HCP

A Program for Children and Youth with Special Health Care Needs

	Policy & Guidelines
	Revised 10/01/2017

All Colorado children and youth with special health care needs will be valued, integrated and thriving.

COLORADO
Department of Public
Health & Environment

HCP
Connecting Kids with Care
for *Children and Youth* with Special Health Care Needs

HCP, a program for children and youth with special health care needs

HCP POLICY & GUIDELINES

Table of Contents

HCP PROGRAM OVERVIEW

HCP Vision

All Colorado children and youth with special health care needs will be valued, integrated and thriving.

HCP Mission

The mission of HCP, a program for children and youth with special health care needs within the Children and Youth with Special Health Care Needs (CYSHCN) Section at the Colorado Department of Public Health and Environment (CDPHE), is to ensure that children and youth with special health care needs have the opportunity to grow, learn and develop to their highest individual potential. HCP serves Colorado children and youth with special health care needs, age birth to 21, and is a resource for families, healthcare providers, and communities. HCP works closely with state agency partners and local public health agencies to implement three core program components:

1. HCP Care Coordination
2. HCP Specialty Clinics
3. Medical Home Systems Development

The Maternal and Child Health Bureau has identified core optimal outcomes for children and youth with special health care needs and their families. These six national outcome measures guide program efforts:

1. Families will be partners in decision-making at all levels and be satisfied with the services they receive.
2. CYSHCN will receive coordinated, ongoing, comprehensive care within a medical home.
3. CYSHCN will have adequate private and/or public insurance to pay for the services they need.
4. Children will be screened early and continuously for special health needs and receive timely follow up to definitive diagnosis and clinical management.
5. Community-based services for CYSHCN will be organized so families can use them easily.
6. Youth with special health care needs will have the services necessary to transition to all aspects of adult life including adult health care, work, and independence.

Definition of Children and Youth with Special Health Care Needs

The Maternal and Child Health Bureau defines the population of children and youth with special health care needs as "those who have, or are at increased risk for having, a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children [and youth] generally" (Maternal and Child Health Bureau, McPherson, et al., 1998).

Supporting a Medical Home Approach

The American Academy of Pediatrics, the American Academy of Family Physicians and the National Maternal & Child Health Bureau are promoting medical home partnerships between providers, families, and community organizations, such as local public health agencies, to support the family and providers. Using a medical home approach, families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential. Essential components of a medical home approach include care that is accessible, patient/family-centered, continuous, comprehensive, coordinated, compassionate and culturally responsive. Visit https://www.colorado.gov/pacific/cdphe/children-and-youth-special-health-care-needs-cyshcn-section for more information on Medical Home.

Population Health: A Policy and Systems Approach

Over the past 10 years, the Colorado Department of Public Health and Environment (CDPHE) Maternal and Child Health (MCH) program, under guidance from the Maternal and Child Health Bureau, has increased its focus on population health systems approaches in order to maximize health outcomes for women and CYSCHN. More recently, there's been an increased focus on policy to support population health.

Ensuring Every Child and Youth Experiences a Medical Home Approach

Our role in public health in serving CYSHCN is twofold: ensure that CYSHCN have access to the needed supports and services including coordinated care and specialty care; and strengthening the healthcare system to deliver needed services and supports. As the healthcare landscape in Colorado continues to be strengthened through Medicaid expansion and reform, the services and supports for CYSHCN have also been expanded and strengthened. Moving forward, public health is uniquely positioned to inform, influence, and drive policy and systems change to maximize health outcomes for CYSHCN. This shift is reflected in the reallocation of resources and the focus of the MCH priorities on policy and systems change. Through our CYSHCN focused MCH Medical Home Priority work, we are focusing our policy and systems efforts on three strategic areas:

1. Care Coordination: Increasing Shared Plans of Care (SPoC) for children and youth receiving care coordination services;
2. Specialty Care: Increasing access to pediatric specialty care
3. Information and Resources: Increasing centralized access to information and resources for children and youth and their families.

Each of these areas correspond to a component of the HCP program services. The experiences, challenges and access issues that our families experience - along with input from care coordinators, clinic coordinators and community organizations - are used to inform policy and systems change strategies at the state and local levels.

At the local level, HCP staff are in a position to influence policies and systems that serve CYSHCN within their communities and regions. With this in mind, it is important that HCP staff identify opportunities to apply their experience and knowledge by engaging in policy and systems discussions.

HCP PROGRAM POLICIES & GUIDELINES

The HCP Policy & Guidelines document is intended for agencies that are implementing components of the HCP program and is focused on two of the CYSHCN Section program components: HCP Care Coordination and HCP Specialty Clinics. This document, as well as information about Medical Home Systems Development, is posted online at www.hcpcolorado.org. The hyperlinks throughout the HCP Policy & Guidelines link to companion documents such as Forms, Instructions, Roles & Responsibilities, Training Materials, and FAQ Sheets posted on the HCP Website. The intent of the companion documents is to ensure fidelity to program components and to provide consistent guidance for local public health agencies (LPHAs) and other partners contracted to provide HCP services.

LPHAs and other partners are responsible for knowing and adhering to the HCP Policy & Guidelines, HCP website materials, companion documents, HCP Training Modules, and other requirements as outlined in their individual contracts.

HCP uses this document to define requirements and clarify expectations; however, each agency is expected to determine the best way to meet those requirements.

Training Requirements

HCP Orientation

LPHAs and other program partners are expected to complete HCP Orientation and program Training Modules as they become available, and as appropriate, for all HCP components. Select online training is available on our website under partner and provider resources.

1. LPHAs should notify their state HCP Consultant of any changes in local HCP staffing, including vacancies and new hires within 15 business days of change date.
2. New LPHA staff should register for and complete the HCP Orientation session (offered monthly) within 45 days of start. If there is a conflict, please contact your HCP Consultant to determine next steps.
3. New LPHA HCP staff will complete HCP Orientation and Training Modules within 45 days of start.
4. New LPHA HCP Managers will contact their state HCP Consultant for an HCP overview within 45 days of start.

Patient Navigator Training

RECOMMENDATION 1: Agencies are encouraged to build Patient Navigator competencies into their job descriptions as minimum requirements for HCP team members.

RECOMMENDATION 2: Agencies are highly encouraged to complete Patient Navigator Training through the Colorado Patient Navigator Training Collaborative, as outlined below. It is important that agencies know:

- the courses are free to Colorado residents.
- agencies may use training funds from their HCP budgets to attend patient navigator training, and other training that directly supports the work of HCP.
- coursework requirements are divided into two categories: *"Recommended"* and *"Nice to Have"* (refresher courses and/or advanced work). These categories take into account competencies already met by licensed staff (nurse or social worker), including nurse supervisors.
- if care coordination activities are delegated to non-licensed HCP team members, those team members are encouraged, at a minimum, to complete level 1 of the Patient Navigator Training. *NOTE: It's understood that many level 1 Patient Navigator Training courses, if not all, will eventually be made available on-line.*

COURSE LEVEL / NAME	RECOMMENDED			NICE TO HAVE		
	Licensed Supervisor	Licensed Staff	Non-Licensed Staff	Licensed Supervisor	Licensed Staff	Non-Licensed Staff
Level 1 - Patient Navigator Fundamentals (3.5 days)			x			
Level 2 – Advanced Motivational Interviewing (1 day)		x				x
Level 2 – Advanced Care Coordination (1 day)		x				x
Level 2 – Advanced Health Literacy (1 day)		x				x
Level 2 – Social Determinants and Health Equity (2 days)				x	x	
Level 2 – Facilitation (2 days)				x		
Level 2 - Emotional & Social Aspects of Disease (online)					x	
Level 2 - Advanced Health Behavior Change course (online + 1 day)					x	
Level 3 - Leading and Administering a Patient Navigation Program (1 day)				x		
Level 3 – Using Evaluation for Program Improvement and Capacity Building (2 days)				x		

CYSHCN Data System (CDS)

The CYSHCN Data System (CDS) is the data system used by LPHAs contracted to provide the care coordination and specialty clinic components of HCP: these LPHAs are required to enter data into CDS. HCP has statutory authority to operate and maintain a program for children with disabilities *(CRS Title 25; Article 1.h, Letter (r))*. CDPHE collects the minimum data necessary to operate and

maintain this program (HCP) through the CYSHCN Data System (CDS). HCP state and local offices use the data for assessment, planning, evaluation, reporting, and, in some cases, contract monitoring.

