Case Management for Children and Pregnant Women (CPW)
Case Management for Children and Pregnant Women

Section 1: Overview
Section 2: Eligibility
Section 3: Components of CPW
Section 4: Referrals
Section 5: Providers
Case Management for Children and Pregnant Women

What is CPW?

- Medicaid program
- Provides health-related case management services to:
  - Children birth through 20 years of age with a health condition/health risk
  - High risk pregnant women
Case Management for Children and Pregnant Women

Who provides the case management?

Case managers:

- Help clients gain access to needed services:
  - Medical
  - Social
  - Educational
  - Other
How Do Case Managers Help?

- Find out **WHAT FAMILIES NEED**
- Make plans to **MEET THOSE NEEDS** using services near where families live
- **COORDINATE** appropriate health care or other services for the client
- **ASSIST with GETTING APPOINTMENTS** that are convenient for work or transportation schedules
- **REFER CLIENTS and FAMILIES** to community resources and service providers
- **TEACH CLIENTS and FAMILIES** how to find and get services they need
- **FOLLOW-UP with FAMILIES** to make sure their needs have been met
Assistance provided by Case Managers

Access

- Medical Home
- Durable medical equipment and supplies
- Specialty care when a referral has been made by a Primary Care Practitioner
- Developmental Services
- Mental health services
Assistance provided by Case Managers

Coordination and Advocacy

- Education / School issues
- Transportation
- Overcoming barriers to service
- Coordination of care
Assistance provided by Case Managers

Referrals for other Needs that could Impact Health

- Housing
- Financial assistance (rent, utilities)
- Other community resources
Case Manager Skills and Knowledge

- Assessing needs, identifying challenges and family strengths
- Advocating
- Empowering
- Facilitating, coordinating and communicating
- Identifying and accessing community resources

Section 1: Overview
Eligibility for CPW Services

✓ Eligible for Medicaid

✓ A child (birth through age 20) with a health condition or a health risk OR a pregnant woman with a high risk condition

✓ In need of services to prevent illness(s) or medical condition(s), to maintain function or slow further deterioration

✓ Want case management
## Health Conditions

<table>
<thead>
<tr>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabilities that result in differences of same-age peers</td>
<td>Limitation of function, activities, or social roles&lt;br&gt;Asthma, Downs Syndrome, Diabetes, Cardiac Conditions, Cerebral Palsy, Paralysis</td>
</tr>
<tr>
<td>Create special health care needs</td>
<td>Anemia, Anorexia/Bulimia, Behavior Disorders, Mental Health problems, Crohn’s disease, Cystic Fibrosis, Drug Abuse, Thyroid Conditions, Scoliosis, HIV</td>
</tr>
<tr>
<td>Require ongoing care</td>
<td>Severe Caries, Abscesses</td>
</tr>
<tr>
<td>Dental problems that require referrals</td>
<td>Severe Caries, Abscesses</td>
</tr>
</tbody>
</table>
### Health Risk Examples

<table>
<thead>
<tr>
<th>Population</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants</td>
<td>- Born with a low birth weight or exposed to prenatal drug or alcohol use</td>
</tr>
<tr>
<td>Children</td>
<td>- Elevated blood lead levels</td>
</tr>
<tr>
<td></td>
<td>- Developmental, nutritional, or intellectual deficits</td>
</tr>
<tr>
<td>Infants &amp; Children</td>
<td>- Family history of genetic diseases or disorders or whose screening results indicate a risk for genetic diseases or disorders</td>
</tr>
<tr>
<td></td>
<td>- Failure to thrive or show possible developmental delays</td>
</tr>
<tr>
<td></td>
<td>- Fallen behind on immunizations</td>
</tr>
</tbody>
</table>

**Section 2: Eligibility**
# Health Risk Examples

<table>
<thead>
<tr>
<th>Population</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children or Adolescents</td>
<td>- Behavior problems atypical of same-age peers</td>
</tr>
<tr>
<td></td>
<td>- Extremely overweight or obese</td>
</tr>
<tr>
<td>All Clients</td>
<td>- Pattern of missing appointments or lack of following through with referrals</td>
</tr>
</tbody>
</table>
High Risk Pregnancy Examples

- Pre-existing medical conditions, such as diabetes, hypertension, asthma, seizure disorders, severe obesity, or heart, thyroid, lung, or renal disease
- Premature labor, gestational diabetes, vaginal bleeding, poor fetal growth, abnormal fetal heartbeat, or pre-eclampsia
- Drug abuse issues
- Mental health issues
- Lack of access to food for proper nutrition in pregnancy
- Homelessness
- Domestic violence situations
Components of CPW

