target symptom**: (circle one only) psychosis, mania, irritability, aggression, impulsivity, inattentiveness, oppositional,
Other ____

C) **Height**: (inches)______ Weight(lbs.)______ Date__________

D) **Labs:** (circle one): a. Done (enter below) or b. Not done.

E) If not done (circle one): Not clinically indicated; Labs Pending; Unable to obtain.

F) Lipids: Date:_______ TC_______ LDL_______HDL____________ TG______

G) **Glucose results:** Date:______________ _______(mg/dl);
(circle one) fasting, non-fasting

H) **Clinical improvement** since starting drug treatment: **(circle one)** very much improved; much improved; modestly improved; no change; modestly worse; much worse; very much worse; not assessed/not applicable

I) **Adverse effects over the past week:** (CHECK ALL THAT APPLY):
   a. Daytime sedation: ☐ none ☐ mild ☐ moderate ☐ severe;
   b. Significant restlessness: ☐ none ☐ mild ☐ moderate ☐ severe;
   c. Stiffness/dystonia/tremor: ☐ none ☐ mild ☐ moderate ☐ severe;
   d. Other dyskinesia: ☐ none ☐ mild ☐ moderate ☐ severe

Signature of Prescriber_______________________________ ___ / ___ / _____

*Prescriber signature mandatory Date

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

FAX TO: **NORTH CAROLINA Medicaid Prior Authorizations**

Fax: (866)-246-8507

PA HELPDESK: (866) 246 - 8505

38826

Network	Behavioral Health Coordinator	Email Contact	Telephone Contact	Counties covered	Network Director
AccessCare	Juan Ortiz	jortiz@ncaccesscare.org	919-380-9962x466	Alamance, Jackson, Macon, Swain, Haywood, Clay, Cherokee, Graham, Caswell, Chatham,Orange, Robeson,	Marcelletta Miles
	Jill McKinney	Jmckinney@ncaccesscare.org	828-443-6147	Alexander, Ashe, Avery, Alleghany, Burke,Caldwell,Catawba, Iredell, Watauga	Marcelletta Miles
Carolina Collaborative Community Care	Karin Suess	KSuess@carolinaccc.com	910-487-8451	Cumberland	Brenda Sparks
	Cheryl Brees	cbrees@carolinaccc.com	910-495-8476		
Carolina Community Health Partnership	Regina B. Haynes	Regina.Haynes@clevelandcounty.com	704-669-3169	Cleveland, Rutherford	Debbie Clapper
	Wanda Jenkins	cccawjenkins@yahoo.com	704-484-5131		
Community Care of Lower Cape Fear	Elissa Hanson	elissa.hanson@carelcf.org	910-332-9543	Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender,	Lydia Newman
Community Care of the Sandhills	Susanne Whiting	susannewhiting@cc-sandhills.org	910-246-9806	Harnett, Hoke, Lee, Montgomery, Moore, Richmond, Scotland	Tammie McLean
	Andrew Clendenin	aclendenin@cc-sandhills.org	910-246-9806 919-356-0410		
Community Care of Wake and Johnston Counties	Jamie Philyaw	jphilyaw@wakedocs.org	919-554-9013	Johnston, Wake	Susan Davis
Community Care of Western North Carolina	Eric Christian	echristian@ccwnc.org	828-348-2833	Buncombe, Henderson, Madison, McDowell, Mitchell, Polk,Translyvania,Yancey	Jennifer Wehe
Community Care Partners of Greater Mecklenburg	Valencia Anderson	Valencia.Anderson@carolinashealthcare.org	704-863-7593	Anson, Mecklenburg, Union	Anita Schambach
	Sarah Brown	sarah.brown@novanthealth.org	704-384-0107		
	Tchernavia Montgomery	Tchernavia.montgomery@carolinashealthcare.org			
	Gloria Conyers-Mutts	Gloria.ConyersMutts@carolinashealthcare.org	704-512-2449		
Community Care Plan of Eastern Carolina	Lindy Kitchin	lindy.kitchin@vidanthealth.com	252-714-7578	Camden, Carteret, Craven, Currituck, Duplin, Edgecombe, Greene, Halifax, Jones, Lenoir, Nash, Northampton,	Laurie Nelson
	Joanne Koster	joanne.koster@VidantHealth.com	252-916-5485		
Community Health Partners	Anne Wheeler	awheeler@gfhs.info	704-874-7017	Gaston, Lincoln	Lynne Perrin
Northern Piedmont Community Care					Fred Johnson
a. Community Care Partners	Sharon Long	sharon.s.long@duke.edu	252-431-6163	Franklin, Granville, Person, Vance, Warren,	Jeaneen Beckham
b. Durham Community Health Network	Atalaysha Churchwell	atalaysha.churchwell@duke.edu	919-613-6533	Durham	Stephanie Triantafillou
Northwest Community Care Network	Peter Rives	prives@nwcommunitycare.org	336-716-8972	Davie, Forsyth, Stokes, Surry, Wilkes, Yadkin, Davidson	Jim Graham
Partnership for Community Care	Laura Davis	ldavis@p4care.org	336-686-3109	Guilford, Randolph, Rockingham	Claudette Johnson
Southern Piedmont Community Care Plan	Erin Greene	ErinGreene@CCofSP.com	704-262-1072	Cabarrus, Rowan,Stanly	Cindy Oakes
Community Care	Amelia Mahan	amahan@n3cn.org	919-926-3918		

Patient Profile - Patient Care Team Summary

Feedback | Logout

Welcome: Training AccessCare

Provider Portal Demo

Community Care of North Carolina

Patient Search:

◉ Medicaid ID	001565854A			Clear All
○ Last Name	Exact	Birth Date	mm/dd/yyyy	
○ Last Name	Partial	First Name	Partial	Birth Year yyyy

Search

My Practices | Patient Profile | Report Site

Patient Care Team Summary

Patient: Jane Doe *	Medicaid ID: 001565854A	Gender: Female	Birth Date: 03/10/1964	Age: 47
Address: 100 Main Street, City, NC 55555		County: County	Phone 1: (555) 555-5555	Phone 2: (555) 555-5555
Months Medicaid-Eligible: 12	Medicaid: Yes	Medicare: No	Other Insurance: No	Program Code: MADC

Carolina Access PCP: PCP Name ET5	Phone: (555) 555-5555	Fax: (555) 555-5555
Carolina Access PCP Address: 100 West Street, City, NC 99999		PCP County: County C8

Care Alerts: 0	Inpatient Visits *: 0	Hospital Observation Stays *: 0	ED Visits *: 0
Imaging *: 14	Office Visits *: 23	ST/PT/OT *: 0	DME Supplies *: 3
Lab Values *: 0	Medications: 39	Medication Fill History: 272	Medicaid Cost Per Month: $ 5671.23

'*' indicates based on 15 months of data.

Information displayed is obtained from claims processed by Medicaid. Services paid out-of-pocket or by 3rd parties, including Medicare, may not appear. Recent services may not appear, if claims have not yet been processed. Services related to substance abuse treatment by a substance abuse treatment program will not appear. Claims data may contain errors and omissions. Information may be used only for patient care, care coordination, and quality improvement purposes.

Care Coordination

Print this Page

Resources:

CCNC Network: Network A			
Care Manager: CM Smith *	Care Management Status: Heavy	Phone: (555) 555-5555	Fax: (555) 555-5555
Network Pharmacist: Pharmacist Johnson *		Phone: (555) 555-5555	Fax: (555) 555-5555
Mental Health Local Management Entity (LME): LME Name *		Phone: (555) 555-5555	
Health Check Coordinator:		Phone:	

Claims Paid Through: 12/16/2010

Most Recent Service Providers:

Id	Type	Name	Phone	Date Last Billed
743657	Pharmacy	Provider Name ADA5	(555) 555-5555	12/16/2010
1336864	Personal Care Services	Provider Name GCH7	(555) 555-5555	12/4/2010
1282369	Home Health	Provider Name BQL7	(555) 555-5555	5/28/2010

Most Recent Office Visit Providers:

Id	Billing Provider	Billing Provider Phone	Attending Provider	Attending Provider Specialty	Date Last Billed
2604246	Provider Name OOA3	(555) 555-5555	Provider Name BYS7	INTERNAL MEDICINE	12/1/2010
2604814	Provider Name EEX0	(555) 555-5555	Provider Name BZA9	ANESTHESIOLOGY	10/21/2010
2604815	Provider Name OTK1	(555) 555-5555	Provider Name TGC8	ORTHOPEDIC/HAND SURGERY	10/19/2010
2604365	Provider Name OLR0	(555) 555-5555	Provider Name QVG5	ONCOLOGY	10/8/2010
2603886	Provider Name DCO8	(555) 555-5555	Provider Name QSO5	GASTROENTEROLOGY	9/15/2010
2604536	Provider Name OFJ4	(555) 555-5555	Provider Name LMA9	OTOLOGY, LARYNGOLOGY, RHINOLOGY (ENT)	1/15/2010
2604211	Provider Name GNG1	(555) 555-5555	Provider Name QSQ0	INTERNAL MEDICINE	1/8/2010
2604406	Provider Name OXD2	(555) 555-5555	Provider Name SXW5	RHEUMATOLOGY	12/3/2009

Patient Profile - Medication Regimen

Welcome: Training AccessCare

Provider Portal Demo

Community Care of North Carolina

Feedback | Logout

Patient Search:

Medicaid ID 001565854A Clear All

Last Name Exact Birth Date mm/dd/yyyy

Last Name Partial First Name Partial Birth Year yyyy

Search

My Practices | Patient Profile | Report Site

Medication Regimen

Patient: Jane Doe *	Medicaid ID: 001565854A	Birth Date: 03/10/1964	CA PCP: PCP Name ET5

Medications listed reflect filled prescriptions paid by Medicaid. Recent fills may not appear, if claim has not yet been processed. Prescriptions paid out-of-pocket or under a Medicare Part D plan do not appear. If patient is dually eligible for Medicaid and Medicare, medication history is likely incomplete. The prescriber(s) listed below may occasionally be misstated due to pharmacy imputation errors when interpreting a prescriber's signature. In many cases the prescriber is unknown.