1. Access to CDS will be granted to local HCP staff, including care coordinators, support staff and managers. Expressed written consent from a supervisor or HCP program manager is required to be sent to the agency's HCP Consultant prior to the accounts approval in CDS. Additionally, CDS user accounts that remain inactive in CDS for 6 months will be deactivated. Should access to CDS be required after that time, users can request a new account, but will be required to re-submit written supervisor approval.
2. HCP staff shall enter data into CDS within 30 days of a client contact, including, but not limited to, care coordination and/or specialty clinic documentation.

Internet Browser Requirements

CDS will operate on all modern internet browsers that are the equivalent versions (or newer) of each of the following:

Chrome	
Firefox	
Safari	✓ **Last Two Versions**
Opera	
Mobile Safari	
IE Mobile	
Internet Explorer	✓ **Versions 11+**
Android Browser	✓ **Versions 2.3+**

It is **required** that users periodically update their internet browser and clear their cache to keep CDS functioning at its highest capacity. Outdated browsers can prevent CDS updates from taking effect and cause issues with the overall functionality of the program. Instructions for clearing the cache can be found under the "help" feature of any internet browser. Additional questions regarding this process can be directed to the HCP Data Manager.

Promoting Bidirectional Learning & Communication

The following tools promote learning and communication between state and local HCP teams:

1. **HCP Meetings:**
    a. Bi-monthly HCP Statewide meetings:
        i. HCP Statewide Meeting Materials are available on our HCP website.

> ii. Agencies are expected to designate appropriate personnel to attend and participate in scheduled HCP statewide meetings: plan on assigning at least one representative to attend each meeting.
>
> b. Other meetings:
>> i. Agencies are expected to designate appropriate personnel to attend other HCP meetings (i.e. annual meetings, training sessions), as organized by the CDPHE HCP Program.

2. **HCP Blast:** HCP teams are expected to read the monthly HCP Blast for relevant information regarding program updates, training opportunities, and more. If you do not receive the HCP Blast via email, please contact your HCP Consultant.
3. **HCP website:** HCP teams are expected to regularly review website documents and content for updates. Changes to documents or website content will be highlighted in the HCP Blast.
4. **Google Docs / Google Forms / Google Chrome:** From time to time, state HCP Consultants will share documents and/or request feedback from LPHA HCP teams using Google Docs or Google Forms. Agencies are asked to work with their IT personnel to ensure access to HCP program materials using Google Chrome.

HCP Consent and Release

LPHAs are required to obtain a signed Consent and Release of Information form from families who receive HCP Care Coordination and/or are seen at HCP Specialty Clinics. The form must be updated at least annually, or as required by LPHA policies. Agencies may use their own form, provided that it is approved by their local HIPAA compliance officer. Talking points are available on our website under *Training* to help HCP teams talk to caregivers about the document.

We strongly suggest that agency forms include the following considerations:

1. Notice of data storage – describes the CDS database and associated risks
2. Notice of privacy practices
3. Information to be released / Supporting Educational Needs – includes information necessary to exchange information between schools and HCP

Transportation

HCP Specialty Clinic Coordinators and/or HCP Care Coordinators are not responsible for the direct transport of pediatric specialists or clients to or from clinics and are encouraged to consult their LPHA policies and guidelines concerning transportation and liability. However, helping families learn how to access and arrange transportation is an appropriate care coordination activity. (*See HCP Care Coordination Section for documentation requirements.*)

Monitoring

Monitoring is a contractual obligation and should be done in partnership with state HCP Consultants. Contract and program requirements will both be monitored; however, the overall purpose of monitoring is to enhance communication, program planning and evaluation efforts, and to determine

the need for resources and technical assistance. This will be accomplished through a variety of mechanisms, including but not limited to:

1. LPHAs are expected to monitor their care coordination caseload volume, including individual progression through the HCP Care Coordination model using reports available within CDS. State HCP Consultants recommend running reports at least quarterly; however, monthly may be more helpful depending on caseload volume.
2. LPHAs are expected to connect with their HCP Consultant at least once per year, unless additional technical assistance (TA) is needed or as contractually required.
3. LPHAs can expect that:
    ● State HCP Consultants will provide a brief written summary, with highlights following a site visit.
    ● State HCP Consultants are available between visits, as needed, for troubleshooting, training, etc. via telephone or email.

Community Outreach & Marketing of HCP

LPHAs are expected to conduct outreach to community organizations to establish connections and strengthen referral systems for CYSHCN with HCP.

To ensure that HCP communications are coordinated, consistent and meaningful, in the spring of 2015, HCP Consultants with the help of a communications workgroup developed a HCP Communications Policy & Guidelines tool for LPHAs to follow. This tool is located in the Appendices section of this document and serves to help HCP clinic and care coordinators as they conduct local outreach to families and partners within their communities. In addition, the document provides guidance on using HCP communications materials, including programmatic requirements, as well as outlines LPHA marketing efforts such as brochures and webpages.

LPHAs are expected to work with their HCP Consultant to determine the amount of time dedicated to community outreach and shall report their efforts in the HCP Annual Report which is due no later than October 31.

2-1-1 Requirement

Agencies are required to share a minimum of five (5) community resources per year to ensure the 2-1-1 Colorado website includes resources relevant to CYSHCN in your local community. Prior to submitting a minimum of five local resources, we encourage agencies to search the 2-1-1 Colorado website to determine whether these resources are already listed.

Continuous Quality Improvement

State HCP staff, in collaboration with LPHAs and other partners, will work to collect aggregate HCP Care Coordination / HCP Specialty Clinic data to help inform state and local decision-making processes and to ensure that HCP is meeting its vision and mission. This includes but is not limited to completion of planning forms and annual reports, family surveys, key informant interviews, follow-up and exit surveys, and focus groups.

Translation & Interpretation

LPHAs receiving federal funding must ensure that they will comply with applicable provisions of federal civil rights laws and policies prohibiting discrimination, including but not limited to Title VI of the Civil Rights Act of 1964, which prohibits recipients from discriminating on the basis of race, color, or national origin, which includes limited English proficiency (LEP). Translation and interpretation is a requirement for all programs receiving Federal MCH Block Grant Funding.

Effective communication with LEP individuals requires LPHAs to have language assistance services in place. There are two primary types of language assistance services: oral and written.

- LPHAs may need to identify and translate vital documents to ensure LEP individuals have meaningful access to important written information.

- LPHAs are required to provide interpretation in the family's native language for any family who does not understand the English spoken language. This includes providing interpretation services for individuals who may use American Sign Language. (see section on ADA, and effective communication 36.303)

More information and guidance can be found in the 'Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs', as well as on our website under the Training section.

Americans with Disabilities Act (ADA)

LPHAs receiving federal funding must ensure that they will comply with applicable provisions of the American's with Disabilities Act (ADA), including but not limited to, Title III, Section 504. "No individual with a disability in the United States, can be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Title III of the ADA applies to all healthcare facilities, regardless of the size of the office, or number of employees. This includes hospitals, nursing homes, psychiatric and psychological services, offices of private physicians, dentists, and health clinics.

HIPAA

LPHAs must adhere to their agency's policies and procedures regarding protected health information (PHI), confidentiality, consent and release of information, and records retention/storage.

