ATTACHMENT A: CALIFORNIA CHILDREN'S SERVICES (CCS) CASE MANAGEMENT CORE ACTIVITIES

Case Finding

- In the event the beneficiary/member does not qualify, or a specific service is not medically necessary or related to the CCS eligible condition, consult with the family and the Medi- Cal Managed Care Plan (MCP) about other resources available to them to meet their needs.

Support For Family Navigation

- Support beneficiary/member participation in the community by providing information on community-based activities, such as resources for exercise and socialization for children with physical disabilities;
- Educate, explain, and link families to resources to help them obtain services their children need including but not limited to CCS, Medi-Cal, County mental health, Regional Centers, public health nursing and/or schools, Enhanced Care Management (ECM), Community Supports, CalFresh and Women, Infants & Children (WIC) Program;
- When the CCS Provider elects to contract with an MCP as an ECM Provider, provide a broader set of ECM services to Medi-Cal beneficiaries/members that qualify for ECM as described in their contract with the MCP and DHCS's ECM Policy Guide; Educate families about the CCS regional system of care, including special care centers and community resources (i.e., peer and family support organizations);
- Reach out to families who are having difficulty maintaining their Medi-Cal enrollment and troubleshoot challenges in maintaining Medi-Cal;

- Provide consultation and support to the beneficiary's/member's educational team in the school setting when requested by patients and/or their families eligibility; and
- Educate families on available transportation resources and provide maintenance and transportation services when they are needed.

Assessments, Interventions, and Coordination of Care

- Link beneficiaries/members to appropriate CCS-paneled physicians, CCS Special Care Centers (SCC), and CCS-approved hospitals, according to program guidelines and standards;[1] [2]
- Review the care plan established by CCS-authorized specialists and SCC; assist the beneficiary/member and family in identifying and utilizing the most appropriate resources to accomplish the recommended care plan while assessing the understanding of and responsiveness to overall care plan. Ensure coordination of the beneficiary's/member's care plan between SCC, community physicians, and the Medical Therapy Program (MTP);
- Maintain list of utilization of services across the healthcare system to limit duplication and ensure access to the most appropriate services;
- Assess eligibility for and coordinate referrals to additional MCP-administered services and benefits, including but not limited to Complex Care Management, ECM, and Community Supports;
- Determine and coordinate referrals to appropriate social support services to meet the needs of beneficiaries/members including services that address social determinants of health needs such as CalFresh and Women, Infants & Children (WIC) Program;
- Link and/or refer beneficiaries/members to appropriate pharmacies and/or providers for their medication needs; appropriate medical home; and programs that coordinate appropriate dental care as determined by the patient's needs and preferences;
- Coordinate appointments with Durable Medical Equipment (DME) vendors and collaborate to identify DME that is appropriate;

[1] California Children's Services Provider List
[2] California Children's Services Provider Standards

- Provide professional support to ensure that families remain engaged;
- Arrange Private Duty Nursing (PDN) services for the CCS eligible condition, as medically necessary, and engage in agency nursing resource finding as needed per NL 04-0520 or any superseded guidance;[3]
- Conduct multidisciplinary case management team conferences, including CCS professional staff, community providers and families as needed to address complex needs and challenges to care coordination; and
- Facilitate referrals for behavioral health services and pediatric palliative care (PPC) services, in accordance with State guidance.

Management of Transitions

- Assist beneficiaries/members families, hospital discharge planners, MCP Transitional Care Services care managers, and community partners to ensure safe and successful transitions from the hospital to the home and/or community, when applicable;
- Partner with families to accomplish a smooth transition from the pediatric to the adult healthcare system; and

  Provide transition assessment and intervention at appropriate age for beneficiary/member and, for selected beneficiaries/members, conduct internal analyses of patients' transition needs and develop a transition plan.

[3] Numbered Letter 04-0520 Early and Periodic Screening, Diagnostic, and Treatment – Private Duty Nursing