TARGETED CARE
COORDINATION TOOLKIT

OPTUM®

Targeted Care Coordination (TCC) Toolkit

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YES System of Care

YES System of Care (YES) is a comprehensive continuum of services for youth under the age of 18 with a serious emotional disturbance or SED. This is defined by the combination of a diagnosable mental health condition and significant functional impairments as assessed with the Child and Adolescent Needs and Strengths Assessment. A system of care must be integrated, community-based, and outcomes driven in order to function effectively. It is not a fragmented collection of services, but rather a coordinated system of services and supports. It is important to build meaningful partnerships with youth and their families, and to be responsive to their individual cultural and linguistic needs. The goal of a system of care is to provide coordinated services to holistically support youth to improve their functioning at home, in school, in the community, and throughout life.

YES Principles of Care

Family-centered emphasizes each family's strengths and resources.

Family and youth voice and choice prioritizes the preferences of youth and families in all stages of care.

Strengths-based identifies and builds on strengths to improve functioning.

Individualized care customizes care specifically for each youth and family.

Team-based brings youth, families and informal supports together with professionals to identify the youth and family's strengths and needs, and to create, implement and revise a coordinated care plan.

Community-based service array provides local services in a location chosen by the youth and family.

Collaboration brings together families, informal supports, providers and agencies to meet identified goals.

Unconditional commits to achieving the goals of the coordinated care plan.

Culturally competent considers the family's unique needs and preferences.

Early identification and intervention assesses mental health early and provides access to services and supports when the need is first identified.

Outcome-based contains measurable goals to assess change.

YES Practice Model

Engagement:

- Communicating in a respectful and honest manner in order to build trusting relationships.
- Learning about the strengths and needs of the youth and their family with the intent of helping them reach their goals.
- Recognizing and valuing cultural identities and language.

Assessment:

- Listening and ensuring families are heard and valued as experts.
- Identifying individual and family strengths and considering them a vital part of understanding the youth and their needs.
- Utilizing the CANS tool for initial assessment and updates.
- Making appropriate referrals based on the assessment.

Care Planning and Implementation:

- Prioritizing youth and family preference when determining which strategies will be implemented to meet their goals.
- Identifying appropriate services and supports.
- Developing and implementing a coordinated care plan.
- Identifying methods to measure outcomes of goals.

Teaming:

- Ensuring families have input regarding who is on their Child and Family Team (CFT).
- Engaging families as full and active partners in the process.
- Creating a decision-making method that is a joint activity with the youth and family.

Monitoring and Adapting:

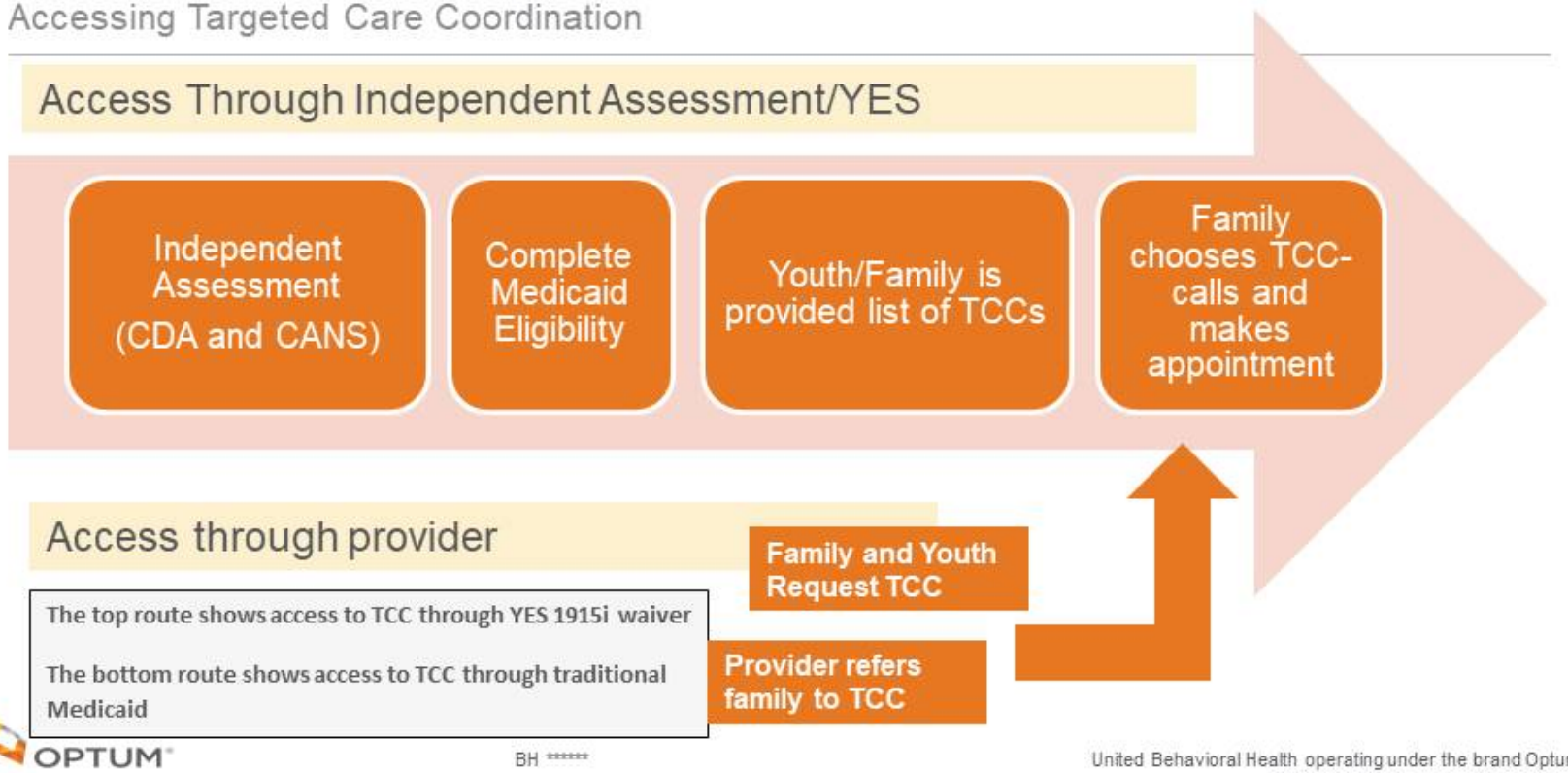
- Identifying services based on individualized need.
- Continuously evaluating the coordinated care plan and modifying it to ensure services are effective and appropriate.
- Understanding that setbacks don't reflect resistance.

