Health Care Progra
for children
with Special Needs
Together we'll find the way.

HCP CARE COORDINATION GUIDELINES

November 2009

Colorado Department of Public Health and Environment
Prevention Services Division
Center for Health Families and Communities
Children with Special Health Care Needs Unit
Health Care Program for Children with Special Needs (HCP)
4300 Cherry Creek Drive South
Denver, Colorado 80246

ACKNOWLEDGMENTS

Many different individuals have contributed to the HCP Care Coordination Model and Guidance since its inception in 1999. We would like to acknowledge and thank all of them for their time and effort in helping us sustain and improve the care coordination services offered by HCP.

The HCP Model Description, also known as the "Rainbow Books" dates back to the care coordination services provided as a component of HCP paid services. The original contributors to these books included: Debbie Costin, Joan Eden, Jan Reimer, Kathy Watters, Mary Adler, Irene Bindrich, Judy Brock, Carolyn Harris, Norma Patterson, Jan McNally, Judy Grange, Molly Benkert, Penny Gonnella, Theresa Greichen, Jamie Gury, Carolyn Johnston, Carolyn Kwerneland, Eddie Scott, Bonnie Sherman, Jennifer Poore, Kellie Teter, and Karen Trierweiler.

Contributors for the 7th Edition, March 2006, included local staff as well as state HCP staff. Local HCP staff included: Molly Benkert (Denver Regional Office), Judy Brock (Western Slope - Grand Junction), Heather Cordova (Jefferson County Regional Office), Brian Dillon, Patsy Ford (Southwest Regional Office - Durango), Sue Foster (South Central Regional Office - Alamosa), Carolyn Kwerneland (Jefferson County Regional Office), Eileen Mathey (Southwest Regional Office - Durango), Lori McCarty (Weld County Regional Office – Greeley), and Libbie Speer (The Children's Hospital – HCP Liaison). State staff included: Lynn Bindel, Judy Grange, and Barbara Deloian. Heidi McNeely, participated during her master's program with the University of Colorado Health Sciences Center, School of Nursing, and Pediatric Nursing Leadership Program.

This 8th Edition, October 2009, also included local and state staff in the revisions to the concept of HCP Health Care Coordination. Local staff included: Molly Benkert (Denver Regional Office), Amy Antuna (Weld County Regional Office – Greeley), Linda Sobeck (Boulder Regional Office), Patti McHardy and Evelyn Morrill (Broomfield HCP Office), Susan Foster and Yvette Lujan ((South Central Office), and Norma Patterson and Heidi McNeilly (Tri-County Office). State staff included: Shirley Babler, Lynn Bindell, Barbara Deloian Judy Dettmer, Paul Gillenwater, Penny Gonnella, Stephanie Lauer, Carla Rowland, Yvonne Yousey, and Laura Zuniga.

Health Care Program for Children with Special Needs
Care Coordination Guidelines

TABLE OF CONTENTS

THE HEALTH CARE PROGRAM FOR CHILDREN WITH SPECIAL NEEDS

INTRODUCTION

In 1935 Congress enacted the Social Security Act. Title V of this act authorized the Maternal and Child Health Services programs. Since that time the children included in the program has changed from children with polio and orthopedic conditions to a wider range of conditions that affect a child's health and well being. In 1995 and 1998, the Maternal and Child Health Bureau (MCHB) and American Academy of Pediatrics (AAP) defined children with special health care needs as those who have or are at risk for chronic physical, developmental, or emotional condition that require health related services of a type or amount beyond those required by children or youth generally.

The Maternal and Child Health Bureau (MCHB), Title V Block Grant and State general funds provide financial support for this program based on the following legislation. **http://mchb.hrsa.gov/**

Federal Social Security Act 501(1) (A) Title V State Responsibilities

> Allocated to States under the Maternal and Child Health Services block grant, "to provide and to assure mothers and children (particularly those with low income or with limited availability of health services) access to quality maternal and child health services by 1) providing direct services where needed to fill gaps; 2) develop and provide enabling (coordination of care) services that help families appropriate use of health care and resources; 3) provide population-based services needed to protect public health and assure optimal health; 4) build an infrastructure of planning, evaluation, research, and training that supports effective and efficient delivery of services to women, children , and families

Colorado Revised Statues, Title 25 Health Administration Article 1.5 Powers and Duties of the Department of Public Health

> To operate and maintain a program for children with disabilities to provide and expedite provision of health care services to children who have congenital birth defects or who are the victims of burns or trauma or children who have acquired disabilities;

THE HEALTH CARE PROGRAM FOR CHILDREN WITH SPECIAL NEEDS (HCP)

The Health Care Program for Children with Special Needs (HCP) is a unique resource for families, health care providers, and communities. The program's goal is to help improve the health, development, and well being of Colorado's children, birth to 21 years of age, with special health care needs and their families. In Colorado, there are an estimated 225,000 children who have special health care needs (CSHCN) who may receive services.

HCP works with families, health care providers, communities, and policy makers to strengthen Colorado's capacity to meet the needs of CSHCN and their families. Through seventeen Regional Offices located within existing public health agencies across the state, efforts are made to assure local community-based health services. Through these offices public health staff supports children, youth, their families and the providers who serve them, by developing an organized, easy to use system of services and supports. They also provide population based services such as vision, hearing, and developmental screening services for children, and assisting family's access primary care and specialty health care providers and resources through HCP Health Care Coordination. **http://www.cdphe.state.co.us/ps/hcp/index.html**

Strategies to Support CSHCN and Their Families

The Colorado Medical Home Initiative (CMHI) has affected the direction of HCP in recent years. The CMHI "vision" is two-fold: 1) All pediatric practitioners will provide a family-centered medical home approach which includes both PCP care coordination and access to community-based care coordination, especially for children with special health care needs (CSHCN) and 2) A medical home system will be developed to support

practitioners and to address systemic barriers to a comprehensive, coordinated, medical home team approach for all children. As a result HCP has identified two primary strategies to achieve this vision.

Strategy #1: Provide Care Coordination

Care Coordination is an important component of a Medical Home Team Approach. Local primary care providers need to understand and be engaged in utilization of Health Care Program for Children with Special Needs (HCP) Care Coordination and available community resources for CSHCN. Contacting primary care providers (PCP) to inform, educate, assist, and engage them with HCP and community resources has been shown to improve care for CSHCN and their families. **http://www.coloradomedicalhome.com/**

Strategy #2: Collaborate with Community Partners for Easy to Use Services

Families with CSHCN need services to be organized so they can use services easily. By collaborating with community partners we can help assess the access and organization of community services for families. Involving the HCP Family Coordinator and/or community Family Leaders is critical with these collaborative efforts. By engaging multiple partners in this effort across different sectors of the community, resources and solutions can be identified to improve community services for families with CSHCN.

CARE COORDINATION BACKGROUND

There are approximately 9.4 million -- or 12.8% of all children in the United States under the age of 18 – that have special health care needs (HRSA, 2004). Meeting the complex needs of children and youth with special health care needs (CYSHCN) and their families often requires special assistance described as care coordination. Children and youth with special health care needs require access to treatment and special services that take into account their overall growth and development. At times, the challenge for families is in accessing these services in an often-fragmented system of care (AMCHP, 2002). Care coordination helps families identify and enroll in programs and services and promotes efficiency by increasing access to care and eliminating duplication of services (AMCHP, 2003).

Definitions of Care Coordination

Care coordination definitions vary among different perspectives. Two are presented here to demonstrate commonalities and differences.

Pediatric care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health. (Antonelli, McAllister,& Popp, 2009)

Care Coordination Competencies	Care Coordination Functions
1. Develops partnerships 2. Communicates proficiently 3. Uses assessments for intervention 4. Is facile in care planning skills 5. Integrates all resource knowledge 6. Possesses goal/outcome orientation 7. Takes an adaptable and flexible approach 8. Desires continuous learning 9. Applies team-building skills 10. Is adept with information technology	1. Provides separate visits and care coordination interactions 2. Manages continuous communications 3. Completes/analyzes assessments 4. Develops care plans with families 5. Manages/tracks tests, referrals, and outcomes 6. Coaches patients/families 7. Integrates critical care information 8. Supports/facilitates care transitions 9. Facilitates team meetings 10. Uses health information technology

. (Antonelli, McAllister,Popp,, 2009)

A client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which:

:

- a client's needs and preferences are assessed
- a comprehensive care plan is developed
- services are managed and monitored by an identified care coordinator following evidence-based standards of care.

Care coordination" encompasses both health care and social support interventions across the range of settings from the home to ambulatory care to the hospital and post-acute care

HCPF Colorado Accountable Care Collaborative, Request for Information, July 2009

Why is Care Coordination Needed?

National data on children with special health care needs in Colorado demonstrates the significance and need for care coordination assistance for families with CSHCN. Of the 225,000 children in Colorado with special health care needs, 12.5% of all children, approximately 24.4 % of these children have conditions that affect their daily activities and 14.3% miss more than 11 days of school due to illnesses. Additional data for Colorado include the following:

- 48.2% of CSHCN do receive coordinated, ongoing, comprehensive care within a medical home compared with 47.1% nationally.
- 20.0% of CSHCN have unmet needs for specific health care services compared with 16.1% nationally.
- 24.9% of CSHCN need referrals and have difficulty getting it compared with 21.1% nationally.
- 8.4% of CSHCN families spend 11 hours or more coordinating care of their child compared with 9.7% nationally.
- 34.6% of CSHCN have inadequate insurance compared with 33.1% nationally.
- 12.7% of CSHCN are without insurance at some point in the past year compared with 8.8% nationally.
- 20.6% of CSHCN have conditions that cause family members to cut back or stop working compared with 23.8% nationally.
- 23.9% CSHCN have conditions that cause financial problems for the family compared with 18.1% nationally.
- 27.7% of CSHCN families pay over $1,000 or more out of pocket in medical expenses per year compared with 20.0% nationally.

(2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website.)

Families with children with special health care needs must take more time off work for medical appointments, therapy appointments, and attending school IEP meetings. They struggle to locate adult health providers who will care for their youth when they become 18 years of age. They spend more out of pocket money for co-pays for medical and therapy appointments. They are often required to coordinate the care of their child because no one else in the health care system has the time, desire, or knowledge to do so. (2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website.)

Although primary care providers are expected to provide coordination of care for families through a medical home approach, the reality is that the time for this is not reimbursed and primary care providers most often lack the knowledge about community resources to provide families with the information they need (2008, Colorado Medical Home Provider-Practice Management Survey). The result is that families either coordinate their child's care or a child's health care is fragmented, unorganized, and results in increased family stress and frustration, delays in seeking care, and complaints that the family is non-compliant or neglectful. Further results of lack of coordination of care include increased ER visits, increased and greater length of stay hospitalizations, lack of preventive services such as immunizations and developmental screenings with appropriate and timely referrals to early intervention services. (Antonelli, 2004; California Health Care Foundation, 2007; McAllister, et.al. 2007; Palfrey, 2004)

MCHB Goals of Care Coordination

The Association of Maternal and Child Health Programs (AMCHP 2000; 2002) outlines specific goals of care coordination including recommendations, roles and training of care coordinators, as well as research and evaluation issues.

Care coordination is considered a standard of care for children and youth with special health care needs due to the following:

- The need to plan beyond the medical needs of the child (social, developmental, educational, vocational, and financial).
- The complexity of the service system with its different entry points and eligibility criteria.
- The importance of the family's role in the center of care coordination; families are the most knowledgeable about their child's condition and they become effective leaders and partners in the care coordination

process as their skills and strengths are supported, and their opinions valued and respected (AAP, 1999).
- Children and their families benefit from understanding their options of services and resources that meet their unique needs.
- Partnerships with families among providers, agencies, programs, specialists, and primary care providers are essential to effective care that truly serves families.

Goals for care coordination are described as follows:

- Improve and sustaining the quality of life for the family and the child.
- Assure access to optimal care.
- Improve systems of care for children with special health care needs

How Do Families Benefit From Care Coordination?