HCP CARE COORDINATION

Care coordination addresses the interrelated behavioral, developmental, educational, financial, medical, and social needs of an individual in order to optimize health and wellness outcomes. *Care coordination is a person-and-family-centered, assessment-driven, team activity designed to meet the needs and preferences of individuals while enhancing the care giving capabilities of families and service providers (Colorado Care Coordination Resource Guide, June 2013).*

HCP provides care coordination services that aim to improve the quality of life for CYSHCN and their families by improving their abilities to appropriately and effectively utilize the health care system in collaboration with the child/youth's primary care provider. *The primary goal of HCP is to equip families with the skills, resources and knowledge needed to be confident in coordinating and advocating for their child's health care needs.*

HCP Care Coordinators shall work with families to:

- promote participation in decision making
- promote independence
- identify community and state services and resources
- help with referrals to community and state services and resources
- provide education and guidance in coordinating health care
- promote communication between providers and community resources

- coordinate access to pediatric specialty care
- navigate options to help pay for health care
- coordinate transition to adult health care
- assist with identifying respite care resources
- collaborate with a child's health care providers
- support a medical home approach using evidence based activities

Policy & Guidelines

Staffing & Competencies
1. Staff who support the delivery of HCP Care Coordination services are to deliver services according to the HCP Care Coordination model.
2. Agencies must ensure that the work is being done by the appropriate individual, paying attention to licensure and scope.
3. The HCP Care Coordination model supports a multi-disciplinary team approach, when appropriate and feasible.
    a. The HCP team must include a registered nurse.
    b. Patient Navigators or other non-licensed HCP team members may carry a caseload and/or provide support to families, if delegated by a nurse or social worker.
    c. It is appropriate to assign a licensed professional (nurse or social worker) as team lead for oversight.
        i. Licensed professionals are always working within their licensure and should provide oversight and delegate as appropriate.
2. HCP team members providing care coordination must be able to meet and/or exceed the Patient Navigator (PN) Entry-Level Competency Statements.

LPHA Capacity

1. HCP Information Only requirements:
    a. LPHAs must provide information and resources to families and community members seeking resources, as a core public health service.
    b. Agencies will submit targets for these services annually as part of the HCP planning process.
    c. Agencies will be required to track and report progress on targets. See Information Only section for details.

2. HCP Care Coordination Caseload requirements:
    a. Effective October 1, 2016, agencies will be expected to meet or exceed a ratio of one full time employee (FTE) equivalent to 58 clients (1:58) average ratio for the budgeted year. Using this ratio, agencies calculate targets based on the number of FTE included on the care coordination budget. Agencies must reach the percent of the targets specified in their contract deliverables.
        i. FTE totals include any work supporting the delivery of care coordination efforts, including administrative time & community outreach/education. Manager oversight and agency level administration are not included in the FTE calculation.
        ii. An agency with significant information only numbers may be able to substitute information only calls to meet care coordination targets. Requests for substitution will be considered by the CYSHCN Section and HCP Consultant on a case-by-case basis.
        iii. Agencies may be allowed to adjust this requirement, in collaboration with their HCP Consultant and with permission from the CYSHCN Section Manager, for the purposes of piloting innovative solutions to meet community-based care coordination needs and positively impact Social Determinants of Health (SDoH).

3. Funding:
    a. If the percent of target met as specified in the contract is not reached, the CDPHE CYSHCN Section reserves the option to cap in proportion to the target reached, the funding that can be budgeted for care coordination the following contract year. The difference in funding amount due to the cap may be added to other MCH priority budgets at the discretion of the agency.
        i. Once this cap is in place, it will not be allowed to increase unless targets are exceeded in the following year. The planning form for the subsequent year will still need to meet the outlined HCP requirements in order to remove the cap.

4. LPHAs are responsible for providing care coordination and/or linking children living within their jurisdiction to care coordination services, unless arrangements have been made with a neighboring LPHA to assume this role.
    a. For children living in counties that have opted out of HCP Care Coordination, local HCP staff is expected to refer the child/youth and their family to their primary care provider, Regional Care Collaborative Organization (RCCO) and/or other community-based organizations for assistance coordinating their care, as appropriate.

b. For children living in counties that have opted in to HCP Care Coordination, local HCP staff is encouraged to collaborate with primary care providers, the RCCO and/or other community-based organizations to coordinate triage and referral for care coordination services, to maximize resources and avoid duplication of services.

c. LPHAs, in collaboration with their RCCO, are encouraged to work toward developing a formal agreement to facilitate the sharing of client information and establish roles and responsibilities for care coordination in the region to maximize resources and avoid duplication of services.

HCP Care Coordination Model

LPHA's are expected to comply with the HCP Policy and Guidelines and the HCP Care Coordination Model. The HCP Care Coordination model consists of the following elements and processes:

HCP Care Coordination Model
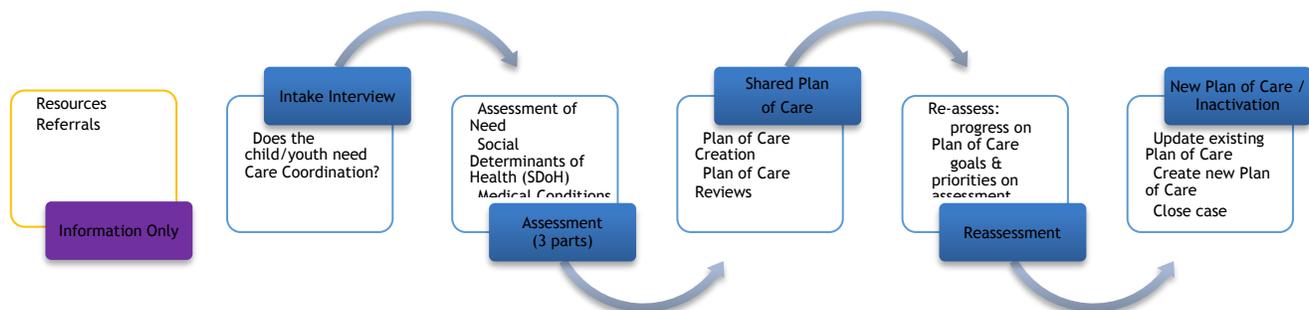
Information Only

In the HCP model of care coordination, providing resources for CYSHCN is referred to as 'Information Only.' It encompasses all information, education, resources, and/or referrals given to families, providers, and other community agencies, when the family does not want or need the full model of HCP Care Coordination.

1. All LPHAs, as a component of their Core Public Health Services, are required to provide, at a minimum, information, resources, and referrals to families, providers, and other community agencies.
2. LPHAs contracted to implement HCP care coordination are required to enter 'Information Only' data in CDS, and are required to provide these numbers as a part of their HCP Annual Report.

Agencies are expected to appropriately categorize families into information only. If an agency is providing information, resources or referral, including consultation to another entity, it should be tracked under Information Only. Educating other community organizations or providers about HCP may also be tracked as information only and should be categorized as *Outreach*. For any other questions related to this process, please consult your team lead and loop in the HCP Consultant as needed.

Intake Interview

The 'Intake Interview' is the first core component of the HCP Care Coordination model. The HCP Care Coordinator uses the Intake Interview to determine whether or not the family needs and wants care coordination. The tool is used to identify and support the family's strengths, concerns, culture, and values. It also is used to collect baseline data about HCP clients before care coordination activities begin.

1. The HCP Care Coordinator must conduct an Intake Interview with each child/youth and their family who may want or benefit from care coordination. The Intake Interview must be documented in CDS.
2. A new Intake Interview is to be completed and entered into CDS when:
   a. a client has been inactivated in CDS and needs to resume care coordination at a later date; a client has transferred between counties and wishes to continue participating in HCP Care Coordination. (Note: Prior to transfer, the client must be inactivated. See the [Transfer protocol](#) training handout for more information.)

In either case, to reactivate a client in CDS, a new Intake Interview must be conducted and documented in CDS before continuing to a new Assessment.

Assessment of Need – 3 parts: Assessment, SDoH, and Medical Conditions

1. **The 'Assessment'**

   The Assessment **is the second core component of the HCP Care Coordination model. The Assessment provides an opportunity to explore, build, and strengthen the relationship with the family, as well as learn about and consider the child/youth's special health care needs and the family's concerns, strengths and goals.**

   1. Every child/youth receiving HCP Care Coordination must have an Assessment on file which has been documented in CDS.
   2. The HCP Care Coordinator must review and update the Assessment every six months, or more frequently as needed, and such reviews must be documented in CDS as an *Assessment Review*.
   3. The HCP Care Coordinator must use the information from the Intake Interview and Assessment to create and update the Plan of Care.
   4. The HCP Care Coordinator must complete an Assessment with each child/youth and their family prior to moving on to the Shared Plan of Care.