Claims Paid Through: 12/16/2010

Medication Regimen - 39 prescriptions

Medication Regimen Report | Pocket Medication List Report

Id	Fill Date	Drug Description	Qty	Days	Paid	Gap In Therapy	Adherence Index	Prescriber	Pharmacy	Source
69094750	12/16/2010	NICOTINE 14 MG/24HR PATCH	28	28	$65.47			Prescriber Name AGS0	Provider Name ADA5	Claims
69094749	12/16/2010	METHIMAZOLE 10 MG TABLET	30	30	$11.55			Prescriber Name AGS0	Provider Name ADA5	Claims
69094748	12/16/2010	ATENOLOL 25 MG TABLET	30	30	$3.28		1 Fill	Prescriber Name AGS0	Provider Name ADA5	Claims
69094747	12/16/2010	NYSTOP 100,000 UNITS/GM POWD	15	30	$9.59			Prescriber Name AGS0	Provider Name ADA5	Claims
69094746	12/16/2010	COMBIVENT INHALER	14.70	30	$153.54			Prescriber Name AGS0	Provider Name ADA5	Claims
69094745	12/16/2010	PREDNISONE 20 MG TABLET	21	7	$0.00			Prescriber Name AGS0	Provider Name ADA5	Claims
69094744	12/16/2010	AZITHROMYCIN 500 MG TABLET	5	5	$17.66			Prescriber Name AGS0	Provider Name ADA5	Claims
69094743	12/16/2010	AMOX TR-K CLV 875-125 MG TAB	10	5	$9.69			Prescriber Name AGS0	Provider Name ADA5	Claims
69094742	12/16/2010	ADVAIR 250-50 DISKUS	60	30	$214.89		0.62	Prescriber Name AGS0	Provider Name ADA5	Claims
68760774	12/8/2010	FLUCONAZOLE 150 MG TABLET	1	1	$3.03			Prescriber Name AGS0	Provider Name ADA5	Claims
68760773	12/8/2010	AVELOX 400 MG TABLET	10	10	$164.18			Prescriber Name BFM2	Provider Name ADA5	Claims
68404262	12/3/2010	POTASSIUM CL ER 10 MEQ TABLE	30	30	$10.21			Prescriber Name AGS0	Provider Name ADA5	Claims
68404261	12/2/2010	HYZAAR 100-25 TABLET	30	30	$109.38			Prescriber Name AGS0	Provider Name ADA5	Claims
68404260	12/1/2010	PROMETHAZINE 25 MG TABLET	40	10	$10.72			Prescriber Name AGS0	Provider Name ADA5	Claims
68404259	12/1/2010	SULFAMETHOXAZOLE-TMP DS TABL	20	10	$4.78			Prescriber Name AGS0	Provider Name ADA5	Claims
68404258	12/1/2010	METAXALONE 800 MG TABLET	90	30	$296.66			Prescriber Name AAF4	Provider Name ADA5	Claims
68404257	12/1/2010	CYCLOBENZAPRINE 10 MG TABLET	60	30	$1.02			Prescriber Name AAF4	Provider Name ADA5	Claims
68404256	12/1/2010	VOLTAREN 1% GEL	500	30	$137.52			Prescriber Name AAF4	Provider Name ADA5	Claims
68404255	12/1/2010	FLECTOR 1.3% PATCH	60	30	$324.51			Prescriber Name AAF4	Provider Name ADA5	Claims
68404254	12/1/2010	CYMBALTA 60 MG CAPSULE	60	30	$273.96		1.05	Prescriber Name HCL6	Provider Name ADA5	Claims
68404253	12/1/2010	NEXIUM 40 MG CAPSULE	60	30	$344.86			Prescriber Name AGS0	Provider Name ADA5	Claims
68404252	12/1/2010	ABILIFY 15 MG TABLET	30	30	$482.85		1.05	Prescriber Name HCL6	Provider Name ADA5	Claims
68404251	12/1/2010	LYRICA 150 MG CAPSULE	90	30	$224.41		1.05	Prescriber Name BDJ6	Provider Name ADA5	Claims
68404250	12/1/2010	ALPRAZOLAM 1 MG TABLET	90	30	$1.46			Prescriber Name HCL6	Provider Name ADA5	Claims
68404249	12/1/2010	POLYETHYLENE GLYCOL 3350 POW	527	30	$21.87			Prescriber Name CKI0	Provider Name ADA5	Claims
68404248	12/1/2010	SPIRIVA 18 MCG CP-HANDIHALER	30	30	$197.13			Prescriber Name BDJ6	Provider Name ADA5	Claims
68404247	12/1/2010	VENTOLIN HFA 90 MCG INHALER	18	30	$31.14			Prescriber Name CKI0	Provider Name ADA5	Claims
68404246	12/1/2010	PREMARIN 1.25 MG TABLET	30	30	$50.98			Prescriber Name CKI0	Provider Name ADA5	Claims
68404244	12/1/2010	ALBUTEROL 0.083% INHAL SOLN	540	30	$25.24			Prescriber Name AGS0	Provider Name ADA5	Claims
68404243	12/1/2010	XOPENEX 0.63 MG/3 ML SOLUTIO	360	30	$550.55			Prescriber Name AGS0	Provider Name ADA5	Claims
67897438	11/24/2010	VESICARE 10 MG TABLET	30	30	$146.27			Prescriber Name MRA3	Provider Name ADA6	Claims
67897437	11/24/2010	OXYCONTIN 60 MG TABLET	90	30	$848.81			Prescriber Name AAF4	Provider Name ADA6	Claims
67897436	11/24/2010	OXYCODONE HCL 30 MG TABLET	150	30	$95.26			Prescriber Name AAF4	Provider Name ADA6	Claims
67897435	11/23/2010	HYDROCHLOROTHIAZIDE 25 MG TA	90	90	$4.22		1.07	Prescriber Name MRA3	Provider Name ADA6	Claims
67114322	11/5/2010	VESICARE 5 MG TABLET	30	30	$146.27			Prescriber Name MRA3	Provider Name ADA6	Claims
67114320	11/5/2010	CIPROFLOXACIN HCL 500 MG TAB	20	10	$4.83			Prescriber Name MRA3	Provider Name ADA6	Claims
67114319	11/5/2010	MUPIROCIN 2% OINTMENT	22	30	$14.25			Prescriber Name MRA3	Provider Name ADA6	Claims
67114316	11/3/2010	LISINOPRIL 10 MG TABLET	30	30	$3.77	14	1.00	Prescriber Name MRA3	Provider Name ADA6	Claims
66783312	10/24/2010	KETOROLAC 10 MG TABLET	20	5	$7.86			Prescriber Name AAF4	Provider Name ADA6	Claims

Patient notes - 0 notes

Patient Profile - Medication History

Welcome: Training AccessCare

Provider Portal Demo

Community Care of North Carolina

Feedback | Logout

Patient Search:

- Medicaid ID: 001565854A — Clear All
- Last Name: Exact — Birth Date: mm/dd/yyyy
- Last Name: Partial — First Name: Partial — Birth Year: yyyy

Search

My Practices | Patient Profile | Report Site

Medication History

Patient: Jane Doe *	Medicaid ID: 001565854A	Birth Date: 03/10/1964	CA PCP: PCP Name ET5

Medications listed reflect filled prescriptions paid by Medicaid. Recent fills may not appear, if claim has not yet been processed. Prescriptions paid out-of-pocket or under a Medicare Part D plan do not appear. If patient is dually eligible for Medicaid and Medicare, medication history is likely incomplete. The prescriber(s) listed below may occasionally be misstated due to pharmacy imputation errors when interpreting a prescriber's signature. In many cases the prescriber is unknown.

