Care Coordination

May 2025

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What is Care Coordination?

- Care coordination is the process of helping the client to access the health care system.

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Why we do this work...

- Promote and protect the health of Iowa's women, children, adolescents, and families
- Provide clients the power of prevention
- Improve health care outcomes through a life course perspective

Who receives Care Coordination services?

- Non-MCO Medicaid enrolled children (birth to 21 years)
- Uninsured or under-insured children (birth to 22 years)

How to Reach Families

- Follow-up from direct care service(s)
- Referrals from providers
- WIC

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Skills of Care Coordination

- Communication skills (verbal & written) that help to develop relationships with clients
  - Listening
  - Cultural sensitivity
- Ability to identify family needs
  - Involve family in the process
  - Refer to appropriate providers
- Knowledge of community resources
  - Establish and maintain linkages with local providers
  - Knowledge of other health related resources

Motivational Interviewing

Motivational Interviewing (MI) is an approach designed to facilitate the resolution of issues that inhibit positive behavior change by actively engaging the client in the process.

The client is the expert. They have the resources it takes to change their own unhealthy behaviors.

The care coordinator's role is to listen and understand their perspective.

Motivational Interviewing Cont.

- The care coordinator is a collaborative client-centered guide and should try to "match" the intervention to the client's current "readiness".

- Try to use open invitation questions – **How, What, and Tell me more**.

- Do you need more training? Go to the Prepare Iowa training site at http://prepareiowa.trainingsource.org/training.

Role of the Care Coordinator

- Educates families on the importance of preventive health care
- Identifies the health needs of the family - medical and dental
- Provides information about available health & support services
- Answers questions regarding health care coverage
- Assists families in locating medical and dental homes and other service providers
- Advocates for children, adolescents, pregnant women and families
- Assists families to become independent health care consumers

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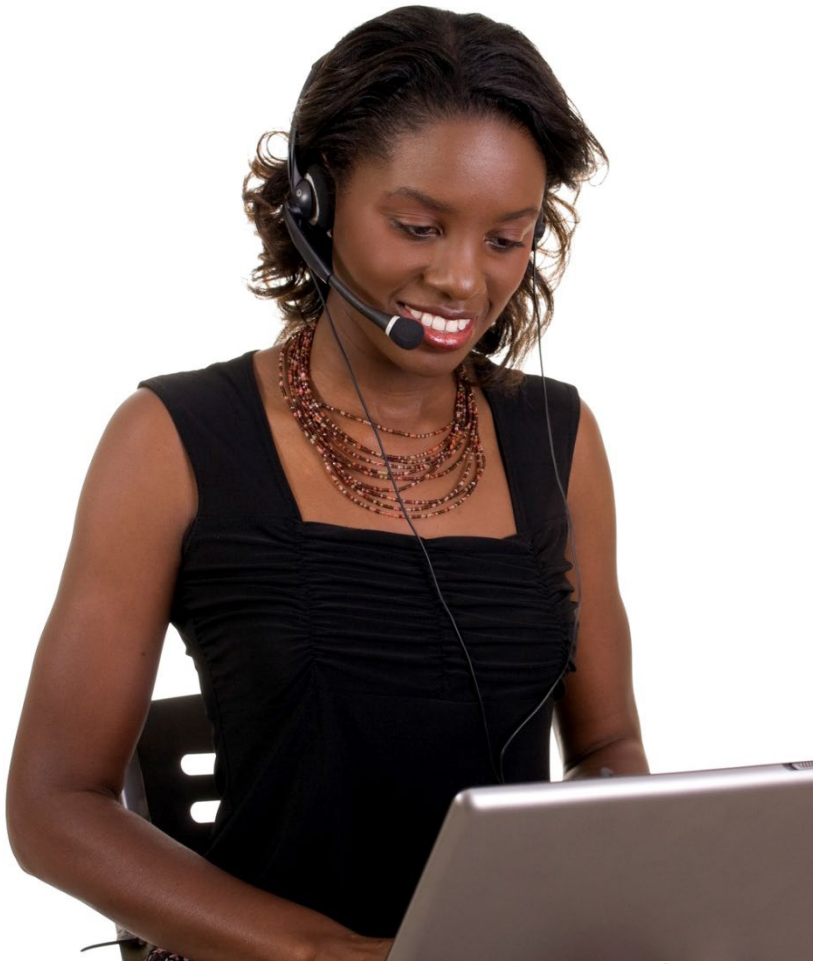
Role of the Care Coordinator Cont.