   HCP does not require that the assessment process be completed by a licensed professional (nurse or social worker); however, if delegated, assessments and shared plans of care must be created by a trained Patient Navigator. This work must be monitored by a licensed professional. *(See Staffing & Competency section, above.) HCP teams must include at least one (licensed) nurse.*

2. **Social Determinants of Health**

   The Social Determinants of Health (SDoH) questions are used to determine Federal Poverty Levels (FPL) and must be collected during the assessment process. Documentation of the SDoH fields in CDS is a requirement: the HCP Care Coordinator uses the responses to the SDoH questions to help identify appropriate community and state services and resources for the child/youth and family.

   HCP Care Coordinators must review this information with the family each time they complete an Assessment Review and any changes should be documented in CDS. If no updates are made to

the data entered in CDS in a year's time, the HCP Care Coordinator will be prompted to verify that the information is still accurate. Use CDS report 001 to monitor review of SDoH entry. If the box on 001 becomes unchecked at a year's time (because the information has not been marked as reviewed), users will receive a "*My Tasks*" prompt to update the information.

3. Medical Conditions

The Medical Conditions form is a place to document the child/youth's medical condition(s). It is required that medical conditions are documented in CDS for each client. This information helps guide HCP Care Coordination activities and identification of potential community and state services and resources and/or referrals. The medical condition(s) must always be kept up-to-date in CDS with the most recent and accurate information.

HCP Care Coordinators must review this information with the family each time they complete a review and document any changes in CDS. If no updates are made to the data entered in CDS in a year's time, the HCP Care Coordinator will be prompted to verify that the information is still accurate. Use CDS report 001 to monitor review of medical condition entry. If the box on 001 becomes unchecked at a year's time (because the information has not been marked as reviewed), users will receive a "*My Tasks*" prompt to update the information.

Shared Plan of Care

A written *Shared Plan of Care* is the third core component of the HCP Care Coordination model. The shared plan of care is intended to be a family-friendly, take-away document and is developed in partnership and *shared with* the child/youth, their family, the HCP Care Coordinator, the CYSHCN's primary care provider, and/or any ancillary service providers identified by the family. This is the child/youth's health care team. Appropriate communication and sharing between members of the child/youth's health care team supports the continuous and coordinated components of a medical home approach. The value of a shared plan of care is evidenced by care that is well coordinated across all involved organizations and systems.

The HCP Shared Plan of Care is used to create goals and next steps for the child/youth and their family related to current care coordination needs.

1. The HCP Care Coordinator must create a Shared Plan of Care for each child/youth and their family who is receiving care coordination. The plan of care must be documented in CDS, and include:
    a. Identification of which pre-populated goal statements have been included on the HCP Shared Plan of Care. Goal statements are flagged and pre-populated in CDS when a family answers "NO" or "Don't Know/Not Sure" to questions 1, 8 or 10 on the Intake Interview.
    b. Other goals added to the current plan of care.
2. The HCP Care Coordinator must develop and prioritize the plan of care goals in partnership with the child/youth and their family.
3. The HCP Care Coordinator must provide the family with a print copy of the Shared Plan of Care.

4. The HCP Care Coordinator must share/communicate the plan of care to other identified health care team members, as appropriate.
5. The HCP Care Coordinator must review and update the Shared Plan of Care as frequently as needed in order to help the child/youth and their family achieve and/or make progress on established goals.
    a. The plan of care drives the work: best practice is to develop a timeline for achieving goals outlined on the Shared Plan of Care, as well as review and follow-up. The plan of care must be reviewed with families for progress regularly to maintain engagement, understanding and promote progress.
    b. *Shared Plan of Care Reviews* must be documented in CDS, including identifying which goal statements have been completed on the Shared Plan of Care and with whom the plan of care has been shared.
    c. It is expected that HCP Care Coordinators review the Consent and Release of Information form regularly to ensure that consent is given to share the plan of care with all identified health care team members. See HCP Consent and Release section for additional information.

Clients not receiving active care coordination must be inactivated in CDS. Active care coordination is defined as a child/youth moving through the HCP Care Coordination model and having a current Shared Plan of Care. If a specific goal and activity cannot be identified, the individual must be discharged from the program and inactivated in CDS.

- Calling periodically to check-in on a family is not considered a care coordination activity.
- Examples of appropriate care coordination activities include: supporting connections to community resources and schools, transitions (hospital, school), transitioning to adult care. See page 14 of the HCP Policy & Guidelines document for other ways to support CYSHCN.

Assessment Review

The Assessment Review is the fourth component of the HCP Care Coordination model. HCP Care Coordinators must complete a review of a child/youth's progression through the HCP Care Coordination model at least every six-months. This Assessment Review is a comprehensive review of the activities and documentation from that period.

1. A reassessment of strengths and concerns is completed by reviewing the child/youth's most recent Assessment forms (Assessment, SDoH and Medical Conditions) and Shared Plan of Care and should occur after any of the following events:
    a. Child/youth and their family's situation or conditions dramatically change prompting reprioritization of family goals and activities.
    b. Child/youth and family have achieved the established goals, as identified on the current written Shared Plan of Care.
    c. Six months have elapsed since the last Assessment Review (fka Reassessment).
2. The Assessment Review should result in one of the following activities or outcomes:
    a. Identification of barriers to achieving established goals and an update the Shared Plan of Care for continued progress.

      b. Identification of new priorities and goals and creation of a new Shared Plan of Care.

      c. Case Inactivation.

3. The HCP Care Coordinator must document both the Assessment Review and Shared Plan of Care Reviews in CDS, including documenting family responses to Follow-up and Exit Surveys. If a family has been lost to follow up, they must be inactivated from the system: be sure to document in CDS accordingly.

Case Inactivation

The fifth core component of HCP Care Coordination is 'Inactivation'. After the Assessment Review, if it is determined that all priorities and goals have been achieved by the family and no further priorities or goals are identified, the HCP Care Coordinator and family should move to Case Inactivation. It is important that all parties understand that the family can return to HCP Care Coordination at any time, should the need arise.

Remember, the goal of HCP Care Coordination is to equip families with the skills, resources and knowledge needed to be confident in coordinating and advocating for their child's health care needs ... on their own.

Questions to ask when considering Inactivation:

- Does child/youth need the intensity of services HCP Care Coordination provides? If a family needs less support (infrequent contact, less intense), or is receiving care coordination elsewhere and the role of HCP cannot be identified, HCP Care Coordination may no longer be the best option.
- Does it make sense to transition care coordination activities to the child/youth's primary care provider, RCCO, or another community-based agency?

Clients not receiving active care coordination must be inactivated in CDS. Active care coordination is defined as a child/youth moving through the HCP Care Coordination model and having a current Shared Plan of Care.

Delivery of Service

HCP staff is encouraged to adhere to a focused timeline for delivery of HCP Care Coordination services, as illustrated in the example below.

Timeline for Delivery of HCP Care Coordination Services

Referral received.

**Day 14
(January 14)**

Intake Interview completed.

Assessment completed and Shared Plan of Care created.

**Day 60 - 150
(March - May)**

Plan of Care reviews.

Assessment Review & Plan of Care Review New Plan of Care or Case Closure

**Day 0
(January 1)**

**Day 45
(February 14)**

Day 180
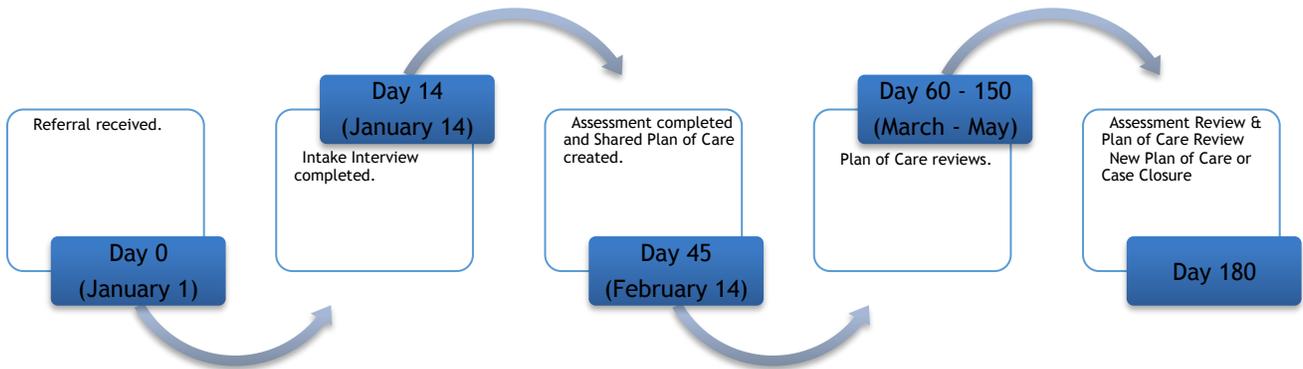
The intent of this focused approach is to address the family's needs while empowering them to navigate day to day issues that affect their family. A family receiving care coordination services should ideally progress through the HCP Care Coordination model - and the identified goals and activities - in approximately six months. Within those six months, families should demonstrate measurable progress toward meeting their care coordination goals.