Claims Paid Through: 12/16/2010

Medication History - 272 prescriptions From: 12/16/2009 To: 12/16/2010 View History — Medication History Report

Id	Fill Date	Drug Description	Qty	Days	Paid	Gap In Therapy	Adherence Index	Prescriber	Pharmacy	Source
69094750	12/16/2010	NICOTINE 14 MG/24HR PATCH	28	28	$65.47			Prescriber Name AGS0	Provider Name ADA5	Claims
69094749	12/16/2010	METHIMAZOLE 10 MG TABLET	30	30	$11.55			Prescriber Name AGS0	Provider Name ADA5	Claims
69094748	12/16/2010	ATENOLOL 25 MG TABLET	30	30	$3.28		1 Fill	Prescriber Name AGS0	Provider Name ADA5	Claims
69094747	12/16/2010	NYSTOP 100,000 UNITS/GM POWD	15	30	$9.59			Prescriber Name AGS0	Provider Name ADA5	Claims
69094746	12/16/2010	COMBIVENT INHALER	14.70	30	$153.54			Prescriber Name AGS0	Provider Name ADA5	Claims
69094745	12/16/2010	PREDNISONE 20 MG TABLET	21	7	$0.00			Prescriber Name AGS0	Provider Name ADA5	Claims
69094744	12/16/2010	AZITHROMYCIN 500 MG TABLET	5	5	$17.66			Prescriber Name AGS0	Provider Name ADA5	Claims
69094743	12/16/2010	AMOX TR-K CLV 875-125 MG TAB	10	5	$9.69			Prescriber Name AGS0	Provider Name ADA5	Claims
69094742	12/16/2010	ADVAIR 250-50 DISKUS	60	30	$214.89		0.62	Prescriber Name AGS0	Provider Name ADA5	Claims
68760774	12/8/2010	FLUCONAZOLE 150 MG TABLET	1	1	$3.03			Prescriber Name AGS0	Provider Name ADA5	Claims
68760773	12/8/2010	AVELOX 400 MG TABLET	10	10	$164.18			Prescriber Name BFM2	Provider Name ADA5	Claims
68760772	12/8/2010	PREDNISONE 20 MG TABLET	15	5	$3.68			Prescriber Name BFM2	Provider Name ADA5	Claims
68760771	12/8/2010	AMOX TR-K CLV 875-125 MG TAB	14	7	$20.36			Prescriber Name BFM2	Provider Name ADA5	Claims
68404262	12/3/2010	POTASSIUM CL ER 10 MEQ TABLE	30	30	$10.21			Prescriber Name AGS0	Provider Name ADA5	Claims
68404261	12/2/2010	HYZAAR 100-25 TABLET	30	30	$109.38			Prescriber Name AGS0	Provider Name ADA5	Claims
68404260	12/1/2010	PROMETHAZINE 25 MG TABLET	40	10	$10.72			Prescriber Name AGS0	Provider Name ADA5	Claims
68404259	12/1/2010	SULFAMETHOXAZOLE-TMP DS TABL	20	10	$4.78			Prescriber Name AGS0	Provider Name ADA5	Claims
68404258	12/1/2010	METAXALONE 800 MG TABLET	90	30	$296.66			Prescriber Name AAF4	Provider Name ADA5	Claims
68404257	12/1/2010	CYCLOBENZAPRINE 10 MG TABLET	60	30	$1.02			Prescriber Name AAF4	Provider Name ADA5	Claims
68404256	12/1/2010	VOLTAREN 1% GEL	500	30	$137.52			Prescriber Name AAF4	Provider Name ADA5	Claims
68404255	12/1/2010	FLECTOR 1.3% PATCH	60	30	$324.51			Prescriber Name AAF4	Provider Name ADA5	Claims
68404254	12/1/2010	CYMBALTA 60 MG CAPSULE	60	30	$273.96		1.05	Prescriber Name HCL6	Provider Name ADA5	Claims
68404253	12/1/2010	NEXIUM 40 MG CAPSULE	60	30	$344.86			Prescriber Name AGS0	Provider Name ADA5	Claims
68404252	12/1/2010	ABILIFY 15 MG TABLET	30	30	$482.85		1.05	Prescriber Name HCL6	Provider Name ADA5	Claims
68404251	12/1/2010	LYRICA 150 MG CAPSULE	90	30	$224.41		1.05	Prescriber Name BDJ6	Provider Name ADA5	Claims
68404250	12/1/2010	ALPRAZOLAM 1 MG TABLET	90	30	$1.46			Prescriber Name HCL6	Provider Name ADA5	Claims
68404249	12/1/2010	POLYETHYLENE GLYCOL 3350 POW	527	30	$21.87			Prescriber Name CKI0	Provider Name ADA5	Claims
68404248	12/1/2010	SPIRIVA 18 MCG CP-HANDIHALER	30	30	$197.13			Prescriber Name BDJ6	Provider Name ADA5	Claims
68404247	12/1/2010	VENTOLIN HFA 90 MCG INHALER	18	30	$31.14			Prescriber Name CKI0	Provider Name ADA5	Claims
68404246	12/1/2010	PREMARIN 1.25 MG TABLET	30	30	$50.98			Prescriber Name CKI0	Provider Name ADA5	Claims
68404244	12/1/2010	ALBUTEROL 0.083% INHAL SOLN	540	30	$25.24			Prescriber Name AGS0	Provider Name ADA5	Claims
68404243	12/1/2010	XOPENEX 0.63 MG/3 ML SOLUTIO	360	30	$550.55			Prescriber Name AGS0	Provider Name ADA5	Claims
68404245	12/1/2010	FLUCONAZOLE 150 MG TABLET	1	1	$0.00			Prescriber Name AGS0	Provider Name ADA5	Claims
67897438	11/24/2010	VESICARE 10 MG TABLET	30	30	$146.27			Prescriber Name MRA3	Provider Name ADA6	Claims
67897437	11/24/2010	OXYCONTIN 60 MG TABLET	90	30	$848.81			Prescriber Name AAF4	Provider Name ADA6	Claims
67897436	11/24/2010	OXYCODONE HCL 30 MG TABLET	150	30	$95.26			Prescriber Name AAF4	Provider Name ADA6	Claims
67897435	11/23/2010	HYDROCHLOROTHIAZIDE 25 MG TA	90	90	$4.22		1.07	Prescriber Name MRA3	Provider Name ADA6	Claims
67459312	11/10/2010	ALBUTEROL 0.083% INHAL SOLN	150	25	$10.45			Prescriber Name MRA3	Provider Name ADA6	Claims
67114322	11/5/2010	VESICARE 5 MG TABLET	30	30	$146.27			Prescriber Name MRA3	Provider Name ADA6	Claims
67114320	11/5/2010	CIPROFLOXACIN HCL 500 MG TAB	20	10	$4.83			Prescriber Name MRA3	Provider Name ADA6	Claims
67114319	11/5/2010	MUPIROCIN 2% OINTMENT	22	30	$14.25			Prescriber Name MRA3	Provider Name ADA6	Claims
67114321	11/5/2010	FLUCONAZOLE 150 MG TABLET	1	15	$3.03			Prescriber Name MRA3	Provider Name ADA6	Claims
67114318	11/4/2010	FLECTOR 1.3% PATCH	60	30	$328.51			Prescriber Name AAF4	Provider Name ADA6	Claims
67114316	11/3/2010	LISINOPRIL 10 MG TABLET	30	30	$3.77	14	1.00	Prescriber Name MRA3	Provider Name ADA6	Claims
67114317	11/3/2010	CYCLOBENZAPRINE 10 MG TABLET	60	30	$6.62			Prescriber Name AAF4	Provider Name ADA6	Claims
67114315	11/2/2010	VOLTAREN 1% GEL	500	30	$141.52			Prescriber Name AAF4	Provider Name ADA6	Claims

Patient Profile - Visit History

Welcome: Training AccessCare

Provider Portal Demo

Community Care of North Carolina

Feedback | Logout

Patient Search:

(•) Medicaid ID	001565854A			Clear All
( ) Last Name	Exact	Birth Date	mm/dd/yyyy	
( ) Last Name	Partial	First Name	Partial	Birth Year yyyy

Search

My Practices | Patient Profile | Report Site

Visit History

Patient: Jane Doe *	Medicaid ID: 001565854A	Birth Date: 03/10/1964	CA PCP: PCP Name ET5

☐ Care Alerts: 0	☐ Inpatient Visits *: 0	☐ Hospital Observation Stays *: 0	☐ ED Visits *: 0
☑ Imaging *: 14	☑ Office Visits *: 23	☐ ST/PT/OT *: 0	☑ DME Supplies *: 3
☐ Lab Values *: 0			Medicaid Cost Per Month: $ 5671.23

☑ All Sections

'*' indicates based on 15 months of data.

Print Selected Sections on this Page | Chronic Care Patient Snapshot Report | 646 Patient Snapshot Report

Information displayed is obtained from claims processed by Medicaid. Services paid out-of-pocket or by 3rd parties, including Medicare, may not appear. Recent services may not appear, if claims have not yet been processed. Services related to substance abuse treatment by a substance abuse treatment program will not appear. Claims data may contain errors and omissions. Information may be used only for patient care, care coordination, and quality improvement purposes.