Public and private agencies involved in human services have historically helped families determine their needs and gain access to services (AAP, 1999). Beginning in the early 20th century, community service coordination began and evolved into the concept of "case management," which appeared in the early 1970s. In the 1980s, commercial insurers used case managers as a way to coordinate care and manage costs in "catastrophic cases" (AMCHP, 2000). Today comprehensive "care coordination" enables people to navigate through complex systems (Rosenbach and Young, 2000).

Proponents of the medical home or health care home as well as insurance providers have recognized the benefits of care coordination and case management for at risk populations. Case management often is associated with HMO's and their efforts in cost containment. The health care home and medical home recognize care coordination as an essential element of quality health care, especially for children with special needs. Outcomes for medical home care coordination include:

- Functional: decreased stress worry, school absence, increased diagnosis and treatment access, and increased family care giving competence.
- Clinical: increased preventive services for CSHCN, decreased episodes of illness, decreased acute encounters.
- Satisfaction: increased communication, office responsiveness, and care plan/continuity, family involvement.
- Cost: decreased ER visits, hospital visits, unnecessary specialty and office visits, lost parental work time, increased care coordination activities received.

(Center for Medical Home Improvement, Outcomes 2001)

o *Case Management vs. Care Coordination*

Historically, case management programs rely on a medical model focused on the patient's health care needs only, while care coordination programs tend to use a broader social service model that considers the patient within a psychosocial context as well. Case managers tend to coordinate services within a single managed care plan, and focus only on covered services. In contrast, care coordinators may work with a full range of health and social support services offered within and outside the managed care plan, therefore often arranging both covered and non-covered services (Rosenbach and Young, 2000).

o *Part C Early Childhood Connections Service Coordination*

Part C Early Intervention Colorado provides service coordination for children birth to 3 years of age. A service coordinator is a person who works with you during your child's involvement with Colorado's early intervention system and to help protect a family's legal rights. Federal and state laws require that all children and families served by the early intervention system have a service coordinator. A service coordinator is your main contact and is assigned to each infant or toddler and their family within three business days of the referral being received.

Service Coordinators:

• Help families identify their strengths and needs, find resources, think about decisions the family needs to make, coordinate all the services being received, and
• Make sure that the rights of the child and family are protected.

(Early Intervention Colorado, 2009).
http://www.eicolorado.org

- ***Health Care Policy and Finance (HCPF) Healthy Communities Outreach Workers – (EPSDT)***

The Department of Health Care Policy and Finance Provides support for clients who are eligible but not enrolled in Medicaid and clients already enrolled in Medicaid and CHP+. This model, called Healthy Communities, combines the best aspects of the EPSDT Outreach and Administrative Case Management Program and the CHP+ regional outreach program.

HCPF, At a Glance. Health Care Policy and Financing Updates. June 10, 2009.
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1218622604254

- ***Family Navigator***

Family to family assistance in resolving problems with a health insurance plans, communicating with a service provider, navigating Medicaid or other public systems, and in receiving individual health insurance counseling (such as in a benefits decision and help with the appeals process). Colorado Family Voices
http://www.familyvoicesco.org/

Differentiating Between Community Based and Primary Care Practice Care Coordination

Care coordination is used in many different ways. Generally it refers to the coordination of resources and services for families to optimize the health and well being of their children. When evaluating the goals and outcomes of care coordination it is important to clarify the perspective that is being used.

- ***Primary Care Practice Care Coordination***:

Primary Care Coordination is based in a medical practice as the services provided to assist families with obtaining medical and specialty care, making appointments, obtaining referrals, dealing with insurance issues and linking with resources. The goal is to reduce utilization of high-cost medical care by preventing unnecessary hospitalizations or emergency room visits.

- ***Community Based Care Coordination***:

Community Based Care Coordination helps families and youth access and manage a wide array of services and needs as determined by the family or youth. The goal is to help families as well as youth learn to effectively navigate the healthcare system, thus giving them the information and skills communicate more effectively with clinicians and deal with insurance issues. (Adapted from Snow, J., 2005)

Essential Care Coordination Activities

MCHB has provided a description of the essential care coordination activities to include:

- **Partnering with Families** – to connect with community resources and parent support.
-
- **Relationship Building** – Identify and support family strengths, culture and values.

- **Assessment** –Collect and review medical and educational information, and family input to identify strengths, needs and available resources

- **Planning** – Assist the family to develop a care coordination plan with specific objectives, goals and actions to meet identified needs.

- **Implementation –** Initiate and facilitate specific activities and interventions that lead to accomplishing the goals set forth in the care plan.

- **Monitoring and Evaluation –** Gather information about the care plan's activities, interventions, and services to determine the plan's effectiveness in reaching desired goals and outcomes, and modify the plan as needed. Look at the overall effectiveness of the care coordination plan to achieve positive outcomes for families and improve the system of care for CYSHCN.

Evidence regarding care coordination outcomes and the direct benefits to the lives of individuals and children with special needs and their families continue to need evaluation. An increasing number of studies have been

completed but are inconclusive due to the variability in sample sizes, study designs, and study outcome evaluations. However, it is clear that professionals in the health care field and those that work closely with children and youth with special health care needs feel strongly about the impact that care coordination has on improving the child's well being and making the lives of family members easier as well (Antonneli, et.al., 2004; McAllister, 2009; Barrett, 2000; Grupta, 2004; Jablonski, 2003).

These benefits include:

- Ongoing health promotion and disease prevention consultation.
- Appropriate utilization of community resources; integration of their family within the community.
- Supportive and enjoyable family-child relationship.
- Accessible and safe home environment.
- Appropriate and accessible family health care.
- Understanding of medical conditions, treatments, and medications.
- Reduced ER visits and avoidable hospitalizations.
- Active participation in child's Individual Family Service Plan (IFSP) and Individual Education Plan (IEP).

HCP CARE COORDINATION

HCP Care Coordination is intended to improve the quality of life for CSHCN and their families by increasing a family's knowledge and ability to appropriately and effectively utilize health and community services through a *medical home team approach*, thus also decreasing health care expenditures.

HCP Care Coordination is the facilitation of access to and coordination of health (physical, mental, and dental) and social support services for CSHCN across different providers and organizations. HCP Care Coordination serves children and youth, birth to 21 years of age in all counties of Colorado. HCP Care Coordination focuses on supporting a family's participation in health care decisions, communication with health care providers, and coordinating health and community services resulting in a families increased knowledge and appropriate utilization of health care resources.

HCP Care Coordinators and the HCP Care Coordination Team

HCP Care Coordinators are public health and social workers who bring their medical and professional training and experience to address the myriad health needs of children and youth with special health care needs. They are experienced in working with other HCP Team Members including other social workers and nurses as well as dietitians, speech-language pathologists, audiologist, family coordinators, and occupational or physical therapists on behalf of families. Family coordinators as well as other members of the HCP team support and assist with the coordination of care for individual children and families as well as the coordination of services with other systems and organizations. HCP Care Coordinators also utilize the expertise of other community disciplines such as the child's primary care provider, pediatric specialists, school nurses, psychologists, early intervention service coordinators, EPSDT Outreach Workers, and others who the family indicates are members of their *Health Care Team.*

The HCP Care Coordinator is responsible for completing a care coordination assessment and identifying strengths as well as unmet needs. They partner with families in the development of a plan of care for their child or youth and based on the Care Coordination Assessment. The HCP Care Coordinator works with the family and/or youth to identify the family/youth goals they hope to achieve, the interventions to meet these goals, and determine what HCP Team Members may be most appropriate to work on different aspects of the child or youths care coordination plan. HCP Care Coordinators also utilize the expertise and consultation of other community discipline resources based on the needs of the family through individual consultation with other disciplines and by holding care conferences, including family members.

Through programs such as Colorado Responds to Children with Special Needs (CRCSN), the Colorado Birth Defects Registry, families of children with special health care needs are contacted to determine their needs and to inform them of local health and community resources. When a family has a question or concern, members of the HCP Team are available to assist them. HCP Care Coordinators assist the family in locating services such as public health services, public insurance programs, early intervention programs, housing, clothing, transportation, quality childcare, prenatal services, WIC programs, immunization clinics, and specialty care providers. Many families need little more than a phone number or address and they are able to navigate the available services. Many more families, especially those in crisis, need assistance prioritizing the steps to take first when faced with multiple needs such as accessing both housing resources and emergency health care.

The HCP Care Coordinators also provide assistance to PCPs to provide a medical home team approach, especially for CSHCN. Examples of this assistance include: providing access to and coordination of primary and specialty care through the HCP rural specialty clinics; helping PCPs to identify community and state resources; and helping families navigate and understand the health care system.

HCP Care Coordination Leads to Identification of Health Services Gaps and Needed Systems Building

HCP Care Coordinators also collaborate with community organizations and agencies to organize services in order to avoid duplication and to identify gaps that prohibit a medical home approach for CSHCN. All too often, available local community or state agencies do not meet a family's needs. When an HCP Care Coordinator identifies the unmet needs of a single family or many families, they are able to mobilize community partners to resolve these unmet needs. Examples include seeking donations for a family in need of specialized formula for their child or assistance in paying for a special medication. Other examples include seeking grant funding to develop Respite Centers so that families who otherwise have no one to watch over their child with special health care needs while they do something as simple as go to a movie. (2004, 2005, 2006, MCH HCP Operational Plan Reports)

HCP Levels of Care Coordination

HCP has defined three levels of care coordination to describe care coordination resource allocations, capacity, and costs associated with state and federal funds. The three levels of care coordination also allow a description of the families receiving different levels of HCP services. HCP care coordination interventions include the referrals, education, and services provided to families.

Level 1 Health Care Coordination:

Outreach and resource information provided to families about HCP, local community health care services (public, primary care, and specialty care) and community-based services.

- **Key Elements:**
  - Identification of:
    1) Parent concerns/unmet needs
    2) Child's condition/diagnosis and age
  - Completion of the *HCP Intake Interview* to determine:
    3) Access to a usual source of care other than the ER
    4) Access to a consistent primary care provider (PCP)
    5) Access to needed specialty providers
    6) Access to private or public health insurance or a source of payment for health care
    7) Access to local community and family support systems
  - Provision of referrals to community support services
  - Determination of the family's need for and desire for HCP Care Coordination Services
  - Contacts with families may be made through letters, phone calls, or e-mail.

Level 2 Health Care Coordination:

Assistance provided to families in accessing health care and community-based services.

- **Key Elements:**
  - Development of a care coordination plan that identifies:
    1. Family strengths and unmet needs based on the family's concerns and questions and the *HCP Care Coordination Assessment and Planning Guide*
    2. Family goals to resolve their unmet needs.
    3. Interventions (referrals, education, and services) needed to achieve the family goals.
  - Notification to the child/youth's primary care provider about HCP involvement, care

coordination progress, and the end of care coordination services. (*HCP Care Coordination Services Request and Report)*

- Follow up to determine whether the interventions (referrals, education, and services) have been completed or acquired and whether further care coordination is needed.

- Contacts with families may be made through phone calls, e-mail, home visits, clinic visits, and office visits.

Level 3 Health Care Coordination:

Assistance provided to families to access health care and community services in collaboration with the family, primary care provider, and/or other members of the child or youth's health care team the family and care coordinator identify.

- ***Key Elements:***
  - Based on local office capacity, local community funding, and/or contracts to reimburse services.

  - Level 3 Care Coordination Includes:
    - Development of a Care Coordination Plan based on:
      - Identification of the family's unmet needs and potential unmet needs based on the family's concerns and questions and the *HCP Care Coordination Assessment and Planning Guide*
      - Identification of the family's goals to resolve their unmet needs.
      - Identification of the interventions (referrals, education, and services) needed to achieve the family goals.

    - Notice to the child/youth's primary care provider about HCP involvement, care coordination progress, and at the end of care coordination services. (*HCP Care Coordination Services Request and Report).*

    - Level 3 Care Coordination Service appropriate to family (e.g.):
      - Assist youth, 14 years of age or older and their family with a Health Transition Plan
      - Assist families with an Emergency Medical Plan
      - Assist families obtain TBI Purchased Services
      - Assist families in increasing their appropriate utilization of health care services.

    - Follow up to determine whether the interventions (referrals, education, and services) have been completed or acquired and whether further care coordination is needed.