HCP is Not …

We frequently receive questions asking us to clarify activities that are outside the scope of HCP. Here is a short, but not exhaustive list:

1. <u>A developmental surveillance program</u> – Developmental surveillance is not a function of HCP care Coordination. HCP staff are expected to provide information and where appropriate, referrals to organizations that provide developmental screening services.
2. <u>A home visitation program</u> – While HCP teams may visit homes in the course of implementing the program, the program is not a home visitation program.
3. <u>Skilled nursing</u> - HCP requires at least one nurse per team; however, skilled nursing is outside the scope of this program. Should a family need skilled nursing, the expectation is that families be provided with a referral.
4. <u>A funding source</u> - HCP does not pay for any services or equipment, including but not limited to: physician services, therapies, hospital care or tests, nursing services, dental or orthodontic care, braces, prosthetics, health insurance, hearing tests or aids, or durable medical equipment.
5. <u>Systems Work (medical home)</u> - Systems work related to the CYSHCN population is part of either the developmental screening or medical home MCH priority work. Outreach and community education can still be part of the care coordination budget. In order to continue to make HCP a more cost effective program, agencies electing to participate in systems level work should first consider selecting the medical home or developmental screening MCH priority. However, for agencies that do not select one of these priorities, these activities may not be charged to care coordination budgets. It is acceptable for agencies to leverage other funding for this work. Contact your HCP Consultant with questions.

HCP SPECIALTY CLINICS

Purpose & Future of the HCP Specialty Clinics

CDPHE will contract with CU Medicine (fka University Physicians, Inc. or UPI) and LPHA specialty clinic host sites if FY18 (October 1, 2017 through September 30, 2017) to:

- Provide access that would otherwise not be available to specialty care in rural and frontier communities of Colorado, in the areas of Neurology, Orthopaedics, and Rehabilitation.
- Coordinate pediatric specialty care in collaboration with local primary care providers and model a medical home team approach for the children and youth with special health care needs and their families who receive care through HCP Specialty Clinics.
- Transform the current HCP model to a more comprehensive and sustainable statewide model by:
    - conducting a statewide scan of pediatric specialty care
    - developing plans to increase patient access to more specialties
    - establishing and enhancing local telehealth options and increasing access and touch points for families
    - facilitating regular meetings of statewide partners (ie LPHAs, RCCOs, HCPF, CHCO, families) to identify systems and policy changes or recommendations, as well as opportunities to leverage resources

HCP expects that the following principles guide the implementation of specialty clinics:

1. Any child/youth can be referred and receive care in any HCP Specialty Clinic location throughout the state, regardless of their county of residence.
2. Clinic locations shall be determined based on need and geographical considerations that affect access.
3. HCP shall work to:
    a. ensure continued access to high quality, specialized services for children and youth with special health care needs.
    b. improve the overall efficiency of HCP Specialty Clinics to maximize the number of children and youth with special health care needs who are able to access care.
    c. prioritize resources to increase access to care in rural areas of Colorado.
    d. establish standard processes across clinic locations to ensure that children and youth with special health care needs and their families experience a consistently high quality of care.
4. HCP Specialty Clinics and pediatric specialists shall support a medical home approach through communication with and referral back to the child/youth's primary care provider to promote coordinated care.

Policy and Guidelines

Through HCP Specialty Clinics, HCP aims to reduce barriers to families such as cost, lost work or school time and travel, and minimize the number of trips to Metropolitan areas for specialty care that a family might otherwise have to make.

The purpose of the HCP Specialty Clinics Policy and Guidelines is to provide consistent guidance for CU Medicine, the University of Colorado School of Medicine departments and LPHAs contracted to host and/or staff HCP Specialty Clinics.

Staffing

1. CU Medicine / Children's Hospital Colorado (CHCO) shall provide credentialed pediatric specialists in Neurology, Orthopaedics, and Rehabilitation medicine, including replacement providers for HCP Specialty Clinics as needed. The providers must provide oversight of health care provided at HCP Specialty Clinics.
2. LPHA host sites must ensure that HCP Specialty Clinic teams meet HCP Specialty Clinic Standards:
   a. Teams are led and/or supervised by a registered nurse (RN).
   b. Each clinic day will have at least 2 staff persons present at each clinic, one of which must be a nurse.
   c. The HCP nurse must participate in triage activities.
   d. An interpreter must be onsite during clinics, when needed.
3. HCP Clinic Coordinators and LPHA host site support staff are to coordinate Specialty Clinics (including all pre-, day of-, and post-clinic activities) according to the HCP Specialty Clinic Policy and Guidelines, the HCP Specialty Clinic Training Guide, and referenced companion documents.

Referring a Child to HCP Specialty Clinic

1. CU Medicine / Children's Hospital Colorado (CHCO) shall provide specialty clinic services to children and youth who are authorized or referred by a primary care or other specialty provider.
2. Referrals for HCP Specialty Clinics must come from a referring physician; LPHAs (and/or the HCP Care Coordinator) from the child/youth's county of residence are encouraged to help facilitate completion of the HCP Referral Form as needed.
3. HCP Care Coordinators and HCP Specialty Clinic Coordinators are responsible for understanding their individual roles and responsibilities.
4. The HCP Specialty Clinic Coordinator will use the referral form to refer the family to their local public health agency for any community-based information and resources and/or care coordination, as needed/available.

Record Release from HCP Specialty Clinics
1. Requests for HCP Specialty Clinic records can only include HCP Specialty Clinic forms, including the HCP Specialty Clinic Referral Form, HCP Specialty Clinic Medical History, and the HCP Specialty Clinic Visit Record.
2. Copies of any records obtained by the HCP Specialty Clinic Coordinator cannot be sent to another agency or party. Record requests must be submitted directly to the agency where the original record resides.
3. See HCP Consent and Release and HIPAA policies for more information.

Supporting a Medical Home Approach

Outreach to primary care providers and community partners, including HCP Care Coordinators in surrounding counties, regarding referral processes and the date, time and location of specialty clinics is the responsibility of HCP Clinic Coordinators.

Documentation
1. For patients who are also receiving HCP Care Coordination, the clinic host site must maintain a chart for patients specifically related to clinic visits that are separate from HCP Care Coordination records.
2. HCP Specialty Clinic Coordinators are responsible for obtaining and/or completing the following documents and documentation, as appropriate, in CDS:
    a. New Referral / Intake
        i. *HCP Referral Form*
        ii. *HCP Specialty Clinic Consent and Release of Information Form*
        iii. *HCP Specialty Clinic Family Information Questionnaire*
        iv. *HCP Specialty Clinic Medical History*
        v. *Any and all forms required by UPI and/or Children's Hospital Colorado*
    b. Day of Clinic
        i. *HCP Specialty Clinic Visit Record*
        ii. *Any and all forms required by UPI and/or Children's Hospital Colorado*
    c. Annually
        i. *HCP Specialty Clinic Consent and Release of Information Form*
        ii. *HCP Specialty Clinic Family Information Questionnaire*
3. HCP Specialty Clinic Coordinators shall confirm the occurrence of HCP Specialty Clinics by completing the online HCP Specialty Clinic Data Collection Tool (Google Form) within 1 week of the scheduled clinic. The link to the form will be provided by the HCP Consultant.
4. HCP Specialty Clinic Coordinators shall monitor clinic wait lists, new specialty providers in the community and number of children scheduled for clinics to support rescheduling or canceling a regional specialty clinic.
5. HCP Specialty Clinic Coordinators shall provide an initial schedule to Children's Hospital Colorado schedulers no later than three weeks prior to the scheduled clinic day. Updates to

the schedule should be sent at least <u>one week prior</u> to the scheduled clinic day, when possible.