Claims Paid Through: 12/16/2010

Imaging - 14

Id	Date	Procedure	Primary Diagnosis	Billing Provider
3627146	12/9/2010	RADIOLOGIC EXAM, CHEST	PULM CONGEST/HYPOSTASIS	Provider Name CPH6
4088675	12/9/2010	RADIOLOGIC EXAM, CHEST	NONSPECIFIC FINDINGS ON RADIOLOGICAL & OTHER EXAM OF LUNG	Provider Name CPH6
4802518	12/8/2010	RADIOLOGIC EXAM, CHEST	OTHER LUNG DISEASE NEC	Provider Name CPH6
3892847	11/4/2010	FLUOROSCOPIC GUIDANCE AND LOCALIZATION OF NEEDLE OR CATHETER TIP FOR SPINE OR	CERVICAL DISC DEGEN	Provider Name EEX0
4225771	10/14/2010	MRI SPINAL CORD (INCLUDING SPINE)	CERVICAL DISC DISPLACMNT	Provider Name ARO2
2518126	9/16/2010	RADIOLOGICAL EXAMINATION, GASTROINTESTINAL TRACT, UPPER, AIR CONTRAST, WITH	NAUSEA ALONE	Provider Name ORP5
2697080	9/16/2010	RADIOLOGY-DIAGNOSTIC-GEN CLASS	NAUSEA ALONE	Provider Name ASA0
479939	5/25/2010	INTRAORAL-PERIAPICAL-FIRST FILM		Provider Name UOG7
2613351	4/16/2010	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM		Provider Name UOG7
2941470	4/16/2010	PANORAMIC FILM		Provider Name UOG7
3130293	4/16/2010	INTRAORAL-PERIAPICAL-FIRST FILM		Provider Name UOG7
261843	3/9/2010	RADIOLOGIC EXAM SPINE. 4 VIEWS	CERVICALGIA	Provider Name ORP5
1539948	1/21/2010	CT SCAN-GEN CLASS	SWELLING IN HEAD & NECK	Provider Name ARY8
4688861	1/21/2010	COMPUTERIZED AXIAL TOMOGRAPHY	SWELLING IN HEAD & NECK	Provider Name CPH6

Scroll to the Top

Office Visits - 23

Id	Date	Primary Diagnosis	Secondary Diagnosis	Attending Provider	Specialty
6021982	12/1/2010	CELLULITIS OF BUTTOCK	VITAMIN D DEFICIENCY NOS	Provider Name BYS7	INTERNAL MEDICINE
5732897	11/5/2010	SKIN DISORDER NOS	CHRONIC AIRWAY OBSTRUCTION NOT ELSEWHERE CLASSIFIED	Provider Name BYS7	INTERNAL MEDICINE
5642721	10/21/2010	LUMB/LUMBOSAC DISC DEGEN	RHEUMATISM NOS	Provider Name BZA9	ANESTHESIOLOGY
5426714	10/19/2010	GANGLION OF JOINT	CERVICAL DISC DISPLACMNT	Provider Name TGC8	ORTHOPEDIC/HAND SURGERY
5485520	10/8/2010	PRIMARY HYDERCOAGULABLE STATE		Provider Name QVG5	ONCOLOGY
5192372	10/2/2010	BRACHIAL NEURITIS NOS	ROTATOR CUFF SYND NOS	Provider Name TGC8	ORTHOPEDIC/HAND SURGERY
4847964	9/15/2010	NAUSEA ALONE	LOSS OF WEIGHT	Provider Name QSO5	GASTROENTEROLOGY
5485519	8/27/2010	PRIMARY HYDERCOAGULABLE STATE		Provider Name QVG5	ONCOLOGY

REQUEST FOR DATA FROM THE NORTH CAROLINA COMMUNITY CARE NETWORKS, INC. INFORMATICS CENTER

> ***This form must accompany requests for data from the North Carolina Community Care Networks, Inc. Informatics Center (the "Informatics Center") by any agency, entity, or provider that has not entered into a System Access Agreement to access data directly from the Informatics Center (the "Requesting Entity"). This form must be accompanied by a list of all individuals who are the subject of the requested data. For those Requesting Entities who are not "facilities" (as defined under N.C. Gen. Stat. § 122C-3), or who have not entered into a written agreement with the Community Care of North Carolina ("CCNC") Program to participate in the care management support network and systems developed and maintained by the CCNC Program for the purpose of coordinating and improving the quality of care for recipients of publicly funded health and related services, this form must be accompanied by a written authorization executed by each individual who is the subject of the requested data.***

The agency, entity, or provider requesting data from the Informatics Center (the "Requesting Entity") hereby affirms the following:

1. The Requesting Entity provides care, treatment, habilitation, or rehabilitation to the individual or individuals who are the subject of the data.

2. The data will be used by the Requesting Entity only for purposes of (a) treatment, or (b) quality assessment and improvement activities, or coordination of appropriate and effective patient care, treatment, or habilitation. Such activities include, but are not limited to, direct patient care, case management and care coordination, disease management, outcomes evaluations, development of clinical guidelines and protocols, development of care management plans and systems, and the provision, coordination, or management of mental health, developmental disabilities, and related services.

3. The data will be received and secured by the Requesting Entity in a manner that is consistent with applicable State and Federal law, and with applicable policies of the North Carolina Department of Health and Human Services.

4. The Requesting Entity assumes liability for the privacy, security, and confidentiality of the data it receives and for compliance with applicable laws governing the use and disclosure of the data.

5. The Requesting Entity has implemented appropriate administrative, technical, and physical safeguards to protect the confidentiality, integrity, and availability of the data, and to prevent any unauthorized access, use, or disclosure of the data.

6. The Requesting Entity has established and implemented appropriate policies and procedures to prevent any unauthorized access, use, or disclosure of the data, including, but not limited to ensuring that members of the Requesting Entity's workforce will obtain access to the data strictly on a need to know basis.

The Requesting Entity understands and acknowledges that:

1. Substance abuse treatment information protected by federal law (42 C.F.R. Part 2) has been excluded from the data to be disclosed in connection with this request.

2. The data contains paid claims data that requires further validation. Claims data has limits that include but are not limited to: missing, pending, denied, and/or third party claims (*i.e.*, Medicare Part D), and billing and coding errors including but not limited to diagnosis.

______________________________	________________
Name of Requesting Entity	*Date*
______________________________	________________
Authorized Signature	*Title*

Authorization to Disclose Data Obtained from the North Carolina Community Care Networks, Inc. Informatics Center

This form authorizes the disclosure of data by a party that is authorized to access the North Carolina Community Care Networks, Inc. Informatics Center (the "Informatics Center") pursuant to a System Access Agreement (the "Disclosing Entity") to a party that has not entered into a System Access Agreement to access data directly from the Informatics Center. It applies to data that the Disclosing Entity has obtained from the Informatics Center ("Informatics Center Data") and authorizes the Disclosing Entity to disclose such Informatics Center Data when North Carolina law requires the subject of the Informatics Center Data (client or patient) to authorize the disclosure. The HIPAA Privacy Rule does not require patient authorization to disclose Informatics Center Data to healthcare providers for the purposes set forth below, but state law governing mental health and developmental disabilities services (N.C. Gen. Stat. § 122C-52 et seq.) requires client authorization in some circumstances. This form authorizes the disclosure of Informatics Center Data that may contain this information.

Client Name ________________________________ Date of Birth ______________ Medicaid ID #_________________

I , ____ authorize
(Client or client's legally responsible person/personal representative)

____ and
(Agency, entity, or person authorized to disclose Informatics Center Data)

____to share with each other
(Agency, entity, or person requesting Informatics Center Data)

my (or the client's) health information. If my (or the client's) health information includes any information relating to my (or the client's) mental health or developmental disabilities services, I understand that my signature on this form authorizes the disclosure of this information. I also understand that the information authorized to be disclosed may include medications, names of health care providers, dates of services, diagnoses, payment information, types of services, and any other health care information.

Purpose of Use and Disclosure

The above information will be used and disclosed only for purposes of (a) coordinating appropriate and effective care, treatment, or habilitation, and (b) quality assessment and improvement activities, which may include, but are not limited to, direct patient care, case management and care coordination, disease management, outcomes evaluations, development of clinical guidelines and protocols, development of care management plans and systems, and the provision, coordination, or management of health, mental health, developmental disabilities, and related services.

Duration of Authorization

This authorization expires when the agency, entity, or person requesting information is no longer coordinating, providing, or managing my care and treatment, or in one year, whichever is sooner.

Right to Revoke Authorization

I understand that I may revoke this authorization at any time except any action taken in reliance on this authorization prior the revocation would not be affected by the revocation.

No Denial of Services Due to Refusal to Sign

I understand that I may refuse to sign this authorization and that the agency, entity, or person requesting this authorization cannot deny me, treatment, payment, enrollment in a health plan, or eligibility for benefits because of my refusal to sign.

Potential for Redisclosure

I understand that the agency, entity, or person receiving information pursuant to this authorization may not be subject to the federal health privacy law (45 C.F.R. Part 164) and, therefore, that law may not prohibit the recipient of my health information from redisclosing it.

________________________________ ______________ ________________________________
(Signature of Client) *(Date)*

________________________________ ______________ ________________________________
(Signature of Personal Representative, if required) *(Date)* *(Personal Representative Relationship/Authority)*

NOTE: This Authorization was revoked on ______________ ________________________________
(Date) *(Signature of Staff)*

NCCCN
Authorization to Disclose MH/DD/SA Information

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of ________________________________
(Name of Client)

signed by____ on ______________________________
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be revoked, effective ________________. I understand that any action taken in reliance on this authorization prior to the
(Date)

revocation is not affected by this revocation.

________________________	__________	____________________________	__________
(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*

________________________	__________	____________________________
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by ________________________________
(Name of Client or Personal Representative)

on ________________________________. The client or his personal representative has been informed that any action
(Date)

taken in reliance on this authorization prior to the revocation is not affected by this revocation.