  - Contacts with families may be made through phone calls, e-mail, home visits, clinic visits, and office visits.

Examples of HCP Health Care Coordination

Level I HCP Health Care Coordination:

- A family requesting assistance in obtaining food and clothing was referred by the HCP social worker to local agencies that assist families needing food and clothing. She also referred the family to LEAP (for energy assistance) and low-income housing. *No further follow up was needed.*

- A family contacted HCP with questions concerning cleft lip and palate. They were considering adopting a child with this condition and needed more information before making this decision. The HCP care coordinator provided the family with contact information for the Cleft Palate Foundation as well as inform them about local resources. *No further follow up was requested.*

Level 2 HCP Health Care Coordination

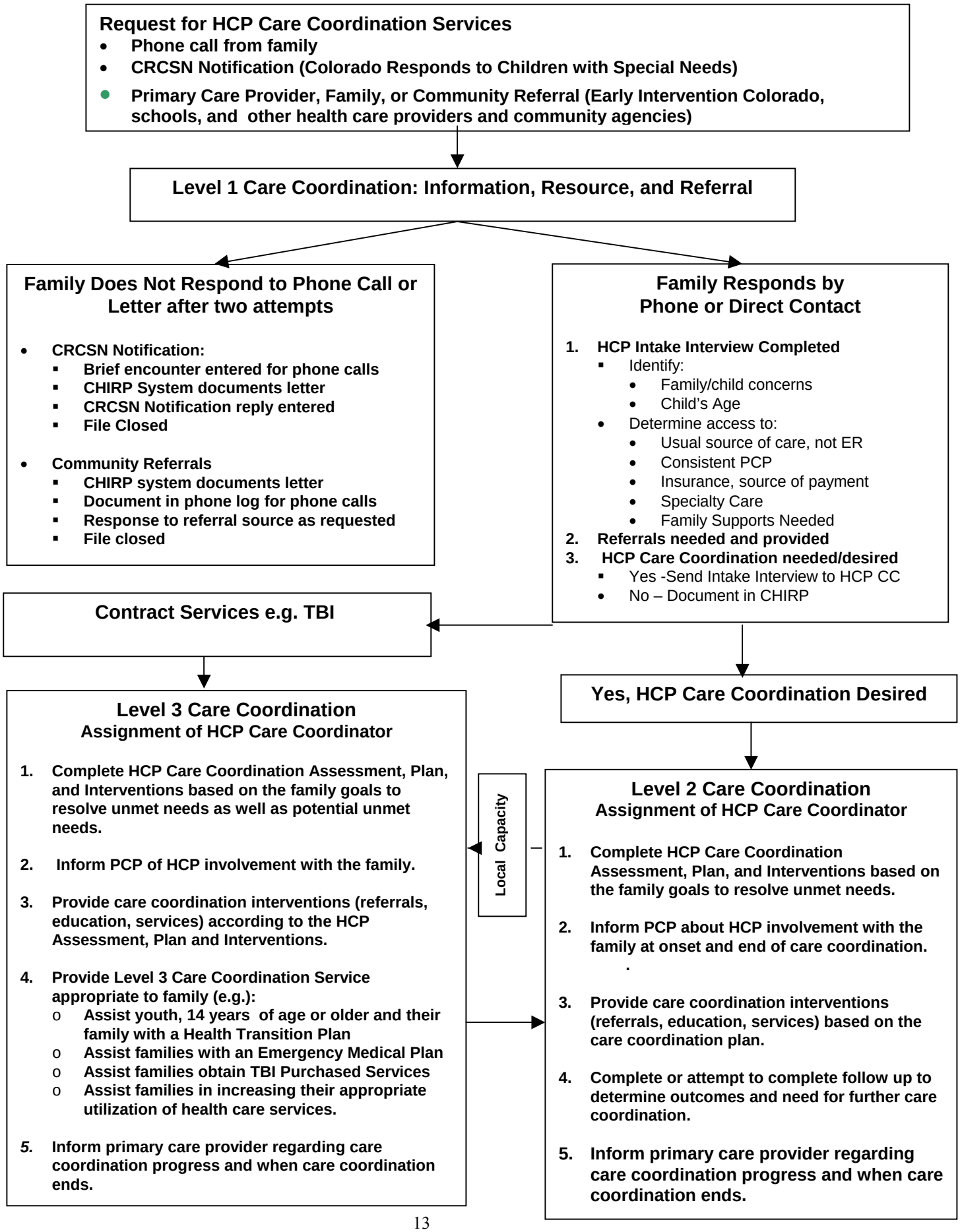
- A teenager with questionable seizure activity and an immediate need for oral surgery contacted an HCP office. This individual did not have insurance and was not living at home. The HCP team provided consultation with the teenager and his parent that resulted in referrals to the Medicaid program for children (EPSDT), the Colorado Indigent Care Program (CICP), a primary care physician, and a local public health nurse. Follow up was provided until the family was appropriately connected to these resources.
- A family with a child with a speech delay due to a medical condition requested assistance because their request for speech therapy was denied by a public insurance plan. The word "delay" was included in the medical diagnosis and this had automatically caused a denial for authorization in the insurance system. The mother contacted the HCP staff requesting information about other possible resources to help continue the therapy while she proceeded through the appeal system. The HCP nurse encouraged the mother to continue with the appeal and to talk with the school speech therapist to see what could be done at school. The mother stated that the school speech therapist told her she does not know how to deal with the child's specific problem. The HCP Speech/Language team member contacted the school therapist and offered the guidance and technical assistance the she needed to provide supportive services to the child until private therapy sessions could resume. *Once the family was connected with the appropriate community resources HCP Care Coordination was closed.*

Level 3 Health Care Coordination

- A family had a son diagnosed with Duchenne's muscular dystrophy. Over the winter, his muscle strength began to deteriorate rapidly. In November he had been able to manage his own self-care; however, by May, he was completely dependent on his mother for assistance with all activities of daily living. The HCP care coordinator helped the family obtain an appointment with a pediatric orthopedic specialist. A referral was made to obtain a power wheelchair and an evaluation of the family's home was completed for possible renovation to allow for the installation of a lift system. The child developed cardiac problems, requiring numerous visits to the PCP and several hospitalizations. The HCP care coordinator helped arrange for homebound education when the youth became too weak to attend school. The family became socially isolated because they only had a car for transportation, which was not capable of transporting the child's power wheelchair. Discussions with the Muscular Dystrophy Association resulted in the donation of a van from another family. The HCP care coordinator and the HCP social worker accompanied the family when they received the van, providing interpretation services and emotional support to both families. As the young man's health status continued to deteriorate, hospice services were set up with the help of the HCP Care Coordinator. The HCP Social Worker contacted the family's church and arranged for additional support services. The HCP social worker provided support to the entire family in numerous ways – food bank referrals, transportation arrangements, and emotional support in dealing with the situation. The HCP nurse and social worker worked with the older brother who was missing school and at risk for associating with gangs. The younger sister received emotional support as well as she experienced her brother's deteriorating condition. *HCP Care Coordination continued for over a year in order to provide continued support, education, and resources for the family.*

- A family contacted the HCP office because their 18-month-old child had multiple medical problems and they wanted to know what services were available to help their child. The HCP Care Coordinator provided consultation to the family and linked them with a consistent primary care provider, Early Intervention Colorado, their Medicaid EPSDT Outreach Worker, and a nutritionist. The HCP Care Coordinator also assisted them in working with their PCP to obtain referrals for the child to be seen in HCP Orthopedic and Neurology clinics. HCP Care Coordination continued to provide consultation to the early intervention team regarding the health and medical implications related to the child's IFSP. *HCP Care Coordination monitoring resumed when the child reached 3 years of age and was no longer eligible for Early Intervention Colorado.*

HCP Care Coordination Model



HCP Care Coordination Standards of Practice

HCP Care Coordination Activities	Responsible Person
Referral /CRCSN Notification received from family, PCP, Specialty Clinic, or community agency. □ Regional Office: send HCP Intake Interview to HCP Care Coordinator □ HCP Care Coordinator: send HCP Intake information to HCP Regional Office for tracking	HCP Regional Office Staff Or Local Public Health Agency Staff
HCP Care Coordination Level 1	
Attempt contact with family: □ All referrals require a minimum of two contacts by letter or phone call including CRCSN. □ If unable to make contact with family after two attempted contacts: o CRCSN, may close to further HCP Care Coordination services ▪ Respond to CRCSN Notification. o PCP or other referral source may close depending on PCP/referral source collaboration within 10 working days of referral.	HCP Technician or Other HCP Staff or HCP Care Coordinator
Contact with family: □ Complete HCP Intake Interview and Identify: o Family Concerns or Unmet Needs: o Usual source of sick and well care o Consistent PCP (physician, nurse practitioner, physician assistant) o Health insurance or source of health care available o Medical specialist available o Community support services available/needed and provided □ Determine desire for HCP Care Coordination o If yes, assign HCP Care Coordinator. ▪ Complete the HCP Care Coordination Request and Report o If no, advise may call HCP available in future as needed	HCP Technician, HCP Staff, or HCP Care Coordinator
HCP Care Coordination Level 2 and Level 3	
Complete Initial HCP Care Coordinator Contact: (phone, office visit, or home visit) ▪ Complete *HCP Family Information Questionnaire* ▪ Complete *HCP Care Coordination Assessment and Plan* o Identify **family concerns or questions** to be addressed o Develop child/youth's **plan for care coordination with family** o Provide needed **interventions (referrals, education, and services)** ▪ Determine need and plan for **ongoing HCP Care Coordination**	HCP Care Coordinator
Communicate back to PCP and/or referral source with in 30 working days of referral: □ Return *HCP Care Coordination Request and Report* or call PCP/ referral source re: ability to contact the family and the outcome of the referral.	HCP Care Coordinator
Documentation in HCP CHIRP with 45 days of referral: ▪ Demographics of child and family ▪ HCP Care Coordination Assessment, Plan, and Interventions o May use *HCP Care Coordination Word Templates* ▪ Communication to PCP or referral source o Automatic in CHIRP if letter sent o CHIRP communications under follow up if phone call or fax ▪ HCP Care Coordination interventions and Follow up o CHIRP Communication screen	HCP Care Coordinator Or HCP Technician with review and signing by HCP Care Coordinator

HCP Care Coordination Standards of Practice:

- CRCSN: Response to CRCSN Notification within 90 days
- HCP Intake Interview and HCP Request for HCP Care Coordination to HCP Care Coordinator: within 3 working days of PCP/other referral.
- HCP Care Coordination Request & Report Back to PCP/Referral Source: within 10 working days (2 weeks) of the referral re: ability to contact family
- HCP Care Coordination Assessment and Plan Completed and Report to PCP: within 30 working days of referral.
- HCP CHIRP Documentation: within 45 working days (6 weeks) of referral.

HCP CARE COORDINATION OUTCOMES

The National Survey of Children with Special Health Care Needs 2005-2006 provides data for Care Coordination measures. This survey indicates the following data for Colorado's population of CSHCN:

- 93.5 % of CSHCN have a personal doctor or nurse, compared with 93.5 % nationally.
- 94.3 % of CSHCN have a usual source of care that is not the ER (sick and well care), compared with 94.3 % nationally.
- 12.7 % of CSHCN were without insurance at some point in the past year, compared with 8.8 % nationally.
- 53.7 % of CSHCN needed specialty care, compared with 51.8 % nationally.
- 5.0% of CSHCN have unmet needs for family support services, compared with 4.9% nationally.

HCP 1 Year Short Term Outcomes:

As a result of HCP Care Coordination, CSHCN will have a reduction in unmet needs and have:

1) A usual source of sick and well care, other than the ER
2) A consistent PCP, physician, nurse practitioner, or physician assistant.
3) A source of payment for health care services (health insurance of other on going sources of health care)
4) Access to needed specialty care
5) Access to needed family support services.
6) Be satisfied with HCP Care Coordination services

HCP 3 – 5 Years Mid-Term Outcomes

1) Increase in family's efficacy to appropriately manage their child's healthcare
2) Appropriate health care utilization (usual source of care)
3) Family satisfaction with medical care received
4) Improved capacity for program evaluation

HCP Long Term Outcomes

1) Improved quality of life for families and children
2) Decrease in health care expenditures
3) Evidence based understanding of the impacts of program factors on effectiveness of care coordination

HCP Care Coordination Priorities and Risk Factors (Attachment F)

The *HCP Care Coordination Priorities and Risk Factors* identify elements that may impact the complexity, acuity, and intensity of HCP Care Coordination services. HCP Care Coordination data will be described and analyzed in relationship to these factors.

