Children’s Regional Integrated Service System

CCS Case Management / Care Coordination Activities
July 2019

Right care, right place, right time

CCS utilizes a family-centered, culturally appropriate approach for case management/care coordination in which the specific needs of the patient and family are primary. We work within and across service systems with each family to build on their strengths and to enhance their capacity to provide appropriate health care for their child. The following is a list of activities that constitute CCS case management/care coordination.

This definition includes the expected core components of CCS case management when programs are fully funded and staffed. We recognize that, due to funding and staffing shortages, particularly since the budget cuts of the Great Recession, not all counties currently have the resources to undertake every one of the activities in the definition (e.g. some counties currently do not have funding to support social workers or registered dieticians). In addition, in dependent counties, where CCS functions are shared between counties and the state, some of these functions may be performed at the state level (e.g. medical necessity determinations and reviews, authorizations for medical services). At the same time, we wish to acknowledge that many counties do ensure that all these components are available to CCS children and their families.

In the spirit of this “classic CCS model”, CCS strives to provide case management services utilizing a multidisciplinary team (physicians, nurses, social workers*, dietician*, physical and occupational therapists, and administrative support staff) that mirrors the teams at Special Care Centers. This enables CCS to maintain a comprehensive, multifaceted view of the needs of the child, the family, and the providers who serve them. In addition, the CCS case management model is proactive, with case management professionals actively working to identify and meet the needs of children with chronic and complex medical disorders, whose families have limited resources and numerous psychosocial challenges in navigating systems of care for their children.

This definition of CCS case management addresses the critical components in the classic CCS program that predates the Whole Child Model and remains in place in non-WCM counties. In Whole Child Model counties, the expectation, per SB 586, is that health plan case management will include all components of the classic CCS program and that the Department of Health Care Services will ensure that these components are met.

*when fully staffed and funded

Case finding

- Engage in active case finding, to identify children and adolescents who may benefit from CCS services
- Receive referrals from any source, including families, health care providers, schools or community members
- Determine medical eligibility for CCS diagnostic, treatment, HRIF, and MTP services
- Determine residential eligibility
- Determine financial eligibility
- Identify and review all relevant clinical reports, as well as requests from specialists, primary care
providers, pharmacies, durable medical equipment (DME) vendors, the family, and other providers. This includes contacting providers and researching electronic medical records to identify clinical information to support eligibility determination and to inform a case management plan.

- In the event the case does not qualify, or a specific service is not authorizable or related to the CCS eligible condition, consult with the family about other resources available to them to meet their needs.

**Assessments, interventions, and coordination of care**

- Link patients to appropriate CCS-paneled physicians, CCS Special Care Centers, and CCS approved hospitals, according to program guidelines and standards.
- Authorize services related to the CCS eligible condition.
- Review medical necessity for all requests for benefits requiring separate authorization.
- Review plan of care established by CCS-authorized specialists and Special Care Centers; assist the family in identifying and utilizing the most appropriate resources to accomplish the recommended care plan.
- Adjudicate requests for second opinions and out-of-state services.
- Adjudicate requests for inpatient and outpatient rehabilitation for physical disabilities.
- Arrange and authorize Private Duty Nursing services, as medically necessary, and engage in agency nursing resource finding as needed.
- Arrange home-based therapies, as medically necessary, and assist in identifying appropriate agencies.
- Facilitate referrals for mental health services as needed.
- Facilitate referrals for pediatric palliative care services, and oversee the provision of those services.
- Ensure coordination of the child’s care plan between Special Care Centers, community physicians, and the Medical Therapy Program (MTP).
- Maintain overview of utilization of services across the healthcare system, in order to limit duplication and ensure access to the most appropriate services.
- Link patients to appropriate pharmacies for their medication needs and assist providers in determining same. For example, this would include requests by providers to assist in determining which pharmacy may offer compounding services for a specific medication.
- Link and/or refer patients to appropriate medical home as determined by patient’s needs and preferences.
- Link and/or refer patients to programs that coordinate appropriate dental care as determined by patient’s needs and preferences.
- Coordinate appointments with durable medical equipment (DME) vendors and collaborate to identify DME that is appropriate and medically necessary for client.
- Assess patient/family understanding of and responsiveness to overall care plan.
- Conduct multidisciplinary case management team conferences, including CCS professional staff as well as community providers and families as needed, in order to address complex needs and challenges to care coordination.
- Provide professional support to ensure that families remain engaged and children are not lost to follow-up; at minimum, conduct an Annual Medical Review to know when professional support is needed to ensure that families remain engaged and children are not lost to follow-up.
Support for family navigation

- Explain resources available to families and help them to navigate systems in order to obtain the services their children need. This includes services provided by CCS, Medi-Cal, County mental health, Regional Centers, public health nursing and schools
- Educate families and health care providers about the CCS regionalized system of care
- Provide consultation and support to the patient’s educational team in the school setting when requested by patients and/or their families. Educate families on available transportation resources and provide maintenance and transportation services when they are needed
- Link families to helpful community resources, such as peer and family support organizations
- Support patient participation in the community by providing information on community-based activities, such as resources for exercise and socialization for children with physical disabilities
- Reach out to families who are having difficulty maintaining their Medi-Cal enrollment and troubleshoot challenges to maintaining Medi-Cal eligibility

Management of transitions

- Identify medical records needed to facilitate transfers between jurisdictions, and provide those records to the appropriate parties
- Work with selected clients, families, hospital discharge planners, and community partners to ensure safe and successful transitions from the hospital to the home and community
- Work directly with families to accomplish a smooth transition from the pediatric to the adult healthcare system.
- Provide transition assessment and intervention at appropriate age for client and, for selected clients, conduct internal analyses of patients’ transition needs and develop a transition plan

Provider support and assurance of standards

- Recruit interested providers to the CCS program
- Highlight gaps in available services – as identified by providers, families, and CCS program staff – for our state counterparts in the Integrated Systems of Care Division (ISCD)
- Facilitate the provider paneling application process as needed
- Educate health care providers about the CCS regionalized system of care
- Foster close relationships with providers and special care centers in the community and surrounding regions to ensure best practices at all times
- Review services provided in order to ensure that they meet CCS program standards
- Concurrently review inpatient stays to ensure appropriate level of service and to negotiate and arrange inter-facility transfers when necessary
- Assist healthcare providers in identifying resources for needed ancillary clinical services, such as DME, specialized laboratory services, etc.
- Assist healthcare providers and families in identifying resources for needed medical supplies, such as incontinence products, diabetic supplies or enteral nutrition products
- Troubleshoot provider billing and reimbursement challenges