KERN COUNTY MVCCP – DATA FORM

Medically Vulnerable Care Coordination Project

Arthur Manalac, RN, PHN - MVCCP Care Coordinator

(o) 661-868-0248 (f) 661-868-0218

FOR MVCCP USE		
	Insight #	
	CCS #	
	Hospital #	
	Synagis?	Blue Ribbon?

MVCCP collects and analyzes patient utilization data in order to identify and troubleshoot system-level barriers

DEMOGRAPHIC INFORMATION

Today's Date:

(please attach relevant face sheets, referrals, summaries, and/or discharge notes)

Infant's Last Name	Infant's First Name	MI	Mother's Last Name	Mother's First Name	MI

☐M ☐F	DOB	Ethnicity	City	Insurance	DOB	Prim Language	G	P

Synagis?	Birth Hosp/ pt #	BW	GA	APGAR	Hx of preterm labor? *(y/n/unk)*	Interval btw pregnancies <6m? *(y/n/unk)*	Hx of fertility txt? *(y/n/unk)*	Known Hx of Cocaine, ETOH, Meth, tobacco use? *(y/n/unk)*

NICU Hosp	NICU LOS	PCP / Clinic	Mult Birth?	If Multi Birth List Name(s)	Known Hx of amnio fluid/ lower GU tract infxn? *(y/n/unk)*	Known Hx of HTN, diab, lupus? *(y/n/unk)*

MVCCP ELIGIBILITY

(please fax if the following criteria are met)

☐ Less than 37 weeks GA ***OR*** ☐ BW <5.5lb (2500g)	***AND / OR*** *is at risk due to:*	☐ Has family issues that may affect the patient receiving proper and timely care ☐ Has condition that requires medical/developmental screenings and follow-up care over the first year or longer	➡ ***Please fax to MVCCP Care Coordinator 661-868-0218***

ACUITY AND SERVICES

(1=Strongly Disagree 2=Disagree 3=Unsure 4=Agree 5=Strongly Agree)

Medical Coverage

1) Select if present ☑	☐ Uninsured medical expenses					
2) Rating *(circle most appropriate)*	The parent(s) understand health insurance and CCS coverage	1	2	3	4	5
	The parent(s) will enroll in health insurance (i.e. Medi-Cal and/or CCS) in a timely manner	1	2	3	4	5
	The parent(s) are currently able to pay for medical expenses of the infant *(including copay if applicable)*	1	2	3	4	5

3) Indicate Services ✓	Medi-Cal	CCS	SSI	WIC	Non-Profit Payer	Other Medical Coverage Resource:

Community Resources

1) Select if present ☑

- ☐ Unfamiliar with options/ procedures for obtaining services
- ☐ Transportation barrier
- ☐ Difficulty understanding roles / regulations of service providers
- ☐ ***(circle)*** Language barrier / Cultural barrier / Educational Barrier
- ☐ Limited access to care / services / goods
- ☐ Dissatisfaction with services
- ☐ Unable to use / has inadequate communication devices
- ☐ Inadequate/ unavailable resources

2) Rating *(circle most appropriate)*						
	The parent(s) are knowledgeable of local community resources *(i.e. WIC, Family Resource Centers, etc.)*	1	2	3	4	5
	The parent(s) are consistently and appropriately using community resources to assist their child	1	2	3	4	5
	The parent(s) have no problems or barriers connecting to community resources	1	2	3	4	5

3) Indicate Services ✓	Family Resource Center (name)	Head Start (location)	Search and Serve	Caring Corner	Non-profit	CPS	Other Community Resources

Healthcare Supervision

1) Select if present ☑

- ☐ Fails to obtain routine/preventative health care
- ☐ Fails to seek care for symptoms requiring evaluation/treatment
- ☐ Fails to return as requested to health care provider
- ☐ Inability to coordinate multiple appointments / treatment plans
- ☐ Inconsistent source of health care
- ☐ Inadequate source of health care
- ☐ Inadequate treatment plan

2) Rating *(circle most appropriate)*						
	The parent(s) are knowledgeable about the healthcare providers, appointments, and treatment plan	1	2	3	4	5
	The parent(s) are consistent in taking their child to all scheduled medical appointments	1	2	3	4	5
	The parent(s) will continue to receive appropriate and timely health care for their infant	1	2	3	4	5

3) Indicate Services ✓

Growth and Development		*Nursing Care*		*Medical Specialties*		
	HRIF		MVIP	Mental Health	Card	Endocr
	KRC		Kern Co PHN	OT/PT/ST	Ophth	Surgery
				GI	Neuro	Pulmo
				Other Healthcare Referrals		

NAME OF REFERRER	TITLE	AGENCY	SIGNATURE

MVCCP DATA FORM INSTRUCTIONS

(Note: this side does not need to be included when faxing)

