

Chapter 4

Care Coordinator

In this Chapter

The following sections are covered:

	Section Title	Page
I.	DEFINITION OF CARE COORDINATION	4-1
	A. State CSH Office Activities	4-2
	1. System Building	4-2
	2. Care Coordinator Support	4-3
	3. Client/Family Support	4-3
	B. PHN Care Coordinator Activities	4-3
	1. System Building	4-3
	2. Care Coordinator Support	4-4
	3. Client/Family Support	4-4
II.	WHO IS ELIGIBLE FOR CARE COORDINATION	4-4
III.	QUALIFICATIONS OF CARE COORDINATOR	4-4
IV.	MINIMUM STANDARDS OF CARE COORDINATION	4-5

I. DEFINITION OF CARE COORDINATION

INTRODUCTION

The Maternal Child Health Bureau has defined care coordination as “services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special healthcare needs and their families (MCHB, 1997)”. Care coordination is a dynamic and ongoing process which involves:

- Working with the child and family to identify strengths and needs
- Locating and accessing needed services
- Assuring that services are coordinated among programs and agencies

- Evaluating the effectiveness of service delivery in meeting child and family needs.

The PHN Care Coordinator is responsible for meeting the following community and client/family goals:

- The community is informed about the services provided by CSH and other MCH programs.
- Wyoming children with special healthcare needs will be identified and have access to care coordination services.
- Families will be assisted to gain skills to manage the care of their child.

Children's Special Health provides care coordination services at two levels, at the State CSH office and by the local Public Health Nurse.

A. State CSH Office Activities

1. System Building - (MCH Staff, CSH Program Manager, and CSH Nurse Consultant)

- Serves as State contact for CSH and other MCH programs nationwide
- Participate in collaborative efforts with other state and regional agencies to extend network of services for CSH children and their families
- Maintain database and data collection system
- Monitor program effectiveness through annual visits
- Monitor and track referrals to medical home/primary care and other state and community resources
- Recruit healthcare providers under CSH policies to provide services to eligible clients
- Serve as a liaison between Consultec and healthcare providers, care coordinators, and families

2. Care Coordinator Support - (CSH Program Manager, CSH Nurse Consultant, and Records Analysts)

1. Send notice of eligibility to parents, PHN, and Consultec
2. Track medical appointments
3. Provide orientation, annual training, and assist PHNs in their role as PHN Care Coordinator

4. Generate monthly reminder reports for PHN of clients due for annual update, assist with monitoring case load by providing report of all clients assigned to the care coordinator
 5. Assist with interpretation of CSH policies
 6. Assist with obtaining medical records
 7. Enroll healthcare providers under CSH policies to provide services to eligible clients
3. **Client/Family Support - (Parent Consultant, Nurse Consultant, and Records Analysts)**
- Review records to determine financial and medical eligibility
 - Determine if covered diagnosis and approved provider
 - Screen for care coordination needs
 - Send appointment authorization letters
 - Provide technical assistance to providers and parents
 - Provide parent consultant services and 800# to families
 - Do periodic needs assessments and parent/provider surveys

B. PHN Care Coordinator Activities

1. **System Building**
 - Educate community groups and providers about CSH and other MCH programs
 - Identify local, regional, and State services available for children with special healthcare needs and their families
 - Provide local contact for CSH and other MCH programs
 - Participate in multi-disciplinary team meetings as needed
2. **Care Coordinator Support**
 - Report new and/or change in data
 - Review reports for accuracy and report discrepancies

- Attend annual updates
- Track medical appointments

3. **Client/Family Support**

- Receive referrals and review for eligibility
- Assess child and family's needs
- Assist families in applying for CSH and other services
- Determine priority and care plan to meet family needs
- Assist families to serve as their own care coordinator with support and training when family so chooses
- Help families choose their goals for care coordination services and revise plans based on ongoing evaluation of needs and progress
- Assure referrals to medical home/primary care and other state and community resources
- Organize and attend care coordinator conferences
- Participate in multi-disciplinary team meeting, as needed
- Assist families in receiving information, assistance, and support in planning for transitions related to their child's needs

II. WHO IS ELIGIBLE FOR CARE COORDINATION

All children with special healthcare needs who are state residents. The PHN Care Coordinator is responsible for the program implementation, and thus the ultimate success of the program at the local level.

III. QUALIFICATIONS OF PHN CARE COORDINATOR

Public Health Nurses (PHNs) are the care coordinators for the CSH program because of their holistic approach to the clients, individuals, families, groups and communities and the management of their complex care. Their goal, in collaboration with others, is to promote in each client an optimum level of functioning. Public Health Nurses function in a variety of roles and have expertise in the delivery of services to achieve that goal.

Minimum Qualifications

- Licensed as a Registered Nurse in Wyoming
- State of Wyoming PHN Senior or equivalent County PHN
- Completion of CSH Care Coordination Orientation

IV. MINIMUM STANDARDS OF CARE COORDINATION

Clients referred to the PHN Care Coordinator will receive an initial contact within the time frame listed below:

- All CSH client referrals will be contacted within ten (10) working days after receiving referral.
- 90% of referrals will be completed by the care coordinator and written report will be sent to CSH within 30 days of receiving referral.

PHN Care Coordinator will base activities and contacts per tier level (See TABLE B).

TABLE B

Level of Care	Activities	Minimum Contacts
Tier I	Provide information about providers/vendors so the family can make choices about the use or participation in these services.	X New eligible will have six (6) month follow-up X Face-to-face for annual with financial update
Tier II	Assist in establishing caregiver/client linkage at least part of the time. Follow-up on travel arrangements to assure out-of-town appointments are kept.	X Every three (3) months X Face-to-face for annual with financial update and PRN
Tier III	Assist in making most of the linkages between caregiver/client. Close follow-up for travel arrangements and assisting/assuring family is making appointments. Multiple services coordination.	X Every month X Face-to-face for annual with financial update and PRN

The PHN Care Coordinator will receive a monthly list of all current clients due for an annual update. The updated information will be submitted by the 5th of the following month to the State CSH office to assure all information in the CSH database is current and correct.

The PHN Care Coordinator will attend a minimum of one yearly CSH training. New PHN Care Coordinators will attend the program orientation provided by CSH.

Local healthcare providers will have the following minimum contacts from CSH:

- Local Healthcare Providers - annually
- New Providers - Contact within three (3) months of arrival in community
- Other Community Agencies - every other year