HCP CARE COORDINATION QUALITY ASSURANCE: MONITORING AND EVALUATION

HCP monitors its care coordination program services through various systems that include, but are not limited to:

- Written HCP Care Coordination Guidance, policies, procedures, and standards of practice based on current review of the literature, best practices, as well as evidenced based practice when available.
- Family satisfaction surveys
- Systematic family participation in policy and program decisions at both the regional and state levels
- Impact of ongoing training and education of HCP care coordinators
- Quarterly and annual review of HCP Care Coordination Outcomes
- Quality improvement strategies based on established Care Coordination Standards of Practice as well as Care Coordination Outcomes

HCP RESOURCE DOCUMENTS

The following documents are available to ensure accurate data collections and documentation in HCP CHIRP for the required HCP Care Coordination outcomes. These forms may be modified to meet local county health agency requirements. They are intended to facilitate communication and consistency among the HCP Regional Offices and county health agencies as well as augment data collection for the purposes of evaluation of HCP Care Coordination.

HCP Intake Interview (Appendix A-1 English and A-2 Spanish)

The ***HCP Intake Interview*** should be completed with an ***initial contact*** with the family about their need for HCP services. It is intended to identify the status of the five HCP Care Coordination Outcomes and determine the family need for HCP Services and/or HCP Care Coordination to assist with:

- Access to a usual source of sick and well care other than the ER
- Access to a consistent primary care provider (physician, nurse practitioner, or physician's assistant)
- Access to needed specialty care
- Access to insurance or a source of payment for health care
- Access to community family support services

Required information for HCP CHIRP entry:

- Child's first and last name
- Child's date of birth and age (to allow identification of child at a later date if needed)

The family may not wish to provide all required information, thus obtaining what is freely offered is the desire. Skills in communicating with families over the phone to build a safe and trusting relationship are needed in order to accomplish this. Trainings are available to build skills in developing safe and trusting relationships with families throughout their care coordination experience.

The result of the ***HCP Intake Interview*** should be documented by the HCP staff completing the family interview. The results may include more than one of the following:

- Initial referrals already provided to the family
- Family desires HCP Care Coordination
- Family is already receiving care coordination services from one of the following agencies or another agencies:
  - Early Intervention Colorado
  - EPSDT Outreach
  - Nurse Family Partnership
  - School nursing
  - Other care coordination resources (e.g. mental health wrap around services)
- Family states that they are able to coordinate child's care
- Family does not need assistance with coordination of care
- No referrals needed
- Unable to contact – after initial contact with family

HCP Regional Office Completes the HCP Intake Interview:

IF the ***HCP Intake Interview*** is completed by the HCP Regional Office and the determination is made that HCP Care Coordination is needed and desired by the family, the ***HCP Care Coordination Service Request and Report*** is forwarded to the HCP Care Coordinator along with a copy of the HCP Intake Interview.

HCP Care Coordinator Completes the HCP Intake Interview:

IF the ***HCP Intake Interview*** is completed by the HCP Care Coordinator, a copy of the ***HCP Intake Interview*** along with the HCP Family Information Questionnaire needed for CHIRP Registration should be sent to the HCP Regional Office.

HCP Care Coordination Services Request and Report (Appendix B)

The ***HCP Care Coordination Services Request and Report*** is used when a request is received for HCP Care Coordination from a primary care provider or other community agency. It also is used if a family indicates the need and desire for HCP Care Coordination as a result of the ***HCP Intake Interview***. The ***HCP Care Coordination Services Request and Report*** may then be sent to the primary care provider or community agency to inform them about the outcome of the request for HCP Care Coordination.

HCP Family Information Questionnaire (Appendix C-1 English and C-2 Spanish)

The ***HCP Family Information Questionnaire*** is intended to obtain required demographic information from the family about the:

- Child's age
- Child's gender
- Child's race
- Child's ethnicity
- Mother's birth date and age
- Mother's marital status
- Parent's educational level

NOTE: The family's income level is requested for the HCP Specialty Clinics ONLY.

HCP Care Coordination Assessment and Planning Guide
(D-1 Long Form and D-2 Short Form)

The ***HCP Care Coordination Assessment and Planning Guide*** is intended to provide guidance in completing a care coordination assessment, plan, and interventions based on the family's identified unmet needs and goals. All six major categories of the assessment should be discussed with the family to determine the family, child or youth's strengths as well as their unmet needs. The subcategories to be addressed are determined by the family or youth's concerns as well as the care coordinators clinical judgment. The HCP Care Coordination Assessment and Plan includes:

- Health Assessment (Subjective and Objective Data)
    - Child/Youth's Health
    - Child/Youth's Development
    - Family Status
    - Psychosocial Status
    - Basic Needs
    - Community Support Services
- Summary of Family Strengths and Unmet Needs
- Family Goals to Resolve the Unmet Needs
- Interventions (Referrals, Education, and Services) Planned
- HCP Care Coordinator Follow Up

Assessment Criteria:

Through the assessment the following should be identified:

- **Child or Family Strengths**: areas where the child or family has skills and knowledge that allows them to advocate for their health care and other needs.

- **Not Applicable**: areas that are not relevant to the age of the child or to the parent's questions or concerns at this time.

- **Unmet Need**: areas that the family has requested assistance in care coordination.

- **Pending**: areas that the family or care coordinator have identified that are potential concerns or unmet needs but are not priorities for the family at this time.

- **Not Yet Assessed**: is the default in CHIRP that will be used if there is no assessment completed

By using the ***HCP Care Coordination Assessment and Planning Guide***, the care coordinator should find it easier to enter the assessment and planning data into the new HCP CHIRP. Both a "short" form and a "long" version are provided of this form based on preferences by different HCP Care Coordinators.

Definitions Used in the HCP Care Coordination Assessment and Plan Guide

BMI; basal metabolic index
CCB: community center board
CCAP: Colorado Child Care Assistance Program
CDAS: Consumer-Directed Attendant Care Services
CHP+: Child Health Plan Plus (State Children's Insurance Program – CHIP)
DME: durable medical equipment
DNR: do not resuscitate
ER: emergency room
ED: emergency department
HCP: Health Care Program for Children with Special Needs
Ht: height
HS: high school
IEP: Individual Education Plan
IFSP: Individual Family Service Plan
LEAP: Low-income Energy Assistance Program
MD: medical doctor
NP: nurse practitioner
O2: oxygen
PA: physician assistant
PCP: primary care provider
PK: preschool /kindergarten
SES: social economic status
TB: tuberculosis
TBI: Traumatic Brain Injury Program
SSDI: Social security Disability Insurance
STD: sexually transmitted disease
TANF: temporary assistance for needy families
TCH: The Children's Hospital
UTD: up to date
WCC: well child care
WIC: Women's, Infant's and Children's nutrition program
Wt: weight

HCP Care Coordination CHIRP Template (Attachments: E – E 3)

- E - HCP Care Coordination Assessment and Plan Word Template Instruction
- E-1 - HCP Care Coordination Initial Assessment and Plan Word Template for CHIRP
- E-2 - HCP Care Coordination Follow Up Assessment and Plan Word Template for CHIRP
- E-3 - HCP Care Coordination Detailed Assessment and Plan Word Template for CHIRP

The HCP Care Coordination Assessment and Planning Word Templates for the initial contact as well as the follow-up are provided so that the HCP Care Coordinator can record their assessment and plan of care in a word document and then copy and paste it into the CHIRP Communication screen until the

HCP CHIRP Data Base is fully implemented. It is not necessary for the assessment to be in a narrative format. Abbreviations are generally discouraged and should follow standard medical documentation guidelines. A sample HCP Care Coordination Assessment and Plan is provided in the HCP Care Coordination Guidelines Appendix.

HCP SPECIALTY CLINIC COORDINATION

A primary care provider may request an appointment in a HCP Specialty Clinic for a child or youth. ***HCP Specialty Clinic Coordination*** involves the arrangements and follow-up for the pediatric medical specialty services. Upon the receipt of a specialty clinic referral the ***HCP Specialty Clinic Coordinator*** is responsible for contacting the family and completing the ***HCP Intake Interview*** if not yet completed and triaging the referral to determine the urgency of the referral to specialty care and determining the appropriate specialty clinic for the child/youth. Some of the specific responsibilities include:

- Completion of the ***HCP Specialty Clinic Referral and Triage*** with the PCP
  - Child/youth's diagnosis and/or symptoms to be evaluated
  - Determining the PCP questions to be answered by the pediatric specialist
  - Identifying the child's current health status, medications, and response to any treatments
  - Identifying tests or procedures done and their results
- Contact with the family to complete the **HCP Intake Interview** to determine if HCP Care Coordination is needed. Obtain additional information for the Triage from the family.
  - IF HCP Care Coordination is NOT needed, sending the family the Family Information Questionnaire to the family for completion.
  - IF HCP Care Coordination IS needed, sending the ***HCP Care Coordination Request and Report*** to the appropriate HCP Care Coordinator
- Consultation with the pediatric specialist to determine:
  - Urgency of the appointment
  - Scheduling priorities
  - Additional tests or procedures needed prior to the specialty clinic appointment
- Consultation with the PCP regarding:
  - Needed tests and procedures prior to the specialty clinic
- Scheduling patient appointments, sending appointment reminders, and confirming appointments with the family
  - Requesting assistance from the HCP Care Coordinator if unable to confirm appointment
- Attending the specialty clinic to provide staff support
  - Verifying all patient contact and insurance information
  - Initiating the ***HCP Specialty Clinic Record*** re: current health status and medications
  - Obtaining vital signs, height and weight measurements
  - Assuring the families understanding to the recommendations and follow up needed
- Follow up with the PCP regarding:
  - Specialty clinic recommendations for follow up tests and procedures
  - Medications changes
  - Specialty clinic follow up appointments
- Follow up with the HCP Care Coordinator (if available) regarding:
  - Clinic recommendations and any needed follow up with the family
- Follow-up with the family, PCP, or HCP Care Coordinator re: follow up appointments.

See the ***HCP Specialty Clinic Coordinators Guidance Manual*** for more information.
(Under development)

APPENDIX

Appendix A-1:	HCP Intake Interview (English)
Appendix A-2:	HCP Intake Interview (Spanish)
Appendix B:	HCP Care Coordination Services Request and Report
Appendix C-1	HCP Family Interview Questionnaire (English)
Appendix C-2	HCP Family Interview Questionnaire (Spanish)
Appendix D-1	HCP Care Coordination Assessment and Planning Guide LONG
Appendix D-2	HCP Care Coordination Assessment and Planning Guide SHORT
Appendix E	HCP Care Coordination Assessment and Plan Word Template for CHIRP Instruction
Appendix E-1 for	HCP Care Coordination INITIAL Assessment and Plan Word Template CHIRP
Appendix E-2	HCP Care Coordination FOLLOW UP Assessment and Plan Word Template for CHIRP
Appendix E-3	HCP Care Coordination DETAILED Assessment and Plan Word Template for CHIRP
Appendix F	HCP Care Coordination Priorities and Risk Factors
Appendix G	HCP Care Coordination Standards of Practice

Health Care Program for children with Special Needs

A-1

HCP INTAKE INTERVIEW

Health Care Program for Children with Special Needs (HCP)

_____Health Department

Address: _____

Phone: _____

Child/Youth's Name:		***Birthdate:***		***Age:***	

Parent/Guardian Name: ***Phone:***

What questions or concerns do you have about your child?

What is your child/youth's usual source of sick and well care?