________________________	__________	____________________________	__________
(Signature of Staff)	*(Date)*	*(Signature of Witness)*	*(Date)*

NCCCN
Authorization to Disclose MH/DD/SA Information

Notice to Accompany Informatics Center Data Disclosures

Instructions: ***This form may be used to accompany disclosures of data from the North Carolina Community Care Networks, Inc. Informatics Center (the "Informatics Center") to any agency, entity, or provider that has not entered into a System Access Agreement to access data directly from the Informatics Center.***

The agency, entity, or provider receiving data from the Informatics Center (the "Receiving Entity") hereby acknowledges the following:

1. **Purpose of Disclosure:**

   - The Receiving Entity provides care, treatment, habilitation, or rehabilitation to the individual or individuals who are the subject of the data.
   - The data will be used by the Receiving Entity only for purposes of (a) treatment, or (b) quality assessment and improvement activities, or coordination of appropriate and effective patient care, treatment, or habilitation. Such activities include, but are not limited to, direct patient care, case management and care coordination, disease management, outcomes evaluations, development of clinical guidelines and protocols, development of care management plans and systems, and the provision, coordination, or management of mental health, developmental disabilities, and related services.

2. **Privacy and Security Expectations:**

   - The data will be received and secured by the Receiving Entity in a manner that is consistent with applicable State and Federal law, and with applicable policies of the North Carolina Department of Health and Human Services.
   - The Receiving Entity assumes liability for the privacy, security, and confidentiality of the data it receives and for compliance with applicable laws governing the use and disclosure of the data.
   - The Receiving Entity has implemented appropriate policies and procedures to include administrative, technical, and physical safeguards to protect the confidentiality, integrity, and availability of the data, and to prevent any unauthorized access, use, or disclosure of the data.
   - The Receiving Entity will ensure that members of the Receiving Entity's workforce will obtain access to the data strictly on a need to know basis.

3. **Provisions for Specific Types of Data:**

   - Substance abuse treatment information protected by federal law (42 C.F.R. Part 2) has been excluded from the data to be disclosed.
   - The data contains paid claims data that requires further validation. Claims data has limits that include but are not limited to: missing, pending, denied, and/or third party claims (*i.e.*, Medicare Part D), and billing and coding errors including but not limited to diagnosis.

References

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Illinois Dept. of Children and Families. (2013). Title 89: social services chapter iii: department of children and family services subchapter b: program and technical support part 325 administration of psychotropic medications to children for whom the department of children and family services is legally responsible. Accessed January 23, 2013 from http://www.state.il.us/dcfs/docs/ocfp/rules/rules_325.pdf

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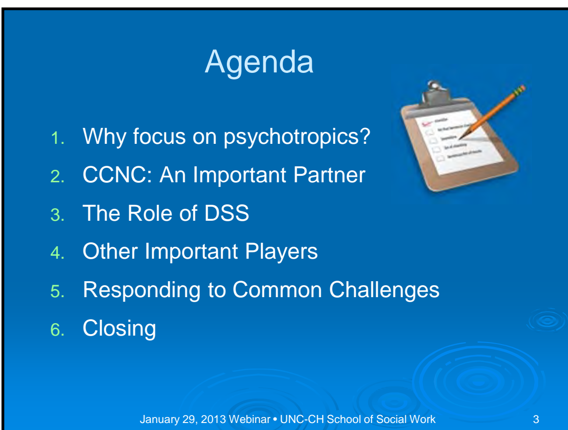
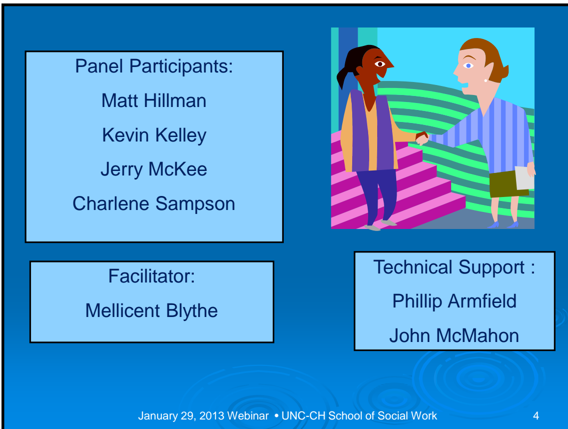
Texas Dept. of Family and Protective Services & University of Texas at Austin College of Pharmacy. (2010, December). *Psychotropic medication utilization parameters for foster children*. Accessed January 7, 2013 from http://www.dfps.state.tx.us/documents/about/pdf/TxFosterCareParameters-December2010.pdf

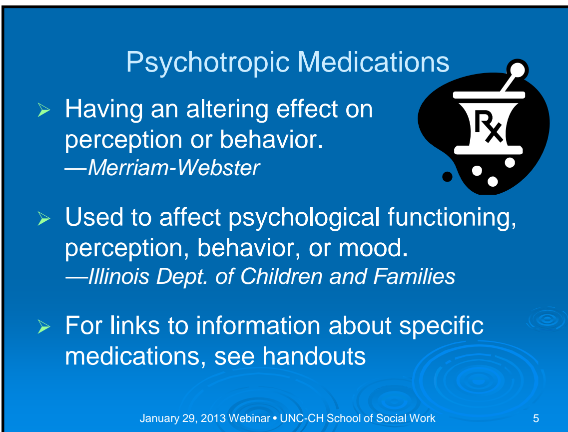
US Dept. of Health and Human Services. (2012). Promoting the Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care (ACYF-CB-IM-12-03). Washington, DC: Administration on Children, Youth, and Families. Accessed January 23, 2013 from http://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf.

Monitoring and Oversight of Psychotropic Medications for Children in Foster Care in NC: The Role of DSS
Welcome!
Please click on the colored link below to download the handout for today:
01-29-13 webinar handout
Statewide Training Partnership
UNC
School of Social Work

Goals of this Webinar
1. Clarify county DSS role in oversight and monitoring of psychotropic medications for children in foster care
2. Suggest resources and practice tips for playing this role successfully
January 29, 2013 Webinar • UNC-CH School of Social Work
2


Agenda
1. Why focus on psychotropics?
2. CCNC: An Important Partner
3. The Role of DSS
4. Other Important Players
5. Responding to Common Challenges
6. Closing
January 29, 2013 Webinar • UNC-CH School of Social Work
3





SETTING THE STAGE

Why Focus on Psychotropics?

6

Antipsychotics	Antidepressants	Mood Stabilizers	Stimulants
Clozaril® - *clozapine*	Prozac® - *fluoxetine*	Depakote/Depakene - *divalproex/valproic acid*	Adderall IR/XR® - *mixed amphetamine salts*
Risperdal® - *risperidone*	Zoloft® - *sertraline*	Tegretol® - *carbamazepine*	Ritalin® - *methylphenidate*
Zyprexa® - *olanzapine*	Celexa® - *citalopram*	Lamictal® -*lamotrigine*	Dexedrine® - *dextroamphetamine*
Seroquel® - *quetiapine*	Paxil® - *paroxetine*	Topamax® -*topiramate*	Concerta® -*methylphenidate*
Geodon® - *ziprasidone*	Luvox® - *fluvoxamine*	Trileptal® -*oxcarbazepine*	Vyvanse® -*lisdexamfetamine*
Abilify®- - *aripiprazole*	Lexapro® - escitalopram		Daytrana® -*methylphenidate transdermal*
Saphris® - *asenapine*			Metadate® -*methylphenidate*
Fanapt® - *iloperidone*			Focalin® -*dexmethylphenidate*
Latuda® - *lurasidone*			

Kids Foster Care Have Greater Need

- **behavior problems** requiring clinical intervention
  - 23% of maltreated children
  - about 3x times rate of general population
- **social skill problems** requiring clinical intervention
  - 35% of maltreated children
  - more than 2x rate of general population
- 62% kids in care exhibit symptoms of both a **mental health disorder** and **trauma** by age 17
- 3% of Medicaid population under age 18, but receive 32% of **behavioral health services**

Sources cited in ACF, 2012

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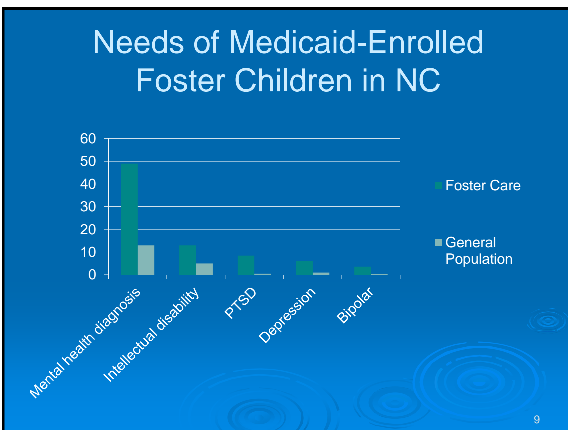

Psychotropic Rx Can Help

Unmet behavioral and MH needs can . . .
- Derail development across all domains
- Cause problems at home, school, and with peers
- Impede safety, stability, and permanency

- Psychotropic medications can be part of legitimate, necessary treatment approach
- Higher rates of prescribing for kids in care may reflect higher need

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Concern: Prescription Patterns

- General needs of children in foster care are the same within and across states
- Prescription patterns for psychotropics are not (range: 0% to 40%)
- Is something other than clinical need influencing the use of these drugs?