6. HCP Specialty Clinic Coordinators shall provide a list of patients seen to the Children's Hospital Colorado transcription department at the end of each clinic day, in order to facilitate the timely and accurate dispersal of visit reports.
7. HCP Specialty Clinic Coordinators shall provide families with a copy of the HCP Specialty Clinic Visit Record at the end of clinic in order to ensure that families are aware of next steps.
8. HCP Specialty Clinic Coordinators shall ensure that a copy of the HCP Specialty Clinic Visit Record and final Pediatric Specialist's dictation are provided, according to the host site's HIPAA Guidelines and as consented to on the Release of Information to:
    a. the child's PCP.
    b. the HCP Care Coordinator in the child/youth's county of residence.

If the child/youth is not enrolled in and actively receiving HCP care coordination in their county of residence, the LPHA HCP Care Coordinator in which the child resides shall not receive a copy of the HCP Specialty Clinic Visit Record or the Pediatric Specialist's dictation.

Clinic Set Up

LPHA host sites are expected to:
1. provide special consideration and access for patients with wheelchairs, walkers, etc.
2. have a scale, height and length measurement devices, head circumference measuring tape, growth charts, and a copier readily available.
3. assure a safe environment that meets the developmental needs of the children and youth seen in clinic.
4. provide a computer with internet access and ensure connection to a printer and EPIC, as needed.

Scheduling Clinics

1. In collaboration with LPHA host sites and pediatric specialists, the University of Colorado School of Medicine departments shall determine HCP Specialty Clinic dates at least 6-12 months in advance.
2. HCP Specialty Clinics shall be held at designated local public health agencies and/or agreed upon regional community locations.
3. Clinic coordination shall be performed by designated public health agencies host sites as contracted with CDPHE.
4. LPHAs shall be responsible for providing clinic space, clinic coordination, and support staff during HCP Specialty Clinics.
5. A full day of clinic is scheduled for 8 hours; a half day is 4 hours.

a. To be considered a full one-day clinic, a minimum number of patients must be scheduled. This minimum number shall be determined annually by the University of Colorado School of Medicine departments for each specialty.
   i. For FY17, the University of Colorado School of Medicine departments have set the following guidelines for scheduling, unless otherwise approved by the HCP Consultant and appropriate University of Colorado School of Medicine department:
      1. Neurology – at least 8 children/youth scheduled
      2. Orthopaedic – at least 20 children/youth scheduled
      3. Rehabilitation – at least 15, and no more than 25, children/youth scheduled
   ii. Should a HCP Specialty Clinic Coordinator not be able to reach the minimum guidelines for scheduling <u>three to four weeks prior</u> to a scheduled clinic, he/she must contact his/her state HCP Consultant prior to cancelling clinic to discuss next steps.
6. On occasion, Fellows may attend Specialty Clinics with UPI pediatric specialists: no changes to the minimum/maximum number of scheduled patients is allowed.
7. UPI and/or University of Colorado School of Medicine department schedulers are to notify the appropriate HCP Specialty Clinic Coordinator if they wish to schedule additional appointments to the master schedule for any day of clinic. Scheduling is at the discretion of the HCP Clinic Coordinator.
8. Clinic dates, locations, and specialties - including changes - must be provided <u>in advace</u> to the HCP Consultant and will be posted on the HCP Calendar at www.hcpcolorado.org as they become available.

Cancelling Clinics
1. If the HCP Specialty Clinic Coordinator is unable to schedule the minimum number of appointments, and it is determined that clinic should be cancelled, the cancellation must be done at least <u>three weeks prior</u> to scheduled clinic.
   a. Clinics cancelled due to low utilization will only be rescheduled when both pediatric specialists and HCP staff have availability.
2. The University of Colorado School of Medicine departments shall notify the HCP Specialty Clinic Coordinator at least <u>three weeks prior</u> to a scheduled clinic if there is a scheduling conflict that would cause a clinic to be cancelled or rescheduled.
   a. Every effort must be made to reschedule clinics cancelled due to (non-emergent) scheduling conflicts.
3. For the safety of families, HCP Program Staff, and Pediatric Specialists, clinics may occasionally need to be cancelled or rescheduled due to inclement weather or unsafe travel conditions.

      a. Pediatric specialists and HCP Specialty Clinic Coordinators must be sure to notify each other as soon as possible in case of flight delays, road closures, or any other problems due to weather.

      b. Clinics cancelled due to inclement weather will only be rescheduled when both pediatric specialists and HCP staff have availability.

4. All cancellations and rescheduled clinics must be reported via email to the state HCP Consultant at the time the decision is made, as well as noted on the HCP Specialty Clinic Data Collection Tool (Google Form).

Triaging Appointments

1. HCP Specialty Clinic Coordinators, in collaboration with the pediatric specialists, shall triage new and follow-up appointments based on the severity of symptoms and not based on the county in which the child resides.
2. HCP Specialty Clinic Coordinators shall connect the referring primary care provider to the pediatric specialist when needed for consultation about the urgency of clinic visit and any tests needed prior to clinic.
3. If clinic is not full and time allows, HCP Specialty Clinic Coordinators and pediatric specialists are encouraged to use up to 1 hour per 8 hour clinic day to consult with and/ or train local providers, or triage patients.

HCP Clinic Support Fees

The HCP Specialty Clinic support fees provide financial support to contracted LPHA host site in order to help off-set expenses related to coordinating the clinics. The HCP Specialty Clinic Coordinator is responsible for charging families according to a sliding scale fee. Families and HCP Specialty Clinic Coordinators should be aware of the following guidelines:

1. Fees are in addition to any co-pays or deductibles that may be collected by UPI.
2. Fees are not charged to families whose child/youth is enrolled in Medicaid.
3. Fees are assessed based on a self-report of household income.
4. If a family refuses to self-report income, a $100.00 maximum fee for each clinic will be charged.
5. A family who has more than one child seen in clinic will be charged a clinic support fee for each child seen that day.
6. Families shall not be denied services for inability to pay any of the sliding fee charges.
7. Sliding scale fees are based on Federal Poverty Level (FPL), and are calculated in CDS once SDoH data has been collected and entered.

HCP SPECIALTY CLINIC SLIDING SCALE FOR CLINIC FEES							
% Poverty Level (FPL)	At or below 100%	101 - 133%	134 – 185%	186 – 211%	212 – 399%	400 – 450%	Greater than 450%
$ Clinic Fee (Per Child/per Visit)	No Charge	$5	$10	$30	$50	$75	$100

Clinic Billing

Families should be aware prior to their appointment that there may be a cost to attend HCP Specialty Clinics. Billing families for HCP Specialty Clinic is only permissible under the following guidelines:

1. CU Medicine may bill Medicaid, CHP+, and private insurance companies:
    a. UPI must accept Medicaid/CHP+ payment as full reimbursement.
    b. UPI may bill a family with private insurance for any co-pay due or when an insurance payment is denied because the deductible has not been met. Families may be responsible for their co-pay and/or deductible and should make payment directly to UPI.
2. Patients unable or unwilling to obtain their own insurance (identified as "self-pay") will not be billed unless the family and the pediatric specialist agree before services are rendered on payment plans based on the family's ability to pay. This should be documented at the time of visit.
3. UPI may choose not to bill families and, if so will receive no further compensation.

Increasing, Reducing, or Closing Specialty Clinics

The HCP Consultant reviews potential changes for regional clinics as part of the state contracting process. Annually, the state HCP staff determines, in collaboration with UPI, the LPHA host sites, and the University of Colorado School of Medicine departments, any changes to the HCP Specialty Clinic Benchmarks based on the following:

● pediatric specialists' availability and capacity
● need and geographical considerations that affect access
● current wait lists and clinic utilization

Revisions during the fiscal year must be mutually agreed upon by state HCP, Contracted LPHA Host Sites, HCP Specialty Clinic Coordinators, UPI, and the University of Colorado School of Medicine department heads for Neurology, Orthopaedic and Rehabilitation.