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(please attach relevant face sheets, referrals, summaries, and/or discharge notes)

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☐ M ☐ F	DOB	Ethnicity	City	Insurance	DOB	Prim Language	G	P
Synagis?	Birth Hosp	BW	GA	APGAR	Hx of preterm labor? (y/n/unk)	Interval btw pregnancies <6m? (y/n/unk)	Hx of fertility txt? (y/n/unk)	Known Hx of Cocaine, ETOH, Meth, tobacco use? (y/n/unk)
NICU Hosp	NICU LOS	PCP / Clinic	Mult Birth?	If multi birth list name(s)	Known Hx of amnio fluid, lower GU tract infxn? (y/n/unk)	Known Hx of HTN, diab, lupus? (y/n/unk)

MVCCP USE

This section is for Kern County Public Health use only.

DEMOGRAPHIC INFO

If attaching a face sheet, you only need to enter the name.

The next area is data MVCCP needs to track. Please try to complete or attach notes, referrals, and/or discharge summaries that contains as much of the information as possible.

MVCCP ELIGIBILITY

(please fax if the following criteria are met)

☐ Less than 37 weeks GA *OR* ☐ BW <5.5lb (2500g)	*AND / OR is at risk due to:*	☐ Has family issues that may affect the patient receiving proper and timely care ☐ Has condition that requires medical/developmental screenings and follow-up care over the first year or longer	*Please fax to MVCCP Care Coordinator*

MVCCP ELIGIBILITY

If the infant is <37 weeks gestational age or <5.5lbs at birth, **AND / OR** is at risk due to medical or family issues, please fax referral

ACUITY AND SERVICES

(1=Strongly Disagree 2=Disagree 3=Unsure 4=Agree 5=Strongly Agree)

Medical Coverage

1) Select if present ✓	☐ Uninsured medical expenses					
2) Rating (circle most appropriate)	The parent(s) understand health insurance and CCS coverage	1	2	3	4	5
	The parent(s) will enroll in health insurance (i.e. Medi-Cal and/or CCS) in a timely manner	1	2	3	4	5
	The parent(s) are currently able to pay for medical expenses of the infant (including copay if applicable)	1	2	3	4	5
3) Indicate Services ✓	Medi-Cal; CCS; SSI; WIC; Non-Profit Payer; Other Medical Coverage Resource:					

Community Resources

1) Select if present ✓	☐ Unfamiliar with options/ procedures for obtaining services ☐ Transportation barrier ☐ Difficulty understanding roles / regulations of service providers ☐ Language barrier / Cultural barrier / Educational Barrier *(circle)* ☐ Limited access to care / services / goods ☐ Dissatisfaction with services ☐ Unable to use / has inadequate communication devices ☐ Inadequate/ unavailable resources					
2) Rating (circle most appropriate)	The parent(s) are knowledgeable of local community resources (i.e. WIC, Family Resource Centers, etc.)	1	2	3	4	5
	The parent(s) are consistently and appropriately using community resources to assist their child	1	2	3	4	5
	The parent(s) have barriers connecting to community resources? (list______________________)	1	2	3	4	5
3) Indicate Services ✓	Family Resource Center (name); Head Start (location); Search and Serve; Caring Corner; Non-profit; CPS; Other Community Resources					

Healthcare Supervision

1) Select if present ✓	☐ Fails to obtain routine/preventative health care ☐ Fails to seek care for symptoms requiring evaluation/treatment ☐ Fails to return as requested to health care provider ☐ Inability to coordinate multiple appointments / treatment plans ☐ Inconsistent source of health care ☐ Inadequate source of health care ☐ Inadequate treatment plan					
2) Rating (circle most appropriate)	The parent(s) are knowledgeable about the healthcare providers, appointments, and treatment plan	1	2	3	4	5
	The parent(s) are consistent in attending all of their child's scheduled medical appointments	1	2	3	4	5
	The parent(s) will continue to receive appropriate and timely health care for their infant	1	2	3	4	5
3) Indicate Services ✓	Growth and Development: HRIF, KRC; Nursing Care: MVIP, Kern Co PHN; Medical Specialties: Mental Health, Card, Endocr, OT/PT/ST, Ophth, Surgery, GI, Neuro, Pulmo; Other Healthcare Referrals					

NAME OF REFERRER ______ TITLE ______ AGENCY ______ SIGNATURE ______

ACUITY AND SERVICES

(Three parts for each subject)

1) Select all that are present in patient/family

2) Rating Scale: Based on interactions with the parent/guardian, please circle the appropriate number on how confident you agree with the statements.

3) Referrals Made: Please check all referrals you have made as well as programs you know the patient to currently be a part of.

At the end, print your name, title, and date. When completed, please fax to the number indicated.