❑ *PCP*	❑ *Clinic*	❑ *Urgent Care*	❑ *ER.*	❑ *None*

Who is your child's primary care provider? ***Consistent PCP:*** ☐ ***Yes*** ☐ ***No***

Name: _____

Office Telephone: _____

Office Address: _____

Does your child/youth have health insurance ☐ ***Yes*** ☐ ***No***

Private insurance: _____ ☐ HMO ☐ PPO ☐ POS

☐ ☐ Child Health Plan Plus (CHP+) ☐ Medicaid Medicaid/CHP+ Number: _____

☐ SSI ☐ Medicaid Waiver ☐ Other payment source _____

Does child have dental insurance? ☐ No ☐ Yes Dental provider: _____

Does child or youth see any medical specialists? ☐ **Yes** ☐ **No**

☐ ***Yes, care is adequate***	☐ ***Need assistance locating***	☐ ***No specialty care needed***

What is your child/youth's medical condition? Please describe

Are you using any family or community support services or resources? ☐ **Yes** ☐ **No**

Do you need any assistance with accessing community support services or resources? ☐ **Yes** ☐ **No**

Current Resources:

Developmental Needs:	**Family and/or Mental Health Needs:**	**Basic Needs and Community Support Needs:**
☐ Developmental assessment	☐ Family health care	☐ Housing and utilities
☐ Early Intervention services	☐ Parent support groups	☐ Transportation
☐ Education/School supports	☐ Child care assistance	☐ WIC/Food Stamps
☐ Community Centered Board	☐ Mental health services	☐ Health insurance
☐ Transition to adult services	☐ Family relationships	☐ TANF
☐ Other: _____	☐ Other: _____	Other: _____

Care Coordination Plan: To be completed by HCP Staff

☐ Referrals provided: _____	☐ Family states that they are able to coordinate child's care
☐ Family would like assistance from HCP Care Coordination	☐ Family does not need assistance with coordination of care
☐ Receiving care coordination services from: EI Colorado ___ ; EPSDT ___; NFP ___; School nursing ___; Other _____	☐ No referrals needed
	☐ Unable to contact

Family Member Providing Information: _____ Relationship: _____

HCP Staff Completing Intake: _____ Date: _____

A-2

HCP INTAKE INTERVIEW

Health Care Program for Children with Special Needs (HCP)

_____Health Department

Address: _____

Phone: _____

Nombre del niño/joven:		**Fecha de nacimiento:**		***Edad:***	

Nombre del padre/madre/tutor: ***Teléfono:***

¿Qué preguntas o inquietudes tiene acerca de su niño?

¿Cuál es la fuente habitual de cuidado de la salud y bienestar de su niño/joven?

☐ *PCP*	❑ *Clínica*	❑ *Cuidado urgente*	❑ *Sala de emergencia*	❑ *Ninguna*

¿Quién es el proveedor de atención primaria (PCP) de su niño? ***PCP Consistente:*** ☐ ***Sí*** ☐ ***No***

Nombre: _____

Teléfono del consultorio:_____

Dirección del consultorio: _____

¿Tiene su niño/joven seguro de la salud? ☐ ***Sí*** ☐ ***No***

Seguro privado: _____ ☐ HMO ☐ PPO ☐ POS

☐ Child Health Plan Plus (CHP+) ☐ Medicaid Núm. de Medicaid/CHP+: _____

☐ SSI ☐ Exención de Medicaid ☐ Otra fuente de pago _____

¿Tiene su hijo seguro dental? ☐ No ☐ Sí Proveedor de cuidado dental: _____

¿Consulta su niño/joven a algún especialista médico? ☐ **Sí** ☐ **No**

☐ ***Sí, cuidado es adecuado***	☐ ***Necesita ayuda para localizarlos***	☐ ***No necesita cuidado de especialidad***

¿Cuál es la condición médica de su niño/joven? Por favor, descríbala a continuación:

¿Está usted usando algun servicio de familia o apoyo comunitario o recursos? ☐ ***Sí*** ☐ ***No***

¿Necesita ayuda para obtener acceso a servicios de apoyo comunitarios o de recursos? ☐ ***Sí*** ☐ ***No***

Recursos:

Necesidades desarrollo:	**Necesidades familiares y/o de salud mental:**	**Necesidades básicas y apoyos comunitarios:**
☐ Evaluación del desarrollo	☐ Cuidado de la salud familiar	☐ Vivienda y servicios públicos
☐ Servicios de intervención temprana	☐ Grupos de apoyo para los padres	☐ Transporte
☐ Apoyos educativos/escolares	☐ Asistencia para el cuidado infantil	☐ WIC/Cupones de alimentos
☐ Junta centrada en la comunidad	☐ Servicios de salud mental	☐ Seguro de la salud
☐ Transición a servicios adultos	☐ Relaciones familiares	☐ TANF
☐ Otro:_____	☐ Otro: _____	☐ Otro: _____

Planes de coordinación del cuidado: a completar por el personal de HCP

☐ Referencias ofrecidas: _____	☐ La familia indica que puede coordinar el cuidado del niño
☐ La familia desearía recibir asistencia para coordinar el cuidado del niño	☐ La familia no necesita asistencia con la coordinación del cuidado
☐ Recibe los servicios de coordinación del cuidado por medio de: EL Colorado ___; EPSDT: ____ ; NFP: ____; Escuela de Enfermería:L ____; Oro;_____	☐ No se necesitan referencias
	☐ No se pudo establecer el contacto

Familiar que suministra la información: _____ Parentesco: _____

Personal de HCP que completa la admisión: _____ Fecha:_____

Health Care Program for children with Special Needs
Together we'll find the way.

B

HCP Care Coordination Services Request and Report

Date: _____

Referral Source: _____

Address: _____City: _____ Zip: _____

Phone Number: _____ Fax Number: _____ e-mail: _____

Child/Youth's Name: _____ BD: _____ Age: _____ M ___ F ___

Parent/s: _____Language/s: _____

Address: _____ City: _____ Zip: _____

Phone: Home: _____Cell: _____ Family Contact: _____

Primary Care Provider: _____ Usual Source of care: Yes ___ No ___

Address: _____City: _____ Zip: _____

Phone Number: _____ Fax Number: _____ e-mail: _____

Insurance: Medicaid ____ ; CHP+ ____; Medicaid/SSI ____; Private _____; None _____

Reason for HCP Care Coordination Request:

- ☐ Assessment of child/youth health and/or developmental needs
- ☐ Assessment of family health needs
- ☐ Assistance connecting to health services or specialty care for _____
- ☐ Health education/anticipatory guidance regarding _____
- ☐ Assistance connecting to community services for _____
- ☐ Other _____

Report back requested by: _____ phone call _____ fax back report _____ e-mail report

Summary of HCP Care Coordinator Visit:

- ☐ Referrals provided: _____
- ❑ Education provided: _____
- ❑ Services provided: _____
- ❑ Unable to contact: _____

HCP Care Coordinator Follow Up Plans:

- ❑ Will continue to follow. I will provide you with updates in _____ months.
  Comments: _____
- ❑ No further contact needed or planned
  Comments: _____
- ❑ No further contact wanted by the family
  Comments: _____

If you have any questions about HCP Care Coordination services please do not hesitate to contact me at the phone number below.

Name of HCP Care Coordinator
Title/Credentials
Address
Phone number e-mail

Health Care Program for children with Special Needs

Together we'll find the way

C-1

HCP Family Information Questionnaire

_____Health Department

Address: _____

Phone: _____

DATE:

Child Information			
	M F	***Birth date***	***Age***

What are concerns or questions about your child?

What are some of the things you enjoy doing as a family? ***What are some of your child's strengths?***

Race	***Ethnicity***
☐ Alaska Native ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian/White ☐ Other _____ ☐ Pacific Islander	☐ Hispanic ☐ Non-Hispanic

Parent/Guardian Information

Marital Status	☐ ***Married***	☐ ***Single***	☐ ***Separated***	☐ ***Divorced***	☐ ***Unknown***

Parents	***Birthdate***	***Age***	***Education: <HS, HS, college, post***	***Phone Number***
Mother				
Father:				

Mailing address: Zip:	Home address (if different) Zip:
Family Emergency Contact:	Language spoken/Read: Non English Speaking Only: _____
Foster Care/ Guardian	Phone Number:
Mailing Address	
Case Worker:	Phone Number:

Family Members:	**M F**	**Age**	**Relationship** to Child	**Contact Phone Numbers**

School District		**Contact:**	**Number:**

FOR HCP SPECIALTY CLINIC PATIENTS ONLY

Please estimate your family's income before taxes: Annual Income: _____ OR
Monthly Income: _____

Family Member Providing Information: _____ Relationship: _____

HCP Care Coordinator: _____ Date: _____

Health Care Program for children with Special Needs
Together we'll find the way.

C-2

HCP Family Information Questionnaire

_____Health Department
Address: _____
Phone: _____

FECHA:

Información del niño			
Nombre del niño	***M F***	***Fecha de nacimiento***	***Edad***

¿Cuáles son sus inquietudes o preguntas acerca de su niño/joven?

¿Cuáles son algunas de las cosas que disfrutan hacer como familia? ¿Cuales son algunos de los puntos fuertes de su hijo?

Raza	***Etnia***
☐ Nativo de Alaska ☐ Afroamericano ☐ Amerindio ☐ Asiático ☐ Caucásico/blanco ☐ Otro _____ ☐ Isleño del Pacífico	☐ Hispano ☐ No hispano

Información del padre/madre/tutor					
Estado civil:	☐ ***Casado***	☐ ***Soltero***	☐ ***Separado***	☐ ***Divorciado***	☐ ***Desconocido***

Padres	***Fecha de nacimiento***	***Edad:***	***Educación: <ES, ES, universidad, posgrado***	***Número de teléfono:***
Madre:				
Padre:				

Dirección: Código postal:	Dirección particular (si es diferente) Código postal:
Contacto familiar para emergencias:	Idioma de habla/lectura: Habla otro idioma además del inglés: _____
Tutela Temporal / Tutor:	Número de teléfono:
Dirección:	
Trabajador del caso:	Número de teléfono:

Miembros de la familia:	***M F***	***Edad***	***Parentesco con el niño***	***Números telefónicos de contacto***

Distrito escolar		**Contacto:**	**Número:**

PARA PACIENTES DE ESPECIALIDAD CLÍNICA DE HCP SOLAMENTE

Por favor, calcule su ingreso familiar antes de impuestos: Ingreso anual: _____
O Ingreso mensual: _____

Familiar que suministra la información: _____ Parentesco: _____

Coordinador de cuidados de HCP: _____ Fecha: _____

Child/Youth's Name: _____ **Date of Birth:** _____ **Age:** _____ **Gender: M** ___ **F** ___

Parent questions and concerns:

CHIRP ENTRY GUIDE ***Strengths and Unmet Needs*** *Assessment Priorities & Risk Factors*	Strength	Unmet Need	Not Applicable	Pending	*Assessment, Family Goals, Plan of Care, Interventions* **NOTES**
CHILD/YOUTH HEALTH					
Access to Health Care:					
• *Usual source of care other than ER*					
• *Consistent MD, NP, or PA for WCC*					
• *Access to specialist*					
Past Medical History:					
• *Complex or No diagnosis*: Rec. Rev..					
• *High risk pregnancy*					
• Birth history: *Premie or Birth Defect*					
• *Immunization UTD*					
• Allergies					
• *ER Visits, Hospitalizations*					
• Accident history					
Current Health Status:					
• Oral health exams/dentist					
• Vision test/provider					
• Hearing test/ audiologist					
• Tests and procedures needed					
Nutrition and Growth:					
• Nutritionist/dietician					
• Feedings: tube feeding or special formula					
• Wt to Ht ration/ BMI explained to family					
• Mealtime schedule and routines					
Medications:					
• Prescribed, OTC or alternative meds					
Treatments/Rehab Needed:					
• Therapists: OT, PT, SLP, SI,					
• Cognitive Therapist					
Equipment:					
• *DME:* O2, vent. wheel chair					
• G-tube, feeding pump					
• Medical supply/seating provider					
• Adaptive equipment					
Personal Safety:					
• Home and community safety					
• *Emergency plan for medical needs*					
• Car seat, crib/bed safety, helmets					
• Sexual abuse/prevention					

