Subject: Care Coordination

Effective Date: July 1, 2010

Related Policy: None

Procedures:

When an intake or new application is received, the care coordinator will review it to determine if immediate contact with the family is indicated. This will occur within two working days. Documentation of phone call should be entered into WebBFH. If it is determined that an evaluation is needed for a diagnosis or current status of condition, the care coordinator and the parent will decide on the provider and an authorization will be generated to go to the parent and the provider.

Regardless of CYSHCN eligibility, identification of a need and appropriate referral to resource is part of the Make A Difference philosophy and standard of CYSHCN practice. Documentation should be noted for data analysis for trends in needs and workload then sent to the section director.

The Medical Home concept philosophy and guidance will be used in the development of health care plan (HCP).

1. If the child has a current medical home: obtain a copy of the treatment plan and identify gaps in needed services, local resources and CYSHCN contracting providers who can address the needs. If there is no current health care plan the CYSHCN care coordinator will develop a care plan, review it with the client/family and make needed referrals.

2. If the child has a current medical home and is receiving case management support from a Medicaid contracted independent case manager, mental health providers, or Infant-Toddler services coordination a copy of the current treatment/ health care plan should be obtained. Identify gaps in needed services, network with the primary care coordinator. Authorize CYSHCN covered services using contracting CYSHCN providers. Other providers can be utilized, but CYSHCN cannot participate in funding. Insurance, Medicaid, and parent out-of-pocket payments can be utilized and will be identified on the health care plan.

3. If the child is being seen in a CYSHCN sponsored multidisciplinary clinic, the CYSHCN staff will review the care needs with the family and barriers to access of service or compliance with the treatment plan. Some of the children

utilizing the CYSHCN specialty clinics are not enrolled in the CYSHCN program. Provide education to all families to strengthen their understanding of the disease management, preventive health measures, and age related skills needed for a smooth transition to adult health services, how to connect with local parent support and community resources. Address barriers to service access (public and private insurance options, language interpreters, travel etc.)

Assure the family, PCP, care coordinator and wrap around community agencies receive updates to accomplish the desired outcomes. Obtain current release of information authorizations.

Document care coordination activities for data analysis.

4. If the child does not have a medical home and is qualified for CYSHCN or SSI care coordination and the child already has a medical card, verify if a provider has been assigned. If no provider has been assigned, provide parent with Medicaid contact information to select a provider. Assist parents as needed in the provider selection process. Send family an introductory letter, release of information and assist the family in initiating care with their selected PCP.

5. If the PCP assigned by Medicaid is not the family's choice, give the family the name and information they will need to have the PCP changed.