**Intake/Initial Prior Authorization**
- Collect Family Information
- Receive Approval

**Comprehensive Visit**
- Family Needs Assessment
- Service Plan Development

**Follow-Up**
- Verify Needs are Met

Section 3: Components
Intake

<table>
<thead>
<tr>
<th>Who:</th>
<th>Conducted with client and/or parent/guardian</th>
</tr>
</thead>
<tbody>
<tr>
<td>What:</td>
<td>Collection of client demographics and CPW eligibility information</td>
</tr>
<tr>
<td>Why:</td>
<td>Collected information will be used to determine client eligibility</td>
</tr>
</tbody>
</table>
## Prior Authorization

<table>
<thead>
<tr>
<th><strong>Who:</strong></th>
<th>DSHS reviews requests to determine eligibility for approval*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What:</strong></td>
<td>Response provided within 3 working days</td>
</tr>
<tr>
<td><strong>Why:</strong></td>
<td>All CPW visits must be prior authorized</td>
</tr>
</tbody>
</table>

*Current approval rate is 92-93%

*Technical assistance is available

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Section 3: Components
<table>
<thead>
<tr>
<th>Who:</th>
<th>Almost always a home visit by Case Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>What:</td>
<td>Family Needs Assessment</td>
</tr>
<tr>
<td></td>
<td>Service Plan Development</td>
</tr>
<tr>
<td>Why:</td>
<td>Identifies all issues that affect the short and long term health of the client and family</td>
</tr>
<tr>
<td></td>
<td>Indicates action to be taken and by whom and the timeframe</td>
</tr>
</tbody>
</table>

Section 3: Components
<table>
<thead>
<tr>
<th><strong>Who:</strong></th>
<th>Conducted in person or over the phone by Case Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What:</strong></td>
<td>Conversation to identify:</td>
</tr>
<tr>
<td></td>
<td>- Needs addressed?</td>
</tr>
<tr>
<td></td>
<td>- Barriers addressed?</td>
</tr>
<tr>
<td></td>
<td>- Evidence of problem solving if not addressed</td>
</tr>
<tr>
<td><strong>Why:</strong></td>
<td>Ensures that the needs identified in the Service Plan are being met</td>
</tr>
</tbody>
</table>
CPW Referral Sources

- Health Care Professionals
- Dentists
- Community Agencies
- Schools
- Self Referral - The client or other family members may request case management
- Outreach/Informing
- Managed Care
How to Make a Referral

Texas Health Steps Hotline
877-THSteps (877-847-8377)

CPW website for a list of providers in your area:
http://www.dshs.state.tx.us/caseman
Information to Provide at Time of Referral

✓ Name of client and parent/guardian
✓ Client’s date of birth
✓ Client’s Medicaid number if available
✓ Address and phone number for family
✓ Reason for referral
✓ Your contact information
✓ Whether or not referral is urgent
Providers are social workers or RNs working as individuals or employed by:

- Schools
- Health Departments
- Counseling Agencies
- Health Clinics
- Other agencies

Providers are approved by DSHS and enroll with TMHP as CPW Medicaid Providers
Case Manager Experience

Case managers must have at minimum two years of experience:

- Assessing the psychosocial needs of children and/or pregnant women and
- Making community referrals to address their service needs
## CPW Current Fee Structure

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Visit</td>
<td>$124.15</td>
</tr>
<tr>
<td>Follow-up (Face to Face)</td>
<td>$62.08</td>
</tr>
<tr>
<td>Follow-up (Telephone)</td>
<td>$23.28</td>
</tr>
</tbody>
</table>
Number of Active CPW Providers, September 2008

Number of Active Providers
- Blue: 1 to 3 additional providers
- Green: 4 to 6 additional providers
- Yellow: 7 to 11 additional providers
- Orange: 12 to 19 additional providers
- Red: 20 or more additional providers
- White: Only DSHS Coverage

Note: DSHS has one provider in each county. Therefore, in each county, the total number of providers is the number of additional providers plus the one DSHS provider.
CPW Providers

If a CPW Provider is not available in the county of need, or does not provide the services needed by the client, regional DSHS Case Management staff will provide services.
Learning More about CPW

- How to become a provider
- List of CPW Providers
- CPW Outreach Materials
- Training Schedule
- CPW Forms
- CPW Policies and Procedures
- List of DSHS Regional Case Management Contacts

http://www.dshs.state.tx.us/caseman
Educational Opportunities

- Free CE Hours for Social Workers and Nurses