Telehealth & Electronic Medical Records

1. HCP, in collaboration with UPI, University of Colorado School of Medicine, and the LPHA Host Sites, shall work to maximize HCP Specialty Clinics through telehealth.

    a. NEW REQUIREMENT FOR FY18: 40 one-half days of telehealth clinics must be scheduled. This increases FY17 telehealth half-day clinics from 7% to 20% of the total number of clinics scheduled for the contract year.

2. HCP Specialty Clinic Coordinators are required to have access to EPIC, an electronic health record used by pediatric specialists.

Workgroup Participation

Representatives from CU Medicine and HCP Specialty Clinic Coordinators are required to participate in HCP Specialty Clinic Workgroup meetings. During these meetings, at least one participant from each agency comes together to develop standardized processes and protocols to support quality improvement and efficiency across all HCP Specialty Clinics in the state. Additionally, the workgroup will plan for the transformation of improved local access to pediatric specialty care.

RESOURCES

[CDPHE CYSHCN Section contact information](#)

[Specialty clinic locations & contacts](#)

[Map - HCP Care Coordination and Specialty Clinics](#)

[Statutory Authority Letter](#)

APPENDIXES

Glossary of Terms

CDS	CYSHCN Data System
CU Medicine	f.k.a University Physicians, Inc (UPI)
CYSHCN	The acronym for Children and Youth with Special Health Care Needs (pronounced 'shin')
EMR/EHR	Electronic Medical Record / Electronic Health Record
FPL	Federal Poverty Level
FY	Fiscal Year; Federal fiscal year runs from October 1 thru September 30 / State fiscal year runs July 1 through June 30.
HCP	HCP- A Program for Children with Special Health Care Needs
HCP Care Coordination Model	The five-component model of care coordination used by HCP to serve families of children and youth with special health care needs.
HCP Care Coordinator	LPHA employee who is responsible for implementing the HCP Care Coordination model.
HCP Program Components	Refers to the three elements of the Program for Children with Special Health Care Needs: 1. HCP Care Coordination 2. HCP Specialty Clinics 3. Medical Home Systems Development
HCP Specialty Clinic Coordinator	LPHA employee responsible for the oversight and coordination of HCP Regional Rural Specialty Clinics.
LEP	Limited English Proficiency individuals
LPHA	Local Public Health Agency
MCH	Maternal and Child Health
OPPI	Office of Planning, Partnership and Improvement
PCP	Primary Care Provider
RCCO	Regional Care Collaborative Organization
State HCP Consultant	CDPHE employee who provides assistance to LPHAs on HCP Care Coordination and/or HCP Specialty Clinics

Roles & Responsibilities

CDPHE – HCP Consultant

CORE RESPONSIBILITIES
- Maintains current HCP Policy and Guidelines and provides technical assistance and orientation and training to support implementation of the policy and guidelines
- Monitors local public health agency HCP contract requirements
- Facilitates and coordinates HCP Specialty Clinic and/or Care Coordination Workgroup meetings and training opportunity
- Maintains standardized HCP forms

CONTINUOUS QUALITY IMPROVEMENT / DATA
- Coordinates collection of data for HCP Care Coordination and Specialty Clinics
- Ensures CDS functionality and provides technical assistance
- Collects and analyzes HCP data

SPECIALTY CLINIC
- Oversees and manages the HCP Specialty Clinic contract with University Physicians, Inc. (UPI)
- Identifies LEAN clinic procedures in collaboration with the HCP Specialty Clinic Work Group, HCP Specialty Clinic Host Sites, and University of Colorado School of Medicine departments of Neurology, Orthopaedic and Rehabilitation and contracted services

LPHA – HCP Care Coordinator and HCP Specialty Clinic Coordinator
- Ensures fidelity to the HCP Policy and Guidelines
- HIPAA/ Confidentiality
  - Maintain confidentiality of HCP care coordination information using local public health agency confidentiality and HIPAA policies
  - Provides training to local public health agency staff on agency HIPAA policies and personal health information confidentiality
- Participates in HCP Workgroup meetings, as requested
- Notifies the state HCP Consultant with changes in name and/or contact information of designated staff
- Designates a consistent HCP Care Coordinator and/or HCP Specialty Clinic Coordinator
- Assists with collection of data, when requested
- Documentation
  - Maintains separate charts for HCP Care Coordination and HCP Specialty Clinics
- Community Outreach
  - Contacts primary care providers and community partners with referral procedures, future specialty clinic dates, types of clinics and provider names
- Referrals
  - Refers families for HCP Care Coordination in the child's county of residence for community-based information and resources, when needed
  - Refers family to a HCP Specialty Clinic, when needed

- All LPHA HCP staff and their supervisors at agencies that have "opted in" to providing HCP care coordination must complete HCP training available online at http://www.hcpcolorado.org.

Referral to HCP Specialty Clinic

When assisting with a referral to HCP Specialty Clinic, the HCP Care Coordinator from the child/youth's county of residence shall:

1. Help the primary care provider complete the HCP Specialty Clinic Referral Form and send completed HCP Referral Form to HCP Specialty Clinic Coordinator
2. Assess if family needs community-based resources and refer, as appropriate/available
3. Share urgency of clinic visit, if known, and whether family will need an interpreter during clinic
4. Provide any additional health history to assist with clinic visit
5. Follow up with the family after HCP Specialty Clinic visit to ensure understanding of pediatric specialist's recommendations and next steps
6. Clarify questions or concerns with the HCP Specialty Clinic Coordinator, as needed
7. Assist family with identifying transportation resources as needed
8. Contact the child/youth's primary care provider with questions or concerns or with clinic follow-up, as needed
9. Update the child/youth's care coordination Plan of Care with clinic follow-up information to include the family's role, Care Coordinator's role and PCP's role, and provide a printed copy for the family
10. File the Plan of Care and clinic documentation in child's care coordination chart
11. Update CDS, as appropriate.

Referral from Specialty Clinic to HCP Care Coordination and/or PCP

In order to facilitate communication between the HCP Care Coordinator and the HCP Specialty Clinic

1. For children/youth receiving active HCP Care Coordination, the HCP Specialty Clinic Coordinators must:
   a. notify the HCP Care Coordinator in the child/youth's county of residence of receipt of new referral to HCP Specialty Clinics
   b. send the appointment date and time to the HCP Care Coordinator
   c. Refer child/youth to HCP Care Coordination in the county of the child's residence if there is reason to believe that the child/youth and their family might benefit from HCP Care Coordination services
   d. Update CDS, as appropriate.
2. For child/youth NOT receiving active HCP care coordination, including those who reside in a county without HCP Care Coordination:
   a. The Clinic Coordinator will refer the family to the HCP Care Coordinator in the county in which the child resides for any community-based information and resources and/or care coordination, as needed/available

b. The LPHA in which the child resides will not receive a copy of the HCP Specialty Clinic Visit Record or the Pediatric Specialist's dictation.

Communication Policy & Guidelines for Local HCP Implementation

Purpose: As part of our efforts to ensure that HCP communications are coordinated, consistent and meaningful, we have developed this communications guidelines tool. This tool serves to help HCP care and clinic coordinators as they conduct local outreach to families and partners within their communities. In addition, the document provides guidance on using HCP communications materials.

The document is divided into six sections:
1. Outreach to community
2. LPHA websites
3. LPHA supplemental materials
4. LPHA Facebook pages
5. Photo and story release
6. Logo usage document

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1. **Outreach to community**

   Care coordinators are expected to reach out to community partners and families to increase awareness, educate and generate referrals, improve referral process, and improve feedback loop.

   WHAT is community outreach:
   - Calling current and potential partners and introducing them to HCP.
   - Face-to-face meetings with partners, equipped with resources.
   - Following calls or meetings with an email, including an electronic copy all of materials mentioned during prior contact.