Sources cited in ACF, 2012

Are prescription drugs being overused to manage emotional and behavior problems better addressed by other treatments?

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Recommendations

- A Comprehensive Clinical Assessment should be completed before any psychotropic medication is started.
- A psychotropic medication should not be the first or only attempt to address behavioral problems or other symptoms.

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Other Rx Concerns

- Psychoactive medication polypharmacy without clear evidence basis
  - Watch out for side effects of one medicine that can be mistaken for a new symptom or disorder
- Off-label use and limited short-term efficacy data or long-term adverse effect studies (off-label use may be an appropriate practice in many cases)
- Lack of monitoring and coordination of care

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Stats on Psychotropic Use by Children in Care in NC

- NC foster care population: 8,884 (approximately 1% of all Medicaid children/teens)
- 9.66% receiving at least one antipsychotic Rx (2 % of non-foster population receiving similar tx)
- 7% receiving a psychostimulant
- 6% treated with an SSRI antidepressant/anxiolytic
- 4.3% receiving a mood stabilizing anti-epileptic Rx
- 24.2% had an Rx for at least one psychoactive Rx (**9%- 1 Rx**; **6.4%- 2Rx**; **8.8%- 3 or more Rx**)
- **3.6% age 5 or less**, **35.0% age 6-11**; **40.9% age 12-18** had at least one psychoactive Rx fill

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Special Concern: Antipsychotics

15

Antipsychotics Can Cause Health Problems: Monitoring Is Crucial

- Well-established relationship between antipsychotics and metabolic abnormalities in adults and children
  - High risk of weight gain → risk of diabetes
- Low compliance with safety monitoring nationally and in NC
  - Baseline Blood Glucose 31.6 %*
  - Baseline Lipids 13.2%*
- Follow up monitoring rates - ????

*Morrato EH, Nicol GE, Maahs D, Druss BG, Hartung DM, Valuck RJ, Campagna E, Newcomer JW. Metabolic screening in children receiving antipsychotic drug treatment. Arch Pediatr Adolesc Med. 2010 Apr;164(4):344-51.

[ŧ] Medicaid Medical Directors Learning Network and Rutgers Center for Education and Research on Mental Health Therapeutics. *Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide from a 16-State Study.* MMDLN/Rutgers CERTs Publication #1. July 2010.

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NC Response: A+Kids

Antipsychotics-Keeping It Documented for Safety

Off-label antipsychotic safety monitoring in beneficiaries through age 17.

What is off-label?

An antipsychotic prescribed…

1. For a clinical diagnosis that hasn't been approved by the FDA.
2. At a different dosage than approved for an indication by the FDA.
3. That will result in the concurrent use of two or more antipsychotics

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A+ Kids

- Requires prescriber to submit documentation when prescribing antipsychotic to any Medicaid or Health Choice recipient ages 0-17
  - Not intended to restrict prescribing of antipsychotics or limit how they are used
  - Intended to be sure prescribing is done safely and monitored appropriately

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Who is involved

- *All* Medicaid and Health Choice Youth 0 – 17
- *Any* antipsychotic Rx, ***New or Refill***
- *All* Medicaid prescribers regardless of discipline

If prescriber hasn't properly filled out information, prescription can't be processed by pharmacy.

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Resources

- A+KIDS policy and fax form
  www.ncmedicaidpbm.com
- Electronic A+KIDS Registry and helpful resources
  www.documentforsafety.org
- Telephone numbers for help?
  - Technical support
    855-272-6576 (local: 919-657-8843)
  - Medicaid support
    919-855-4300

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Document For Safety

Document For Safety Introduction

Programs

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A+KIDS Initial Findings Provider Participation

- From April 2011-August 21, 2012
  - 1241 prescribers with at least 1 authorization from the registry
    - 1522 registered providers have not attempted to authorize a Rx
  - 29,691 total authorizations
  - 15,194 total patients

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CCNC: An Important Partner

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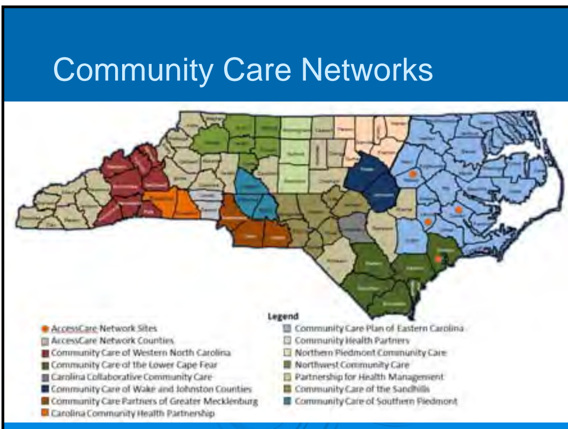
Community Care: "How it works"

- Primary care medical home available to 1.2 million individuals in all 100 counties.
- Provides 4,500 local primary care physicians (94% of all NC PCPs) with resources to better manage Medicaid population
- Links local community providers (health systems, hospitals, health departments and other community providers) to primary care physicians
- Every network provides local care managers (600), pharmacists (50+), psychiatrists (14+) and medical directors (20) to improve local health care delivery



Each Network Has…

- Clinical Director
  - A physician who is well known in the community
  - Works with network physicians to build compliance with care improvement objectives
  - Provides oversight for quality improvement in practices
  - Serves on the Sate Clinical Directors Committee
- Network Director who manages daily operations
- Care Managers to help coordinate services for enrollees/practices
- PharmD to assist with Med management of high cost patients
- Psychiatrist to assist in mental health integration

Children in Care and CCNC

- 80% are enrolled in CCNC PCMH (increase from 31% in October, 2011)
- Foster care recipients had more OP visits, spent more on Rxs, more on mental health treatment, more on inpatient and ED visits and cost significantly more overall than non-foster Medicare children/adolescents ($9,040 versus $1,864 annually)
- Foster children enrolled in a CCNC PCMH cost less than
  non-enrolled similars ($8,333 compared to $9,040 annual mean cost/patient)
- **This cost difference underscores the effort to get children in foster care enrolled in PCMH**

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Resources at CCNC

CCNC Care Managers

- Goal: help high need patients get care
- Use data to select 30-40 people most in need of management--patients getting services atypical of peers
- Provide care management until care team is stable/improved
- Link and prompt sharing of info; can connect to pharmacists
- Enrolling a child in CAII saves $1,100/year.

Not all children in foster care qualify for care management

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Eligibility for CM through CCNC

What should DSS do if they are working with a child who is complicated and who does not yet have care management (i.e., not enrolled in Carolina Access II)?

Ask the physician: "Is this a child who might benefit from care management?"

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Resources at CCNC

Pharmacists

- All CCNC networks have one
- Can advise and assist with understanding of meds
- Can sometimes simplify complex regimens (e.g., remove duplication)

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Resources at CCNC

Behavioral Health Coordinators

- All CCNC networks have one
- Prepares/supports enrolled MDs to deal with mild to moderate behavioral health issues
- For more severe problems, help MDs build relationships with specialists
- Can discuss whether child is eligible for more intensive care coordination

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Resources at CCNC

Patient Profiles

- Detailed medical history available:
  - All prescription info
  - Medical visits
  - Procedures
- Can access through CCNC's Behavioral Health Coordinators

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What's the Role of DSS?

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Our Job Is to . . .

1. Advocate: Stay on top of treatment to ensure child has an appropriate, individualized plan. Seek out resources, ask questions, speak up on behalf of child and family.
2. Educate: Make sure child and caregivers are informed about what is going on and why.
3. Communicate: Ensure everyone's on same page.
   - Timely documentation in the record
   - Share information with birth parents, foster parents, provider agencies

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And *Sometimes*

4. Make responsible, informed decisions about a child's treatment

But not always

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Responsibilities of Medical Decision Makers

1. Be a consistent interested party
2. Provide informed consent for treatment
3. Coordinate treatment planning and clinical care
4. Provide longitudinal oversight of treatment
5. Overcome barriers to needed and appropriate services

Adapted from American Academy of Child & Adolescent Psychiatry

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Birth Parents Are Primary Source of Informed Consent

For children in foster care, birth parents must give consent for medical treatment. Exceptions:

- Emergencies
- Both parents unknown or unable/unavailable to act on child's behalf

Source: NC G.S. 7B-903(a)(2)(c)

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Continuing Consent

- Birth parent may consent to trying a medication for a specific period of time. A new consent would then be needed to continue/re-fill prescription.

    or

- Birth parent may sign a consent to continue treatment unless/until consent is revoked. A new consent would not be needed to continue/re-fill prescription.

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Courts and Informed Consent

Circumstances in which DSS needs a court order to give consent for psychotropic medication for children in foster care:

- TPR
- Relinquishment
- Birth parents refuse to give consent but DSS strongly disagrees

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Working with Birth Parents on Treatment Planning

Use your chat pod:

- What are some common challenges in getting consent from birth parents?
- What has your agency done to overcome these challenges? What could you do differently going forward?