CHIRP ENTRY GUIDE ***Strengths and Unmet Needs*** *Assessment Priorities & Risk Factors*	**Strength**	Unmet Need	Not Applicable	Pending	*Assessment, Family Goals, Plan of Care, Interventions* NOTES
CHILD/YOUTH DEVELOPMENT					
Screening/Assessments:					
• *Developmental screening*: PCP or other					
• Child Find evaluation					
• Evaluations: motor, speech, social-emotional					
• Neuropsychological screen/evaluation					
• *Developmental delay/disability*					
Cognitive Functioning:					
• Learning and memory					
• Problem solving and decision making					
• Math and calculation					
• Organizational skills, multitasking					
• Handling change and transitions					
Self care/Daily routines:					
• Caregiver and self regulation					
• *Sleep/wake routines and activity*					
• Dressing, self care					
• Hygiene and bathing					
• Play: active and quiet play					
• TV, computer and screen time					
Early Intervention Services (0-3 Years):					
• **Early Intervention Colorado**					
• Service coordinator					
• IFSP completed					
Education (PK – 12) (PS through HS):					
• IEP					
• 504 Plan					
• Special Ed. eligibility, services, grievance					
Transition:					
• CCB for supported living services					
• *Transition plan to adult provider*					
• College entry assistance					
• Vocational rehab					
• Employment options					
• Guardianship					
• Health literacy					
Additional Notes:					

CHIRP ENTRY GUIDE ***Strengths and Unmet Needs*** *Assessment Priorities & Risk Factors*	**Strength**	Unmet Need	Not Applicable	Pending	*Assessment, Family Goals, Plan of Care, Interventions* NOTES
FAMILY STATUS					
Family Health:					
• *Family primary care source*					
• Family specialty care					
• Prenatal care					
• Family planning					
• Cultural health beliefs					
Family Functioning/Advocacy Skills:					
• *Single parent*					
• *Teen parent/s*					
• *Foster care, grandparent care*					
• *Planning, prioritizing*					
• *Decision making, coping strategies*					
• *Geographic isolation*					
• Family communication and relationships					
Parent Child Relationships					
• Parenting knowledge and skills.					
• Discipline strategies					
• Child abuse concerns					
Support Systems:					
• *Extended family support system*					
• *Utilization of resources*					
• Child care and respite					
• Faith based resources					
• Cultural supports. Interpreter					
• *Parent and grief supports*					
• Parent leadership interest					
Education:					
• *Parent education (< high school)*					
• *Language barrier*					
• Health Literacy/ Learning style					
PSYCHOSOCIAL STATUS					
Child emotional-mental health:					
• Infant mental/emotional health					
• *Mental health diagnosis*					
• *Depression*					
• *Mental health evaluation/provider*					
• Adjustment and coping behaviors to diagnosis					
• Relationships with family					
• Relationships with peers					
Family mental health:					
• *Mental/emotional health* diagnosis					
• *Mental health evaluation/provider*					
• *Depression, post-partum depression*					
• *Substance abuse*					
• *Past abuse or neglect*					

CHIRP ENTRY GUIDE ***Strengths and Unmet Needs*** *Assessment Priorities & Risk Factors*	**Strength**	Unmet Need	Not Applicable	Pending	*Assessment, Family Goals, Plan of Care, Interventions* NOTES
BASIC NEEDS					
Home Environment:					
• Housing and utilities, *homelessness*					
• Food					
• Clothing					
• *Transportation*					
• Home safety, repairs/modifications needed					
Financial Status:					
• *Low SES, below 200% poverty*					
• Employment or workman's co					
• Child support (received/paid)					
• Large debt					
Insurance:					
• Medicaid, SSDI, CHP +, waivers					
• Adequate private insurance					
• Presumptive eligibility					
• *No insurance*					
• Insurance grievance or bill reconciliation					
COMMUNITY SUPPORT SERVICES					
Community Supports Available:					
• *Appropriate local supports available*					
• Philanthropic or charity funding sources: TCH, Rotary, Shiners, etc.					
Public Health:					
• HCP/TBI					
• WIC					
• Family Planning					
• Prenatal + or Nurse Family Partnership					
• TB, HIV, STD program, wellness programs.					
Human Services:					
• Food stamps					
• CDAS, LEAP, CCAP, TANF					
Legal Issues:					
• Juvenile detention					
• Immigration					
• DNR					
• Legal aid					
Home Health Services:					
• Home care services, readiness for home care					
• Long term, extended or acute care, hospice.					
• Parent certification as CNA					
• Home care allowance					
FOLLOW UP PLAN:					*Next Visit:*

HCP Care Coordinator: _____ **Date:** _____

HCP Care Coordination Assessment and Planning Guide

D-2

Child/Youth's Name: _____ Date of Birth: _____ Age: _____ Gender: M ___ F ___

Parent questions and concerns:

CHIRP ENTRY GUIDE ***Strengths and Unmet Needs*** *Assessment Priorities & Risk Factors*	Strength	Unmet Need	Not Applicable	Pending	*Assessment, Family Goals, Plan of Care, Interventions* NOTES:
CHILD/YOUTH HEALTH					
Access to Health Care: *Usual source of care other than ER; Consistent MD, NP, or PA for WCC; Access to specialist*					
Past Medical History: *Complex or No diagnosis*: **Rec. Rev.;** High risk pregnancy; Birth history: Premie or Birth Defect; *Immunization UTD;* Allergies; *ER Visits, Hospitalizations;* Accident history					
Current Health Status: Oral health exams/dentist; Vision test/provider; Hearing test/ audiologist; Tests and procedures needed					
Nutrition and Growth: Nutritionist/dietician; Feedings: tube feeding or special formula; Wt to ht ration/ BMI explained to family; Mealtime schedule and routines					
Medications: Prescribed, OTC or alternative meds					
Treatments/Rehab Needed: Therapists: OT, PT, SLP, SI, ; Cognitive Therapist					
Equipment: *DME:* O2, vent. wheel chair; G-tube, feeding pump; Medical supply/seating provider; Adaptive equipment					
Personal Safety: Home and community safety; *Emergency plan for medical needs;* Car seat, crib/bed safety, helmets; Sexual abuse/prevention					
CHILD/YOUTH DEVELOPMENT					
Screening/Assessment: *Developmental screening*: PCP or other; Child Find; evaluation; Evaluations: motor, speech, social-emotional; Neuro-psychological screen/evaluation; *Developmental delay/disability*					
Cognitive Functioning: Learning and memory; Problem solving and decision making; Math and calculation; Organizational skills, multitasking Handling change and transitions					
Self care/Daily routines: Caregiver and self regulation; *Sleep/wake routines and activity;* Dressing, self care; Hygiene and bathing Play: active and quiet play; TV, computer and screen time					
Early Intervention Services (0-3 Years): **Early Intervention Colorado;** Service coordinator ; IFSP completed					
Education (PK – 12) (Preschool through HS): IEP; 504 Plan; Special Ed. eligibility, services, grievance					
Transition: CCB for supported living services; *Transition plan to adult provider;* College entry assistance; Vocational rehab; Employment options; Guardianship; Health literacy					
Additional Comments:					

CHIRP ENTRY GUIDE ***Strengths and Unmet Needs*** ***Assessment Priorities & Risk Factors***	Strength	Unmet Need	Not Applicabl	Pending	*Assessment, Family Goals, Plan of Care, Interventions* NOTES
FAMILY STATUS					
Family Health: *Family primary care source;* Family specialty care Prenatal care; Family planning; Cultural health beliefs					
Family Functioning/Advocacy Skills: *Single parent; Teen parent/s; Foster care; Grandparent care; Planning & prioritizing: decision making, coping strategies;* Family communication and relationships					
Parent-child relationships: Parent knowledge & skills; Discipline strategies; Child abuse concerns					
Support Systems: Extended family support system; *Geographic isolation; utilization of resources*; Child care; Respite; Faith based resources; Cultural supports. Interpreter; *Parent and grief supports;* Parent leadership interest					
Education: *Parent education (< high school); Language barrier;* Health Literacy/ Learning style					
PSYCHOSOCIAL STATUS					
Child emotional-mental health: *Infant mental/emotional health; Mental health diagnosis Depression;* Evaluation/provider*;* Adjustment and coping behaviors to diagnosis; Relationships with family; Relationships with peers					
Family mental health: *Mental/emotional health diagnosis;* Mental health valuation and provider*; Depression, post-partum depression; Substance abuse; Past abuse or neglect*					
BASIC NEEDS					
Home Environment: Housing and utilities, homelessness; Food; Clothing; transportation, Home safety, repairs/modifications needed					
Financial Status: *Low SES, below 200% poverty*; Employment or workman's comp; Child support (received/paid); Large debt					
Insurance: Medicaid, SSI, CHP +, waivers; Adequate private insurance; Presumptive eligibility; No insurance; Insurance grievance or bill reconciliation					
COMMUNITY SUPPORT SERVICES					
Community Supports Available: *Appropriate local supports available;* Philanthropic or charity funding sources: TCH, Rotary, Shiners, etc					
Public Health: HCP/TBI; WIC; Family Planning; Prenatal + or Nurse Family Partnership; TB, HIV, STD program, wellness programs.					
Human Services: Food stamps; CDAS, LEAP, CCAP, TANF					
Legal Issues: Juvenile detention; Immigration; DNR; Legal aid					
Home Health Services Home care services, readiness for home care; Long term, extended or acute care, hospice; Parent certification as CNA; Home care allowance					
FOLLOW UP PLAN: *Next Visit:*					

HCP Care Coordinator: _____ **Date:** _____

HCP CARE COORDINATOR ASSESSMENT and PLAN
INSTRUCTIONS FOR WORD TEMPLATE FOR CHIRP COMMUNICATION NOTE

E

INSTRUCTIONS FOR DOCUMENTATION UNTIL NEW CHIRP SYSTEM AVAILABLE:

1. Regional Office OR HCP Care Coordinator completes the *HCP Intake Interview* and determines if HCP Care Coordination is needed and desired by the family. Referrals provided as needed.

2. Regional Office completes *HCP Care Coordination Request and Feedback Guide* and sends to assigned HCP Care Coordinator along with a copy of the HCP Intake Interview.
   - o If HCP Care Coordinator receives initial referral, *HCP Care Coordinator Request and Feedback Guide* is completed for report back to PCP and/or referral source.

3. HCP Care Coordinator completes *HCP Family information Questionnaire*.
   - Information from the *HCP Intake Interview* and *HCP Family Information Questionnaire* are required to complete CHIRP Registration.
   - HCP Care Coordinator sends copies of these documents to Regional Office for assistance with HCP CHIRP Registration.

4. HCP Care Coordinator completes the *HCP Care Coordination Assessment and Planning Guide.*
   - Review all six areas of the assessment with the family discussing those subcategories most relevant to the families identified concern or question.
     - o Child/youth Health
     - o Child/Youth Development
     - o Family Status
     - o Psychosocial Status
     - o Basic Needs
     - o Community Supports
   - Assess these area for family strengths, unmet needs, as well as areas that may need further discussion or assessment at a later date (pending).
   - Note any identified risk factors or priority areas that are in bold on the Assessment Guide. (e.g. lack of primary care provider, lack of immunizations, or geographic isolation.)
   - You DO NOT need to address ALL areas of the assessment……..only those areas related to the family concerns/questions or condition of the child.

5. Use the *HCP Care Coordination Assessment and Plan Word Template* to document your assessment, assessment summary, family goals, interventions, and follow up in CHIRP Communication Screen.
   1. If you did not discuss or cover a topic delete it from the template.
   2. Save this your HCP Care Coordination Assessment and Plan for the child in a word file with the child's name or CHIRP Number
   3. **Enter the concerns you identified as usual in CHIRP**
   4. Copy the HCP Care Coordination Assessment and Plan in word and paste it into the CHIRP Communication Screen.