   WHO to outreach to:
   1. Internal referral sources (potential and current)
      a. Examples:
         i. WIC
         ii. Home Visitation Programs
         iii. Healthy Communities
         iv. Immunization Nurse
   2. External referral sources (potential and current)
      a. Examples (for more examples, see Intake Interview)
         i. School Nurses / Special Education Teachers
         ii. Home Visitation Programs
         iii. Child Care Centers
         iv. Appropriate Hospital Liaisons
            1. social workers
            2. discharge planners
            3. NICU
      b. Regional Care Collaborative Organization (RCCO)
      c. Early Intervention
      d. Pediatric/ Family clinics

     e. DHS / CPS
     f. Mental Health providers / Behavioral Health Organizations (BHO)
     g. Community Centered Boards (CCB)
     h. Community organizations who serve CYSHCN

WHEN to outreach:
1. To introduce new local HCP team members to communities.
2. To increase referrals to HCP.
3. To correct misinformation about HCP in the community (i.e., direct services provided/not provided by HCP).
4. To educate new community organizations.
5. To educate new staff in community organizations.
6. At regularly attended community meetings (i.e. Early Intervention meetings)

TOOLS to identify current referral sources and gaps in community referrals:
1. CDS Report 014 - Information Only
2. CDS Report 025 - Intake Interview

RESOURCES to use when communicating with the community:
1. HCP (state) Brochure*
    a. Include local public health agency logo and contact information
    b. Available in English and Spanish
2. HCP (state) Rack Card*
    a. Available in English, Spanish, Somali & Arabic.
3. Referral Form*
    a. We recommend use of the state HCP referral form.
    b. If you use your own referral form, be sure that you collect the necessary information.
    c. Encourage community partners to use the referral form to collect appropriate information.
4. Consent and Release Form*
    a. We recommend use of the state HCP Consent and Release of Information form.
    b. Agencies may choose to use the form that has been approved by your internal HIPPA compliance officer or the form available at www.hcpcolorado.org.
    c. Consider whether Consent and Release Form needs to accompany the Referral Form.
    d. For questions, refer to your agency's HIPPA compliance officer.
5. HCP map* - This map includes specialty clinic and care coordination locations.
6. PowerPoint Overview of HCP*
7. HCP Blast - Refer to monthly *HCP Blast* for new tools and resources.
8. HCP Data Snapshot - Use the HCP Snapshot to communicate statewide data to partners. The snapshot includes CDS data on:
    a. Care coordination, HCP specialty clinics and Information-only.
    b. Pull CDS reports to compare local data to statewide data (CDS 021 and 025).
9. Your business card

*All state resources can be found at www.hcpcolorado.org. *Please check with your state HCP Consultant prior to changing state resources. Rack Card & Brochure content may not be edited, with the exception of adding local contact information and logos.*

REQUIREMENTS: Refer to *Policy and Guidelines*

2. Local public health agency website - HCP page

RECOMMENDATIONS:
1. Link to state HCP resource page at www.colorado.gov/cdphe/hcp-families
   a. CDPHE will update these resources.

REQUIREMENTS:
1. Use current HCP logo
   a. Request the logo from your HCP consultant.
2. Use current, formal HCP name: HCP, a program for children and youth with special health care needs
3. Include current HCP brochure
   a. Outdated HCP (state) brochures must be removed from websites.
4. Include Referral Form
   a. May use state or local version of form.
5. Include local HCP contact information, including how to submit a referral form.
6. Include HRSA funding statement:
   a. This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number B04MC28087, Maternal and Child Health Services. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
7. Include definition of CYSHCN and population served:
   a. The Maternal and Child Health Bureau defines the population of children and youth with special health care needs as "those who have, or are at increased risk for having, a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children [and youth] generally" (Maternal and Child Health Bureau, McPherson, et al., 1998).
8. Review and update web content as needed, at least annually.
9. Ensure that contact information is accurate and up-to-date.

3. Supplemental materials used by local public health agencies
This refers to materials that local public health agencies use to market HCP and/or educate partners and families on the local HCP services available (e.g., brochures, flyers).

RECOMMENDATIONS:
1. Choose HCP (state) materials first.
    a. CDPHE will update these resources.

REQUIREMENTS:
1. Use any locally-developed materials in conjunction with the HCP (state) brochure.
2. Use current HCP logo
    a. Request the logo from your HCP consultant.
3. Use current, formal HCP name: HCP, a program for children and youth with special health care needs
4. Include definition of CYSHCN and population served:
    a. The Maternal and Child Health Bureau defines the population of children and youth with special health care needs as "those who have, or are at increased risk for having, a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children [and youth] generally" (Maternal and Child Health Bureau, McPherson, et al., 1998).
5. Include local HCP contact information, including how to submit a referral form.
6. Include HRSA funding statement:
    a. This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number B04MC28087, Maternal and Child Health Services. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

4. LPHA Facebook pages

RECOMMENDATIONS for establishing a local HCP Facebook page

1. Include HCP logo, name, etc. (see above)
2. Tips
    a. Share resources with families (from HCP resources page).
    b. Follow recommended Facebook pages for parents and providers (see list below)
    c. Share posts from recommended Facebook pages
    d. Follow local partner Facebook pages
    e. Tag partners in posts, when appropriate
    f. Share photos of partner events, as long as clients are not involved

RECOMMENDATIONS for using local public health agency Facebook page to promote HCP
1. Use current, formal HCP name: HCP, a program for children and youth with special health care needs
2. Link to local HCP website to provide public with more information
3. Tips

    a. Share resources with families (from HCP resources page)
    b. Follow recommended Facebook pages for parents and providers (see list below)
    c. Share posts from recommended Facebook pages

FACEBOOK PAGES to FOLLOW (examples for parents and providers)*:
1. Family Voices Colorado: www.facebook.com/FamilyVoicesColorado
2. Parent to Parent of Colorado: www.facebook.com/pages/Parent-to-Parent-of-Colorado/324801439086
3. CDPHE: https://www.facebook.com/CDPHE

For the full list of Facebook pages, https://www.colorado.gov/cdphe/hcp-families (click on Facebook pages for families and providers link).

* CDPHE is not responsible for nor do we endorse the content on these pages.

5. 2-1-1 Colorado

Agencies are encouraged to keep their information updated on the 2-1-1 Colorado website. View these instructions on how to update your HCP listing. Please refer to this template for a guideline of what to include in your agency listing. The contact information fields should remain unique to your agency.

Agencies are required to share a minimum of five (5) community resources per year to ensure the 2-1-1 Colorado website includes resources relevant to CYSHCN in your local community. Prior to submitting a minimum of five local resources, we encourage agencies to search the 2-1-1 Colorado website to determine whether these resources are already listed.

6. Photo and story release

The release is to be used to gather photos, stories and/or quotes from family members and partners. These materials can be used by you and CDPHE to promote the value of HCP care coordination and help describe HCP. A copy of the release form is included in the appendix.

RECOMMENDATIONS
1. Print and have copies of the releases on hand for any interactions with families and partners.
    a. Complete/sign one release for each individual over 18 years of age
    b. For families with multiple children/youth, list each individual on the same release and obtain proper signatures
2. Take photos of, or have someone else take photos of, yourself interacting with families and partners.
3. Save emails and/or write down quotes of instances where families speak to the value of HCP and how care coordination has improved the health and well-being of their family.

4. Email these photos, quotes and stories to your HCP Consultant with the signed release form.

REQUIREMENTS*
1. Any time photos, quotes or stories are obtained from a family or partner, this release must be signed by the parent or guardian of the child and accompany the media.
2. Check the box for "Other media described here" and write in or "story" or "quote", as appropriate.

*In addition to the CDPHE release form, be sure to also follow and local requirements set forth by your public health agency.

Media Notice and Release

Office of Communications

This release concerns (check all that apply):

☐ Photographs

☐ Videotape

☐ Film

☐ Sound recording

☐ Other media described here _____,

I, the undersigned, hereby give the Colorado Department of Public Health and Environment (CDPHE) permission to publish, copyright, distribute and/or display media images of me taken on the below listed date.

I understand that CDPHE may use, re-use, publish and republish the media images in whole or in part, individually or in conjunction with other photographs or images, in any medium.

I understand that my participation in this media project is strictly voluntary.

As such, I relieve and hereby agree to hold CDPHE free and harmless from any and all liability arising out of the release of photograph, videotape, film or sound recording and subsequent publication or broadcast. I understand that the photo session(s) or interview(s) are being carried out upon my consent and authorization and so assume full responsibility.

By signing this limited consent and release form I, the undersigned, represent that I am over 18 years of age. (If under 18, a parent's signature is required.)

SUBJECT'S NAME (PRINTED)_____

SUBJECT'S SIGNATURE _____

PARENT'S OR GUARDIAN'S SIGNATURE (if subject is under 18 or not an emancipated minor)

_____

DATE _____