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Other Important Players

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Physicians/Prescribers

- It's okay to ask questions
- DSS can facilitate communication between medical professionals and families:
  - You may know when a parent or youth isn't getting it
  - You may know worries or questions that haven't been expressed
- Use CCNC as a resource

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Questions for Treatment Providers

1. Why have you recommended this treatment? What are the alternatives?
2. What is the goal of the treatment? What's expected?
3. How will we know if we're reaching our treatment goals?
4. What are the risks and benefits associated with this treatment?
5. What are common side effects?
6. Is there research to support this treatment for this condition?
7. Does research say this treatment works for families like ours?
8. What training or expertise do you have with this treatment?
9. What non-medical treatments should we consider in addition to or instead of the prescription(s)?

Adapted from NAMI, 2007

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Children and their Caregivers

- Know purpose of meds kids are on
- Know side effects to watch for and what to do if they occur
- Need clear expectations re: communication and who can consent for treatment

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Private Agency Staff

- Psychotropic medications is important issue for CFTs and other team meetings
- Should also be clear part of child's referral information and on-going documentation
- Consider adding protocol for medication management and oversight to contracts

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Summary of Key Points

- DSS has a critical role to play: advocate, educate, and communicate
- Work closely with medical homes/CCNC

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Final Steps for DSS Staff

1. Please take a brief survey
   - We will provide link for those logged on
   - Can also access thru ncswlearn.org
2. To receive training credit, you must do "Complete Course" **WITHIN ONE WEEK**
   - Log in to www.ncswlearn.org
   - Select "PLP"
   - Select "Webinars"
   - Click "Enter"
   - Click "Complete Course" button

Follow-up Document from the Webinar

Monitoring and Oversight of Psychotropic Medications for Children in Foster Care in North Carolina

Webinar delivered January 29, 2013

Follow-up document date: February 11, 2013

Presented by

Kevin Kelley, Jerry McKee, Charlene Sampson, Matt Hillman, Amelia Mahan, and Mellicent Blythe

Produced by

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North Carolina Division of Social Services

Handouts. Be sure to consult the handouts for this webinar:
https://www.ncswlearn.org/ncsts/webinar/handouts/26_Webinar_1-29-13_Handouts.pdf

Recording. If you missed the webinar or want to view it again, you can access a recording of this event by going to: http://fcrp.unc.edu/videos.asp

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Recommendations and Questions and Answers from the Webinar

1. General Questions

Where can I turn to develop a basic general knowledge about psychotropic drugs?

The following are good sources for learning more about psychotropic medications:

National Alliance on Mental Illness

- http://www.nami.org/template.cfm?section=About_Medications
- http://www.nami.org/Template.cfm?Section=Ask_the_Pharmacist&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=61&ContentID=28925
- http://www.nami.org/Template.cfm?Section=By_Illness

Texas Dept. of Family and Protective Services & University of Texas at Austin College of Pharmacy. (2010, December). *Psychotropic medication utilization parameters for foster children*. Accessed January 7, 2013 from http://www.dfps.state.tx.us/documents/about/pdf/TxFosterCareParameters-December2010.pdf

When children take psychotropic medications, what are possible side-effects and/or long-term effects?

Antipsychotic medications can cause metabolic abnormalities, including weight gain, increase in cholesterol, blood glucose, lipids, etc. This is one of the reasons North Carolina has developed the A+KIDS program described in the webinar, in your handouts, and online at http://www.documentforsafety.org/pub/. Children taking antipsychotic medications should have metabolic monitoring performed routinely, and a minimum would be prior to beginning an antipsychotic medication and then at minimum once a year. Weight and height should be checked on each visit to assess BMI changes over time which *may* predict the onset of metabolic disorders in some patients.

For more detail about the kind of tests/assessments that should be done before children are put on antipsychotics and/or periodically once they are taking antipsychotic medications, see page 16 of the Texas guidelines: http://www.dfps.state.tx.us/documents/about/pdf/TxFosterCareParameters-December2010.pdf

Why are psychotropic medications so readily prescribed? Shouldn't we be considering behavior modification interventions?

A comprehensive clinical assessment should be completed before any psychotropic medication is started. A psychotropic medication should seldom be the first or seldom be the only attempt to address behavioral problems or other symptoms. Instances when medications may be used initially are those which are clinically urgent and may include (but are not limited to) suicidal ideation, extreme self-injurious behavior, or significant physical aggression which endangers the child or others. Attendees are encouraged to review the Texas guideline section on general principles regarding the use of psychotropic medications in children (beginning on page 4).

Can you tell me about the medication Intuniv?

Intuniv is an alpha adrenergic agonist—similar to Kapvay, Tenex, and Clonidine. It is used alone or in combination with psychostimulants to address symptoms of ADHD. For details, see page 13 of the following resource:

Texas Dept. of Family and Protective Services & University of Texas at Austin College of Pharmacy. (2010, December). *Psychotropic medication utilization parameters for foster children*. Accessed January 7, 2013 from http://www.dfps.state.tx.us/documents/about/pdf/TxFosterCareParameters-December2010.pdf.

How should we dispose of old medications when a child's prescription has changed?

Pharmacies are not authorized by the federal DEA to take back controlled substances. Increasingly, local law enforcement agencies are locating medication drop boxes at their local offices for this purpose. For a list of those drop box locations and a listing of local medication take-back days, go to: http://www.ncdoi.com/osfm/SafeKids/sk_OperationMedicineDrop.asp

Flushing of medications down the toilet as a means of disposal is no longer generally recommended for patients. For the NC Board of Pharmacy reference on proper disposal of medications in the home, please see: http://www.ncbop.org/faqs/ProperMedDisposal.pdf

2. A+KIDS Registry

What happens when a psychiatrist refuses to participate in the A+KIDS registry?

In North Carolina if a prescriber wants to prescribe an antipsychotic for a child, they are asked to interface with this registry or submit the information via fax. If a prescriber hasn't submitted information to the registry, Medicaid will not pay the prescription claim when submitted by the pharmacy, and the child will not receive the medication. To prevent delays and possible negative

outcomes for children, social workers should verify with prescribers of psychotropics that they use the A+KIDS registry. If a provider is known to be reluctant to use this registry, please consider discussing the issue with your local CCNC behavioral health care manager and network psychiatrist for additional support and ideas.

Do private insurance companies require monitoring of prescriptions of antipsychotics to children?

While there are not any known publications on this specific topic at present, we believe there is less monitoring of this by private insurance companies for a variety of reasons. Some private insurers will not authorize the prescription of antipsychotics to very young children, and will encourage providers to identify alternative treatments.

Should we encourage prescribers to use the fax form included in the handouts?

Encourage them to use the online method (at http://www.documentforsafety.org) instead. Fax is an option. However, we strongly encourage providers to submit safety documentation using the web-based program. The approval period always takes longer when the fax method is used, while the online registry approval is immediate.

3. Partnering with CCNC

How would you coordinate services for children in foster care who move out of their CCNC network?

Contact the CCNC network locally that you know. They can walk you through the process of connecting with the other network to get children the care they need. In CCNC, all patients should be served by the network associated with their primary care provider.

What can be done to locate providers when the children are out of their home area and the provider has to be contracted with the LME?

You'll need to work through the LME/MCO that oversees services and providers, wherever the child is living. They should be able to assist in the process. It may be that the provider has to enter in to a single-patient contract with the LME/MCO that manages BH services in the child's county of eligibility.

How do you find out who the CCNC Behavioral coordinator is for your county?

See the revised list of CCNC Network Behavioral Health Coordinators, then contact the person with the network that serves your county. You can also find an interactive map that can help you connect to your local CCNC network if you go to https://www.communitycarenc.org/our-networks/

In addition, please feel free to contact Amelia Mahan (amahan@n3cn.org) if you're unsure of who your local BH Coordinator would be.

Does CCNC provide access to intensive in-home treatment or to intensive in-home reunification services?

No. Intensive in-home providers are specialty behavioral health providers who must enroll with the LME/MOs and must get authorization from the LME/MCO to provide services. When you need these intensive services, contact your LME/MCO.

Can we request the medical history from the Patient Profiles?

Yes. This CCNC Informatics Center resource is called the provider portal. This is not an electronic health record, so it does not give that level of detail seen in an electronic health record. However, the provider portal does go back 5 years, and gives claims-level information regarding visit history (primary care, mental health, ED, hospitalization) and medication fill history in a format that is easy to read and understand. In addition, caregiver contact information and provider contact information is posted. Contact the network administrator in your local CCNC network for data requests.

4. Informed Consent/Working with Birth Parents

When a child in DSS custody, must DSS obtain written consent from the birth parents before the child can be given a prescription for psychotropic medications?

Even when children are in foster care, birth parents must give consent for medical treatment. Source: NC G.S. 7B-903(a)(2)(c). Exceptions to this include:

- Routine medical care (starting or changing a course of psychotropic medicines does **not** constitute routine care)
- Emergencies (when the child is at imminent risk of harming self or others)
- Both parents are unknown or unable/unavailable to act on child's behalf

Birth parents may wish consent to trying a medication for a specific period of time. A new consent would then be needed to continue/refill prescription. Alternatively, the birth parent may be willing to sign a consent to continue treatment unless/until consent is revoked. In this situation a new consent would not be needed to continue/refill prescription.

Are both parents required to provide parental consent for psychotropic medications? What if the parents disagree?