- Coordinates access to care
  - Schedules appointments (outside of agency)
  - Assists with transportation to Medicaid providers and medical/dental interpretations needs
  - Follows-up to assure clients received scheduled care and assists with missed appointments
  - Assists families when referral for further care is needed
  - Links to other community services



Role of the Care Coordinator Cont.(2)

- Coordinates care to improve child & adolescent health outcomes
  - Assists client in finding a medical home, dental home, and mental health care as needed
  - Remind families of dental exams that are due based on risk assessment and dental periodicity

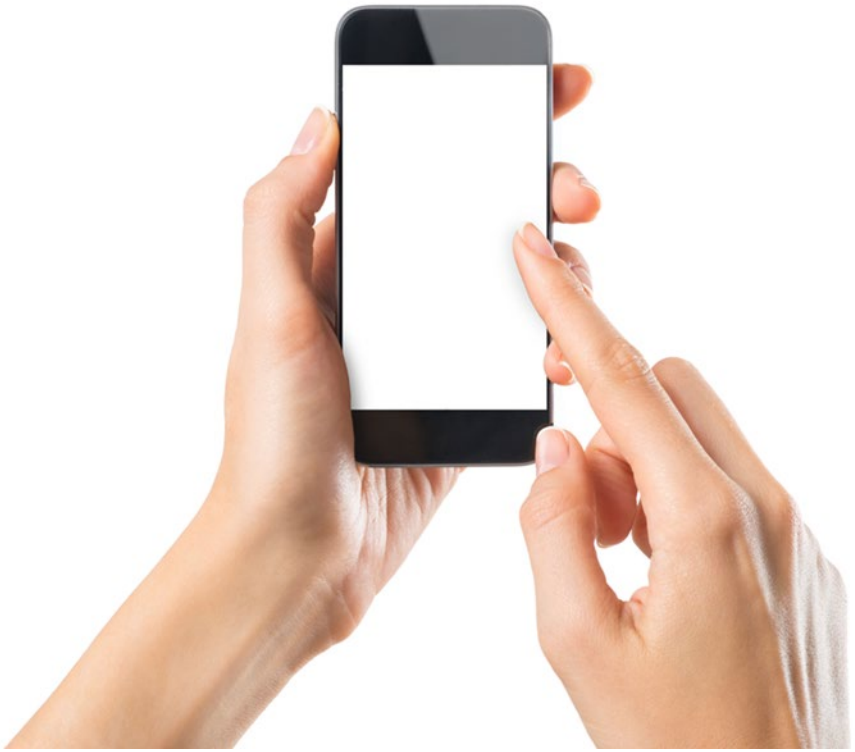
Care Coordination Protocols

- Assure that your agency has a protocol on file for care coordination services including those for referral and follow-up.
- Read your agency's protocol before providing care coordination.
- How is Care Coordination Provided:
  - Phone
  - Face-to-face
  - Text
  - Email

Care Coordination: Phone or Face-to-Face

- These are the preferred formats
- Manner in which most care coordination occurs
- Allows for the most in-depth interaction with the client/family
- All documentation is captured in the MCAH data system

Care Coordination: Texting



- Two way dialogue required.
- Do not use a personal phone for agency business. Be sure to use an agency issued phone.
- Medicaid related services must be the central topic of the care coordination.
- Document the exchange in the MCAH data system according to guidelines.

Care Coordination: Email

- May be used with enrolled clients when phone or face-to-face care coordination is not possible.
- Use of personal email accounts is NOT allowed.
  - Emails sent must be from the employee's agency email address. All responses from the client must be sent to the employee's agency email address.
- Non-secure email may not include protected health information such as: social security #, Medicaid ID #, NOA #, address, or phone #.

Care Coordination: Email Cont.

- Secure email may include Protected Health Information
- One way communication will not be considered payable. There must be a response to the email to be considered payable care coordination.
- The local agency protocol must include means for saving these communications (e.g. client chart, paper file, or electronic file)

Opportunities for CAH Care Coordination

- Presumptive Eligibility
- Home Visits
- Support Services
  - Interpretation (oral)
  - Transportation

Care Coordination during PE Period

- Care coordination to link children and adolescents to needed medical/dental/mental health resources, can be provided anytime during the approved PE period.

