Our Learning Objectives

The webinar participant will be able to:

1) State the goal of Colorado’s Health Care Program for Children With Special Needs (HCP).

2) Describe the nurse’s role within the Health Care Program for Children with Special Needs (HCP).

3) Identify the five core components of the Health Care Program for Children with Special Needs (HCP) model of care coordination.
The Association of Maternal and Child Health Program (AMCHP) considers care coordination a standard of care for children and youth with special health care needs due to the following:

- The complexity of the service system with its different entry points and eligibility requirements
- The need to plan beyond the medical needs of the child (social, developmental, educational, vocational, financial)
- Partnerships with families among providers, agencies, programs, specialists, and primary care providers are essential to effective care that truly serves families.

HCP Program

The goal of Colorado’s HCP program:

To improve the health, development, and the well-being of Colorado’s children and youth, birth to 21, with special health care needs.

HCP Care Coordination

- HCP Care Coordination is a service provided by all of Colorado’s 54 Local Public Health Agencies
- HCP Care Coordination services are offered free of charge for any child or youth from birth to age 21 who may have special health care needs.
HCP Care Coordination

- Children and youth with special health care needs (CYSHCN) are defined as “...those who have or are at increased risk for 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 generally”.

Statement of ANA’s Position

The American Nurses Association recognizes and promotes the integral role of registered nurses in care coordination to:

- Improve health care quality and outcomes
- Steward the efficient and effective use of health care resources.

HCP Care Coordination

- The HCP Care Coordination team is always led by a Registered Nurse.
- The HCP Care Coordination team may also include a:
  - Social Worker
  - Dietitian
  - Family Advocate
  - HCP Technician
Registered nurses' skill sets include:

Conducting an assessment
- capture an individual’s unique needs, values and beliefs, assets and resources, and relevant social and environmental determinants of health.

Developing an individualized action plan
- A plan between the family and the care coordinator to determine and document
  - Goals
  - Next Steps
  - Persons Responsible
  - Target Dates

HCP Care Coordination Model
5 Core Components

- Intake Interview
- Assessment
- Development of an action plan, created in partnership with the family
- Six-month reviews
- Case closure

Intake Interview

- Summary Data
- 16 Intake Interview Questions
- Social Determinants of Health
SOME EXAMPLES OF WHAT THE DATA WILL TELL US?

Identified data points that will enable us to describe the population served and the service they've received

Who are the HCP Care Coordination clients?

What is the distribution of HCP clients who receive Care Coordination?

- Age
- Gender
- Hispanic ethnicity
- Race
- Single parent household
- Age of biological mother
- Household education level
- Annual household income
- Poverty level
- Household language
- Medical Conditions
Can children/youth access medical providers?

- How many children/youth have a personal doctor or nurse?
- Do children/youth encounter barriers to seeing a specialist or other medical provider?

What is the health status of children/youth?

- Are children/youth missing school more often than necessary?
- Are children/youth utilizing the emergency room more often than necessary?

HCP Care Coordination Model 5 Core Components

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For more information, visit our website

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