Whether or not both parents' consent is needed may vary by provider. Usually, one parent's consent is sufficient, absent a court order directing otherwise. If the parents disagree with one another, the Court may have to decide what is in the Juvenile's best interest. It may be helpful to involve the juvenile's Guardian ad Litem in discussions with medical providers, if you anticipate that a Court order will be necessary.

Do parents have to consent to therapy as well?

Yes. Note that under North Carolina law the consent of one parent is sufficient for psychiatric management. For psychological therapy the consent of both parents is needed.

What forms should county DSS agencies use to obtain this consent?

The North Carolina Division of Social Services does not have a required form for documenting the parent informed consent for medication. As many local child welfare agencies have developed documentation tools / forms, the Division will facilitate sharing these across counties as made available.

Does the need to obtain parental consent only apply to psychotropic meds or to routine medical treatment?

Parental consent is not required for routine medical care. Source: NC G.S. 7B-903(a)(2)(c). It is required for medical care that is not routine or emergency.

How does this apply to hospitalization/stabilization of a child in care?

Parental consent would be required for any planned hospitalizations, but not for emergencies. Source: NC G.S. 7B-903(a)(2)(c).

If our court order states that "DSS is authorized to arrange for and consent to medical treatment as may be necessary for the juvenile," does that make it so that DSS can consent to medications when the birth parents are not involved but still have rights?

Broad based approval for medical treatment ***may*** meet the minimally sufficient legal requirement. Best practice guidance would encourage more detailed information sharing with all available partners, including parents, parent attorney, Guardian ad Litem, etc.

We automatically request the courts to give authorization for medical consents to DSS. Is this wrong?

This may be acceptable but should not be interpreted as a sufficient level of communication. Following a system of care approach, ongoing communications are critical to case planning and achieving the case plan goals.

Providers I've worked with want consent of the legal guardian (of children in foster care) and that would be the social worker, not the birth parent—isn't that right?

While your county Department of Social Services may be the legal custodian, the parents retain some of their rights, unless the court has found the termination of parental rights, or the child has been adopted, after a relinquishment. Ideally, the county DSS and the parents would both sign the consent or authorization.

What should we do about consent when parents are absent?

When parents are absent, document this fact and ask the court to empower your agency to provide informed consent.

What about children who are in DSS custody and we have been relieved of visitation and reunification efforts with birth parents?

Parents may still retain the right to have informed consent for medical treatment (including psychotropic medication) for their children even if the court has relieved the agency of visitation and reunification efforts. Written consent would still need to be obtained unless the parent is unknown, unavailable, or unable to act on behalf of the juvenile; or the court specifically authorizes DSS to consent to treatment. See NC G.S. 7B-903(a)(2)(c).

What about parents who are "anti-medication"? In other words, how should we respond to birth parents who reject the notion of putting their child on a psychotropic prescription, especially when a pharmacological intervention is really needed? Some parents are in denial regarding their child's behavioral & mental health status/needs.

Solution suggested by a webinar participant: I have included birth parents in conference calls and med management meetings so that they can address their concerns with the psychiatrist directly. CFT meetings are another important venue for discussing treatment issues with the parents and medical providers. The provider should be encouraged to engage in a frank discussion with the stakeholders of the child's short-term and long-term prognosis if the recommended care plan is not executed (i.e., risks and benefits), along with any alternative plans that may be considered.

5. Working with Children and Foster Parents

What information should foster parents have about psychotropic drugs?

Foster parents should know that they do not have the authority to provide informed consent for children to take psychotropic medications. In addition, all caregivers of children in foster care should:

- Know the purpose of medicines children are taking – including specific symptoms being targeted
- Know the side effects to watch for and what to do if they occur
- Receive from their supervising agencies clear expectations about communication and who can consent for treatment.

How can we help children express their concerns about the medication they take to the prescriber?

Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care is an excellent resource for educating and empowering youth. Sponsored by the Administration for Children and Families (ACF) and written for youth in care, this guide looks at how psychotropic medication can help and what other options are available. Available online at http://www.nrcyd.ou.edu/learning-center/med-guide

6. Working with Prescribers

I have had experiences in which doctors became VERY upset when they felt a SW was questioning their recommendations when they were asked questions. This is an issue when there are a limited number of doctors willing to prescribe these meds to kids. Is there any work being done with the doctors letting them know to expect SW will be asking these questions?

The provider should be clear that the case manager is acting as a parent in the clinic. As such, the questions suggested on slide 46 are entirely appropriate and necessary in order to be in a position to give true informed consent regarding care. Assure the provider that you have are simply acting with the patient's best interests in mind in asking these questions. It can help to be clear about what is motivating your questions. Let them know that as the child's social worker you are accountable and have to be ready to answer questions from the judge, birth parents, attorneys, and others about the child's treatment and medication regimen.

However, if this is a consistent response from a prescriber, let the CCNC network know and we can reach out to them. Particularly where there is a care manager embedded in the practice, they may be able to assist when you are meeting resistance.

7. Need for a PRTF for Medical and Psychiatric Treatment in NC

The local LME/MCO has lists of referral resources for acute inpatient or long-term stay beds in the state which are available. The LME/MCOs are also performing a gap analysis regarding local service needs, which will identify the need for additional acute or residential treatment beds. The goal of early and effective intervention is to avoid and/or delay the need for admission to such any acute inpatient or residential treatment facilities. A compilation of these current PRTF facilities in NC is located at: http://www.ncdhhs.gov/mhddsas/providers/childandfamilymhs/prtf/index.htm

8. Updated List of CCNC Behavioral Health Coordinators by Network

2/5/2013

Network	Behavioral Health Coordinator	Email Contact	Telephone Contact	Counties Covered	Network Director
AccessCare	Juan Ortiz	jortiz@ncaccesscare.org	919-380-9962x466	Alamance, Jackson, Macon, Swain, Haywood, Clay, Cherokee, Graham, Caswell, Chatham,Orange, Robeson, Sampson, Wayne	Marcelletta Miles
	Jill McKinney	Jmckinney@ncaccesscare.org	828-443-6147	Alexander, Ashe, Avery, Alleghany, Burke,Caldwell,Catawba, Iredell, Watauga	Marcelletta Miles
Carolina Collaborative Community Care	Karin Suess	KSuess@carolinaccc.com	910-487-8451	Cumberland	Brenda Sparks
	Cheryl Brees	cbrees@carolinaccc.com	910-495-8476		
Carolina Community Health Partnership	Wanda Jenkins	cccawjenkins@yahoo.com	704-484-5131	Cleveland, Rutherford	Debbie Clapper
	Debbie Clapper	Debbie.Clapper@clevelandcounty.com	704-484-5216		
Community Care of Lower Cape Fear	Elissa Hanson	elissa.hanson@carelcf.org	910-332-9543	Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender,	Lydia Newman
Community Care of the Sandhills	Susanne Whiting	susannewhiting@cc-sandhills.org	910-246-9806	Harnett, Hoke, Lee, Montgomery, Moore, Richmond, Scotland	Tammie McLean
	Andrew Clendenin	aclendenin@cc-sandhills.org	910-246-9806 919-356-0410		
Community Care of Wake and Johnston Counties	Jamie Philyaw	jphilyaw@wakedocs.org	919-554-9013	Johnston, Wake	Susan Davis
Community Care of Western North Carolina	Eric Christian	echristian@ccwnc.org	828-348-2833	Buncombe, Henderson, Madison, McDowell, Mitchell, Polk,Translyvania,Yancey	Jennifer Wehe
Community Care Partners of Greater Mecklenburg	Valencia Anderson	Valencia.Anderson@carolinashealthcare.org	704-863-7593	Anson, Mecklenburg, Union	Anita Schambach
	Sarah Brown	sarah.brown@novanthealth.org	704-384-0107		
	Tchernavia Montgomery	Tchernavia.montgomery@carolinashealthcare.org	704-863-9707		
	Gloria Conyers-Mutts	Gloria.ConyersMutts@carolinashealthcare.org	704-512-2449		
Community Care Plan of Eastern Carolina	Lindy Kitchin	lindy.kitchin@vidanthealth.com	252-714-7578	Beaufort, Bertie, Camden, Carteret, Chowen, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Nash, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Washington, Wilson, Tyrrell	Laurie Nelson
	Joanne Koster	joanne.koster@VidantHealth.com	252-916-5485		
Community Health Partners	Anne Wheeler	awheeler@gfhs.info	704-874-7017	Gaston, Lincoln	Lynne Perrin
Northern Piedmont Community Care					Fred Johnson
a. Community Care Partners	Sharon Long	sharon.s.long@duke.edu	252-431-6163	Franklin, Granville, Person, Vance, Warren,	Jeaneen Beckham
b. Durham Community Health Network	Atalaysha Churchwell	atalaysha.churchwell@duke.edu	919-613-6533	Durham	Stephanie Triantafillou
Northwest Community Care Network	Peter Rives	prives@nwcommunitycare.org	336-716-8972	Davie, Forsyth, Stokes, Surry, Wilkes, Yadkin, Davidson	Jim Graham
Partnership for Community Care	Laura Davis	ldavis@p4care.org	336-686-3109	Guilford, Randolph, Rockingham	Claudette Johnson
Southern Piedmont Community Care Plan	Erin Greene	ErinGreene@CCofSP.com	704-262-1072	Cabarrus, Rowan,Stanly	
Community Care	Amelia Mahan	amahan@n3cn.org	919-926-3918		