6. Document the "Concerns" you will be addressing in CHIRP

7. Document the referrals in CHIRP

8. Sign your name and title.

HCP CARE COORDINATOR INITIAL ASSESSMENT and PLAN
WORD TEMPLATE FOR CHIRP COMMUNICATION NOTE

E-1

Date of Visit:

Name of Child/Youth:
Birthday: **Age**: **CHIRP Number**:
Care Coordinators Name:
Date of Visit:
Family Members Interviewed:

Referral Source

FAMILY CONCERNS/QUESTIONS:

FAMILY/CHILD ACTIVITIES TOGETHER:

ASSESSMENT (subjective and objective information)

Child Health:

Child Development:

Family Status:

Psychosocial Status:

Basic Needs:

Community Support Services:

ASSESSMENT SUMMARY: **Strengths and unmet needs**

FAMILY GOALS: **Family goals identified with the family**

INTERVENTIONS: **Referrals, education, services to be implemented by family & care coordinator**

FOLLOW UP PLANS: **Next care coordination contact with family**

HCP Care Coordinator *Date*
Title

HCP CARE COORDINATOR FOLLOW UP ASSESSMENT and PLAN
WORD TEMPLATE FOR CHIRP COMMUNICATION NOTE

E-2

Date of Visit:

Name of Child/Youth:
Birthday: **Age**: **CHIRP Number**:
Care Coordinators Name:
Date of Visit:
Family Members Interviewed:

Referral Source:

FAMILY CONCERNS/QUESTIONS:

FAMILY/CHILD ACTIVITIES TOGETHER:

ASSESSMENT (subjective and objective information)

ASSESSMENT SUMMARY: **Unmet needs addressed**

FAMILY GOALS: **Goals being addressed**

INTERVENTIONS: **Referrals, education, services to be implemented by family & care coordinator**

FOLLOW UP PLANS: **Next care coordination contact with family**

_____
HCP Care Coordinator
Title

HCP CARE COORDINATOR DETAILED ASSESSMENT and PLAN
WORD TEMPLATE FOR CHIRP COMMUNICATION NOTE

E-3

Date of Visit:

Name of Child/Youth:
Birthday: **Age**: **CHIRP Number**:
Care Coordinators Name:
Date of Visit:
Family Members Interviewed:
Referral Source:

FAMILY CONCERNS/QUESTIONS:

FAMILY ACTIVITIES TOGETHER:

ASSESSMENT:

Child Health:

Usual Source of Well and Sick Care:

Primary Care Provider Name:

Specialty Care Provider/s:

Past Medical History:

***Current Health Status*:**

Nutrition and Growth:

Medications:

Treatments/Rehabilitative Services:

Equipment:

Personal Safety:

Child Development::

Screenings/Assessments:

Cognitive Functioning/Status:

Self Care/Daily Routines:

Early Intervention Services (0 – 3 Years)

Education (PK- 12 Services) Preschool through HS)

Transition Plans

HCP CARE COORDINATOR DETAILED ASSESSMENT and PLAN
WORD TEMPLATE FOR CHIRP COMMUNICATION NOTE

Family Status:

Family primary care source

Family Functioning/Advocacy Skills:

Parent Child Relationships

Support Systems:

Education:

Psychosocial Status:

Child emotional-mental health:

Family mental health:

Basic Needs:

Home Environment

Financial Status

Insurance

Community Support Services

Public Health Services

Human/Social Services

Legal Issues

Community Support Services

Home Health Services

ASSESSMENT SUMMARY**: List unmet needs/concerns to be addressed**

FAMILY GOALS**: List family goals identified with the family**

INTERVENTIONS*:* **(Referrals, Education, Services provided)**

FOLLOW UP PLANS*:* **(Next care coordination contact with family)**

_____

HCP Care Coordinator
Title

HCP CARE COORDINATOR ASSESSMENT AND PLAN
SAMPLE WORD TEMPLATE FOR CHIRP COMMUNICATION NOTE

E-4

Date of Visit:

Child/Youth's Name: Hunter Brown
Date of Birth: 10/25/08
Care Coordinators Name: Allison Green, RN
Date of Visit: 8/18/09
Family Members Interviewed:
Mary Brown (mother) 24 yo
Jeff Brown (step father) 25 yo

Referral Source: Mother

FAMILY CONCERNS/QUESTIONS:

Parents are concerned about some developmental delays, feeding concerns, and have no insurance for Hunter to see their primary care provider.

FAMILY ACTIVITIES TOGETHER: Family enjoys hiking and going to the local park. Visit maternal grandparents about 1 X per month.

CHILD HEALTH

Primary Care Provider:
- Dr. Jim Brown – last visit on 4/28/09. At that time no concerns noted.

Specialty Care Provider/s: None at this time

Past Medical History:
- Birth History: Normal pregnancy and delivery. Birth weight: 6 # 8 oz, Length: 20 inches. No illnesses since birth.
- Immunizations: up to date at 6 months. Using delayed immunization schedule, due for PCV7, Influenza, and Rotovirus.
- Allergies: none
- ER/Hospitalizations - none

Current Health Status: No current health problems.

Nutrition and Growth: Breast-feeding went well in first 6 months. Transition to solids difficult and Hunter is only taking breast milk every 4 – 5 hours in the day time and solids once a day.

Medications: None

Treatments/Rehabilitative Services: None

Equipment: NA or delete

Personal Safety: Home in safe neighborhood, parents have made efforts to childproof home.

CHILD DEVELOPMENT:

Screenings/Assessments: None

Cognitive Functioning/Status: N/A or delete

Self-Care/Daily Routines: Cooperates with diapering and dressing. Will not try self-feeding. Breast feedings take over 30 minutes.

Early Intervention/Education PK- 12 Services: None at this time

Transition Plans: N/A or delete

HCP CARE COORDINATOR ASSESSMENT AND PLAN
SAMPLE WORD TEMPLATE FOR CHIRP COMMUNICATION NOTE

FAMILY:

Family Health: Family had Kaiser prior to Jeff's lay off from the postal service. Both parents are healthy. Mother cares for her mother daily who has early Alzheimer disease as the family has no other resources for her care. Her father works long hours and is unable to care for Mary's mother during the day.

Family Functioning: Parents communicate well with each other. State decision-making shared. Stress currently with Mary's mother and concerns with Hunter.

Parenting: Mother uses web and actively reads materials provided. She then shares with father.

Support Systems: No other extended family in the area except maternal grandparents.

Education: N/A

PSYCHOSOCIAL:

Child Social Emotional-Mental Health: Concern with evolving self-care skills.

Family Mental Health: Stress as noted above. Family uses friends and faith for support

BASIC NEEDS:

Home Environment: Live in own 2 bedroom, 1 bath home in NW Denver. Neighborhood considered safe. Home utilities functional. Transportation: One car in working order. Access to bus lines.

Financial Status: Jeff works as postal employee but has recently been laid off and thus lost his health insurance. Currently applying for unemployment insurance. Mary considering returning to work as a nurse for income and insurance.

Insurance: None at this time.

COMMUNITY PROGRAMS

Public Health Services: Mary used the WIC clinic when she was pregnant. After delivery income change and she does not know if she is now eligible.
Human/Social Services: None
Legal Issues: None
Philanthropic Assistance: None
Home Health Services: None

ASSESSMENT SUMMARY (Family Strengths and unmet needs to be addressed)
Close family unit with good communication and shared decision-making. Enjoy hiking and visiting local parks.

1. Lack of income and insurance
2. Lack of access to primary care, immunizations
3. Lack of resources for appropriate nutrition, possibly eligible for WIC.
4. Need for developmental screening/assessment re: delays in self feeding
5. Lack of resources for Mary's mother who has Alzheimer's disease

FAMILY GOALS AND INTERVENTIONS (Referrals, Education, and Services):

1. Hunter will have health insurance and continue primary care w/ Dr. Brown or identify another PCP in six months so that he has a consistent primary care provider.
   - Family will contact with PCP to see what office visit would cost out of pocket.
   - Care coordinator will follow up with Dr. Care Clinic or Children's Hospital Philanthropy Program for family as alternative
   - Family will apply for Medicaid and/or CHP +
   - Family will consider using public health to up date immunizations until health insurance and PCP determined.

2. Hunter will have appropriate development and nutrition resources to maximize his health in six months.
   - Family will contact WIC about appointment and nutrition consultation
   - Care Coordinator will initiate referral to EI Colorado for family
   - Care Coordinator will request nutritional consultation if WIC dietitian is not available.

3. Mary will be able to reduce her stress from concerns about maternal grand mother and Hunter in the next six months.
   - Continue to use stress management strategies – walks together, continuing with family and church activities.
   - Care Coordinator will explore resources of Alzheimer family support groups and resources.

4. Jeff will have unemployment as needed and identify alternative employment possibilities in the next 3 months.
   - Jeff will follow up with results of application for unemployment.

FOLLOW UP PLANS (Next contact with family)

1. Follow up in one month by phone regarding the outcomes of referrals.
2. Letter to PCP re: HCP Care Coordinator contact with family.
3. HCP dietician consultation re: feeding/growth concerns

Allison Green, RN
HCP Care Coordinator

F

HCP Care Coordination Priorities and Risk Factors

HCP Data Priorities and Risk Factors	HCP Care Coordination Forms		
	Intake Interview	Family Questionnaire	Assessment and Plan
OUTCOMES OF CARE COORDINATION			
▪ **Usual source of care other than ER**	**X**		**X**
▪ **Access to consistent to PCP: MD, NP, or PA**	**X**		**X**
▪ **Access to specialty care**	**X**		**X**
▪ **Available insurance, source of health care**	**X**		**X**
▪ **Family support services**	**X**		**X**
▪ **Desire for HCP CC**	**X**		**X**
▪ **Already receiving care coordination services**	**X**		
DEMOGRAPHICS: Population Description			
▪ **Child age**		**X**	
▪ **Child gender**		**X**	
▪ **Child insurance**		**X**	
▪ **Child ethnicity**		**X**	
▪ **Child race**		**X**	
▪ **Child primary care provider**		**X**	
▪ **Mother's birthday – age**		**X**	
▪ **Parent education**		**X**	
▪ **Parent marital status**		**X**	
PRIORITY AND RISK FACTORS			
Child/Youth Health			
• **Usual source of care ER**			**X**
• **Inconsistent PCP**			**X**
• **Lack of access to specialist**			**X**
• **Complex medical diagnosis or No diagnosis**			**X**
• **High risk pregnancy**			**X**
• **Premature birth or Birth Defect**			**X**
• **Immunization not up to date**			**X**
• **Frequent ER Visits, Hospitalizations**			**X**
• **Lack of Emergency plan for medical needs**			**X**
Child/Youth Development			
• **Lack of development screening**			X
• **Developmental delay/disability**			X
• **Lack of self care or daily routines:**			X
• **Lack of sleep/wake routines and activity**			X
• **Lack of transition plan to adult provider when needed**			**X**

HCP Data Priorities and Risk Factors	HCP Care Coordination Forms		
	Intake Interview	**Family Questionnaire**	**Assessment and Plan**
Family Status			
▪ **Family primary care source**			**X**
• **Single parent**			**X**
• **Teen parent/s**			**X**
• **Foster care, grandparent care**			**X**
• **Parent child relationship**			**x**
• **Lack of planning, prioritizing skills**			**X**
• **Lack of decision making, coping strategies**			**X**
• **Geographic isolation**			**X**
• **Parent support systems: extended family**			**X**
• **Parent education (< high school)**			**X**
▪ **Language barrier**			**X**
Psychosocial Status			
• **Mental health diagnosis**			**X**
• **Depression or post-partum depression**			**X**
• **Substance abuse**			**X**
▪ **Past abuse or neglect**			**X**
Basic Needs			
• **Homelessness**			**X**
• **Transportation**			**X**
• **Low SES, below 200% poverty**			**X**
• **Lack of insurance:**			**X**
Community Supports Available:			
• **Lack of appropriate local supports**			**X**