Care Coordination: Home Visit

- Care coordination may be provided in a home visit for a medically necessary condition. It can assist families by:
  - Providing information about available health care services
  - Coordinating access to care
  - Assisting clients in making health care appointments (outside of agency)
  - Making referral appointments
  - Coordinating access to needed support services
  - Following-up to assure services were received

Care Coordination: Interpretation

- Links families with interpreters to overcome communication barriers related to client's health care
  - language barriers
  - hearing impairment
- In MCAH data system mark "Yes" for interpreter needed in demographic section

Care Coordination: Transportation

- Links families with transportation resources for visits to Medicaid health providers (medical, dental, mental health)
- This benefit is known as non-emergency medical transportation (NEMT). All Medicaid enrolled children up to age 21, and pregnant women, have transportation available to them.

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Care Coordination specific to Child and Adolescent Health Clients

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Opportunities for Child and Adolescent Health Care Coordination

- Linking clients to periodic well child screens
- Linking clients to a dental visit by age 1 year
- Providing selected components of the Iowa Child Health and Development Record (CHDR)
- Making care coordination home visits for high lead clients
- Referring to a mental health provider
- Linking to family planning services
- Following up on needs identified during a direct care service

Care Coordination: Child Health and Development Record (CHDR)

- Screening forms developed for specific ages by the Iowa Chapter of the American Academy of Pediatrics (AAP).
- Located on the iowaepsdt.org website.
- Care coordination can be payable when addressing sections entitled
  - Development
  - Family/Social History & Risk Factors
  - Anticipatory Guidance
- Document in MCAH Data System
  - Use of CHDR/age range of form
  - Summary of topics discussed
  - Family feedback
  - Issues to be addressed

Care Coordination Home Visit: High Lead Clients

Follow-up by an RN on a blood lead level equal to or greater than 15 µg/dL.

- Includes skilled nursing assessment and instructions to family
- Assists caregivers in making and keeping follow-up appointments
- Reminds caregiver to notify child's lead case manager if the family moves
- Reminds caregiver to inform the child's current and future health care providers of elevated level

In MCAH data system

- Select "Care Coordination Home Visit" as Interaction Type
- Record detailed service notes
- If a direct care service is provided during the home visit, then Care Coordination Home Visit cannot be selected.

Payable Care Coordination for Non-MCO Enrolled Children and Adolescents

Payable care coordination must *include* linkage or follow-up to medical, dental, mental health or other Medicaid covered services/ programs.

Medicaid Covered Services

- Medical, dental services
- Mental health
- Child Health Specialty Clinics
- Early ACCESS
- Area Education Agencies
- Family Planning
- Immunizations
- Lead Program
- Substance abuse
- Hawki coverage
- Interpretation (oral)
- Transportation to medical appointments

Other Possible Services

- Head Start
- Home Visitation
- Child Care
- WIC Program
- Injury Prevention
- Written translation
- Parenting education
- Social services
- Legal services
- Food, clothing, & housing
- Foster care planning/placement
- Shelter services

Documenting Care Coordination

- Document for each client receiving care coordination
- In MCAH data system enter:
  - Demographics, language, and interpreter need
  - County of residence
  - Place of service (if not main agency address)
  - With whom you spoke
  - Issues addressed and Medicaid related concerns
  - For coordination of well child medical & dental services, report timeframe of past or upcoming medical and dental appointments and providers
  - Review immunization status
  - Information/feedback/concerns from family
  - Agency staff response to family concerns
  - Outcomes including referrals and plan for follow-up
  - Name (first and last) and credentials of service provider
  - Intake Assessment addressed
- Maintain a signature log

Documenting non-payable care coordination

- Service notes for care coordination provided as a part of an inform completion should be documented with the inform completion.

- Service notes for care coordination provided on the same date as a direct care service should be documented with the direct care service.

Direct Care and Care Coordination

- Any care coordination on the same day as a direct service is part of the direct service.
- Do not bill or document these activities as care coordination.

- Example: The referral for medical treatment made the same day as the screening is part of the direct care service.
- Document the referral with the documentation of the direct care service. It is not separately payable as care coordination.
- However, follow-up in subsequent days/weeks to monitor care *would* be payable care coordination.


Thank You
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