G

HCP Care Coordination
Standards of Practice

HCP Care Coordination Activities	Responsible Person
Referral /CRCSN Notification received from family, PCP, Specialty Clinic, or community agency. □ Regional Office: send HCP Intake Interview to HCP Care Coordinator □ HCP Care Coordinator: send HCP Intake information to HCP Regional Office for tracking	HCP Regional Office Staff Or Local Public Health Agency Staff
HCP Care Coordination Level 1	
Attempt contact with family: □ All referrals require a minimum of two contacts by letter or phone call including CRCSN. □ If unable to make contact with family after two attempted contacts: o CRCSN, may close to further HCP Care Coordination services ▪ Respond to CRCSN Notification. o PCP or other referral source may close depending on PCP/referral source collaboration within 10 working days of referral.	HCP Technician or Other HCP Staff or HCP Care Coordinator
Contact with family: □ Complete HCP Intake Interview and Identify: o Family Concerns or Unmet Needs: o Usual source of sick and well care o Consistent PCP access o Health insurance or source of health care available o Medical specialist available o Community support services available/needed and provided □ Determine desire for HCP Care Coordination o If yes, assign HCP Care Coordinator. ▪ Complete the HCP Care Coordination Request and Feedback Form o If no, advise may call HCP available in future as needed	HCP Technician, HCP Staff, or HCP Care Coordinator
HCP Care Coordination Level 2 and Level 3	
Complete Initial HCP Care Coordinator Contact: (phone, office visit, or home visit) ▪ Complete *HCP Family Information Questionnaire* ▪ Complete *HCP Care Coordination Assessment and Plan* o Identify family concerns or questions to be addressed o Develop child/youth's plan for care coordination with family o Provide needed interventions (referrals, education, and services) ▪ Determine need and plan for ongoing HCP Care Coordination	HCP Care Coordinator (HCP CC)
Communicate back to PCP and/or referral source with in 30 working days of referral: □ Return *HCP Care Coordination Request and Report* or call PCP/ referral source re: ability to contact the family and the outcome of the referral.	HCP Care Coordinator
Documentation in HCP CHIRP with 45 days of referral: ▪ Demographics of child and family ▪ HCP Care Coordination Assessment, Plan, and Interventions o May use *HCP Care Coordination Word Templates* ▪ Communication to PCP or referral source o Automatic in CHIRP if letter sent o CHIRP communications under follow up if phone call or fax ▪ HCP Care Coordination interventions and Follow up o CHIRP Communication screen	HCP Care Coordinator Or HCP Technician with review and signing by HCP Care Coordinator

HCP Care Coordination Standards of Practice:

- CRCSN: Response to CRCSN Notification within 90 days of Notification
- HCP Intake Interview and HCP Request for HCP Care Coordination to HCP Care Coordinator: within 3 working days of PCP/other referral.
- HCP Care Coordination Request & Report Back to PCP/Referral Source: within 10 working days (2 weeks) of the referral re: ability to contact family
- HCP Care Coordination Assessment and Plan Completed and Report to PCP: within 30 working days of referral.
- HCP CHIRP Documentation: within 45 working days (6 weeks) of referral.

REFERENCES

Antonelli, R.C., & Antonelli, D.M. Providing a medical home: The cost of care coordination services in a community-based, general pediatric practice. *Pediatrics*. 2004. 113: 1522- 1528.

Antonelli, R.C., McAllister, J.W., & Popp, J. Making care coordination a critical component of the pediatric health care system: A multidisciplinary framework. *The Commonwealth Fund*. 2007 at www.commonwealthfund.org.

Antonelli, R.C., McAllister, J.W., & Popp, J. Making care coordination a critical component of the pediatric health care system: A multidisciplinary framework. *The Commonwealth Fund*. May 2009. at www.commonwealthfund.org.

American Academy of Pediatrics, Committee on Children with Disabilities. Care Coordination in the Medical Home: Integrating health and related systems of care for children with special health care needs. *Pediatrics*, 2005. 116; 12138-1244.

American Academy of Pediatrics, Committee on Children with Disabilities. Care Coordination: Integrating health and related systems of care for children with special health care needs. *Pediatrics*. 1999: 104: 978-981.

American Academy of Pediatrics, Children with Special Health Care Needs Project Advisory Committee. The Medical Home. Pediatrics. 2002; 110:184-186.

Committee on Children with Disabilities. Care Coordination in the Medical Home: Integrating health and related systems of care for children with special health care needs. Pediatrics. 2005: 116(5)

The Association of Maternal and Child Health Programs. Protecting children with special health care needs, Fact Sheet. March 2003. Retrieved from www.amchp.org

The Association of Maternal and Child Health Programs Policy and Program Committee. *Meeting the Needs of Families: Critical elements of comprehensive care coordination in Title V Children with Special Health Care Needs Programs.* Washington, DC. 2002.

The Association of Maternal and Child Health Programs. *Care coordination for children with special health care needs and their families in the new millennium: principles, goals and recommendations*. Developed by the AMCHP working group on care coordination. 2000.

Barrett, J.C. A school-based care management service for children with special needs. *Family and Community Health*, 2000. 23.

Case Management Society of America (CMSA). *Standards of Practice for Case Management*. CMSA: Little Rock, Arkansas. 2002.

Chernoff, R.G., Ireys, H.T., DeVet, K.A., Kim, Y.J. A randomized controlled trial of a community-based support program of children with chronic illness: Pediatric outcomes. *Archives of Pediatrics and Adolescent Medicine*. 2002; 156: 533-539.

Center for Health Care Strategies, Inc. *The Faces of Medicaid: The complexities of caring for people with chronic illness and disabilities.* Princeton, New Jersey. 2000.

"Definitions of Care Coordination and Case Management," Title V Social Security Act.

Early Childhood Connections. Definition of Service Coordination. 2005. Retrieved on January 2, 2005 from: http://www.cde.state.co.us/earlychildhoodconnections/service_co.htm

Gilbert, M., Counsell, C. M., Ross, L. Evolution of a Role to Enhance Care Coordination. *Nursing Case Management*, 1997: 2.

Grupta, V. B., O'Connor, K. G., & Quezada-Gomez, C. (2004). Care coordination services in pediatric practices. Pediatrics, 2004: 113.

Huston, C. J. The Role of the Case Manager in a Disease Management Program. Lippincott's Case Management, 7(6). 2002.

Jablonski, D. Program coordinates care, resources for medically complex children: special needs case managers are liaison between providers. *Hospital Case Management*, 2003.

Johson, K. & Rosenblaum. *Medicaid Case Management in a Maternal and Child Health Context: An Overview of Policy and Practice.* Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. 2008.

Lipak, G.S., Shone, L.P. Auinger, P., Dick, A.W., Ryan, S.A. Szilagyi, P.G. Short-term Persistence of High Health Care Costs in a Nationally Representative Sample of Children. Pediatrics. 2006; 118(4) e1001-1009.

Lipak, G.S., Burns, C.M., Davidson, P.W., McAnarney, E.R. Effects of Providing Comprehensive Ambulatory Services to Children with Chronic Conditions. Archives of Pediatric and Adolescent Medicine. 1998; 152:1003-1008.

McAllister, J, Presler, E., & Cooley, W.C. Practice-based care coordination: A medical home essential. *Pediatrics.* 2007. 120: 723-733.

McPherson, M. Arango, P., Fox H., Lauver, C., McManus, M., Newacheck, P.W., Perrin, J.M., Shonkoff, J.P., and B. Strickland. "A New Definition of Children with Special Health Care Needs." *Pediatrics*. 1998. 102:.No1.

Newacheck, P.W. Rising, J.P., & Kim, S.E. Children at risk of special health care needs. *Pediatrics*. 2006: (188) 334-342.

Nichols, D. & Zallar, M.J. Care Coordination: A New Role in a Customer-Focused Healthcare System. *Nursing Case Management.* 1997: 2(6).

Novak, D. A. Nurse Case Managers' Opinions of Their Role. *Nursing Case Management*, 1998: 3(6).

Palfrey, J.S., Sofis, L.A., Davidson, E.J., Liu, J., Freeman, L., and Ganz, M.L. The Pediatric Alliance for Coordinated Care: Evaluation of a Medical Home Practice Model. *Pediatrics*. 2004; 113(5 supplement): s1507-1516.

Peterson, V. M. When Quality Management Meets Case Management. *Lippincott's Case Management*, 2004: 9(2).

Presler, B. Care coordination for children with special health care needs. *Orthopedic Nursing*, March/April Supplement, 1998: 45-51.

Rosenbach, M. & Young, C. Care coordination and Medicaid managed care: emerging issues for states and managed care organizations. *Mathematica Policy Research, Inc*.,Princeton, NJ. 2000.

Strickland, B.B., Singh, G.K., Kogan, M.D., Mann, M.Y., van Dyck, P.C., & Newacheck, P.W. Access to the medical home: New findings from the 2005-2006 National Survey of Children with Special Health Care Needs. *Pediatrics*. 2009: 123; e998-e1004.

Tahan, H. A. Clarifying Case Management: What is in a Label? *Nursing Case Management*, 1998: 4(6).

U.S. Department of Health and Human Services/Health Resources and Services Administration. (2004). *The National Survey of Children with Special Health Care Needs, Chartbook 2001*. Rockville, Maryland.

Walsh, E.G., Osber, D.S., Nason, C.A. Porell, M.A., & Asciutto, A.J. Quality Improvement in a Pediatric Care Case Management Program. *Health Care Finance Review*. 2002; 23: 71-84.

Wayman, C. Hospital-Based Nursing Case Management: Role Clarification. Nursing Case Management, 1999: 4(5).

U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA). Recommendations for Improving Access to Pediatric Subspecialty Care Through the Medical Home. 2008.

WEB SITES:

Colorado Department of Public Health and Environment – Maternal and Child Health
http://www.cdphe.state.co.us/ps/mch/index.html

Colorado Department of Public Health and Environment – Children with Special Health Care Needs Title V
http://www.cdphe.state.co.us/ps/hcp/index.html

Colorado Department of Public Health and Environment – Medical Home Initiative
http://coloradomedicalhome.com/cmhi.html

Colorado Federation of Families for Children's Mental Health
http://www.coloradofederation.org/

Early Intervention Colorado
http://www.eicolorado.org

Family Voices – Colorado
http://www.familyvoicesco.org/

Health Care Policy and Finance – EPSDT Program (Medicaid)
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1218622604254

Health Resources and Services Administration - EPSDT
http://www.hrsa.gov/epsdt/

Health Resources and Services Administration - Maternal and Child Health Bureau
http://mchb.hrsa.gov/

OTHER RESOURCES

"Case Management for Mothers and Children," National Maternal and Child Health Resource Center, Association of Maternal and Child Health Programs, Annual Meeting, May 22, 1988.

"Children with Special Health Care Needs in Managed Care Organizations: Definitions and Identification Family Participation, Capitation and Risk Adjustment, Quality of Care," Division of Services for Children with Special Needs, Maternal and Child Health Bureau, December, 1996.

Colorado Department of Public Health and Environment, Women's Health Section, Colorado Department of Health Care Policy and Financing, Health Plans and Medical Services, *Prenatal Plus Provider Manual*, 2/16/96.

Eden, Joan, M.S.P.H., R.D., "Care Coordination", 1997.

"Enhanced Care for High Risk Individuals," Maryland contract between CSHCN and Medicaid, Attachment 1.E, 1/24/96.

Hamilton, Haynes, Todd, Gomez, Horne, Feldman, Johnson, Knaack, Slay, Care Coordination Training and *Resource Compendium*, Spring, 1998.

Hays, Beverly J., "Nursing Intensity as a Predictor of Resource Consumption in Public Health Nursing," *Nursing Research*, Mar/April, 1995.

McAteer, Patsy, R.N., M.S.N. and Sue Dabiri, "Care Coordination Guidelines," January 29, 1997.

Miller, Jerri and Sandy Petersen, "Colorado Guidelines for Service Coordination," Early Childhood Connections (Part C)

Renken, Catherine A., RN, MPH, Director and Judith Wickman, RN, B.S.N., Nurse Consultant, "CaCoon--CAre COordinatiON," *CaCoon Program Manual*

"Skilled Professional Assessment, Care Planning and Coordination Activities (Enhanced)," Seattle/King County Cooperative Agreement with Washington State Social Services,.

SSDI-Ciss-news: *PIC Alert*, July, 1998.

"Standards for Social Work", *National Association of Social Workers (NASW*), June 1992.

Trierweiler, Karen, C.N.M., M.S., Jane Cotler, R.N., M.S., C.S.N., Jan McNally, R.N., M.S., *An Introduction to Home Visitation,* Colorado Department of Public Health and Environment, March, 1996.

University of Kentucky College of Nursing, *National Standards of Nursing Practice for Early Intervention Services*, July 1993.