Transition:

- Recognizing that the youth and family are key in identifying resources and supports.
- Viewing the community as the preferred resource.
- Developing a transition plan and adapting level of care.

Targeted Care Coordination (TCC)

Accessing Targeted Care Coordination



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CANS Orientation for Child and Family Team

The CANS Tool

The Child and Adolescent Needs and Strengths (CANS) is a tool that uses the information gathered during an assessment to create a record of the youth and family's strengths and needs. Strengths are areas of the youth's and family's life where they are doing well or have an interest or ability. Needs are areas where the youth and family needs support.

In addition to identifying strengths and needs, the CANS is used to:

- Capture information about the youth's ability to function within their family and community.
- Determine if the youth has a functional impairment.
- Create meaningful care plans.
- Monitor the outcome of services.
- Provide a common language for providers, youth and families to use when discussing strengths and needs.

Completing a CANS

The CANS is organized into individual and family life domains (areas). Each domain contains items that specifically relate to that area. The provider, youth and family use the information gathered during the assessment to work through each item in the CANS. They discuss items and collaboratively decide how to rate the items on a 4-part scale. Through this work the provider, youth and family are able to identify the strengths and needs of both the youth and family.

The ratings as determined by the provider, youth and family are then used to help determine the amount of support the youth and family need. After the CANS is complete, the provider talks to the youth and family about the results to make sure they are accurate and reflect their story. The family should receive a copy of their CANS so they can review and refer to it during care planning.

Some of the domains identified in the CANS are not considered in other types of functional assessments, and are part of what makes the CANS unique. The core CANS domains and some examples of the items under the domain are listed below:

Exposure to Potentially Traumatic/Adverse Childhood Experiences domain

- Sexual abuse
- Physical abuse
- Emotional abuse
- Neglect

Strengths domain

- Family
- Interpersonal skills
- Talents/interests

Life functioning domain

- Living situation
- Social functioning
- Resourcefulness
- Sleep

Cultural domain

- Language
- Identity

Behavioral/emotional needs domain

- Emotional and/or physical regulation
- Attention/concentration
- Depression
- Anxiety

Risk behaviors domain

- Suicide
- Self-harm
- Danger to others

Caregiver resources and needs domain physical health

- Mental health
- Substance use
- Involvement with care

Using the CANS

The CANS is used in different ways to help improve the lives of youth and families. It can be used in care planning, for measuring outcomes and as a communication tool.

Care planning

One of the most significant ways the CANS is used is in care planning. When the Child and Family Team meet to plan the youth's treatment, they discuss the CANS ratings to make sure that the youth and family's strengths and needs are included in the plan. Sometimes a plan may focus on a subset of the youth and family's strengths and needs.

Need items identified within the CANS with a 2 or 3 rating should be considered when determining the youth's goals for improvement.

Strength items identified within the CANS with a 0 or 1 indicate a strength that can be used throughout treatment.

Measuring outcomes

Youth and families' needs and strengths may change over time due to mental health support, and the CANS should be updated to reflect these changes. One of the ways to determine if supports are helping is to revisit the CANS and track changes. This may be done upon request or when there is a substantial change that indicates the need for re-assessment outside of the standard 90 day update schedule. The youth's plan can then be updated to more accurately reflect their current strengths and needs.

Communication tool

The CANS provides a common language for providers, youth, families and their formal and informal supports to use when discussing the youth's mental health. It can also provide a picture of the progress that's been made and can help with recommendations for future care.

Targeted Care Coordination (TCC) -
Phases of Child and Family Team (CFT) and Description of TCC Tasks

Phases	Tasks	Documents/ Forms
Engagement	• TCC makes initial contact(s) with youth and family (telephonic or in-person) prior to first CFT meeting. • Gather necessary documents (for example: CDA, CANS, psychological testing, current treatment plans, IEP, etc.) • Complete intake, and needed ROIs. • Informed Consent/Confidentiality. • Build rapport and listen to family's description of life experiences. • Address immediate needs and/or potential risk of crisis. • Link to primary master's level clinician if not already (family is given options and choice of agency and provider). • Orient the family (and identified CFT members) to TCC, CFT process, and CANS (initial in-person or phone contact.) • Identify CFT members and informal supports • Review CANS and/or update CANS if appropriate and the primary treating master's level clinician agrees to TCC updating the CANS. • Identify actionable CANS items. (Actionable items are strengths scored 0 or 1 and needs scored 2 or 3.) • Develop a plan with the family to share CANS items and family goals with the rest of the team during the first CFT meeting. (Could include all scores or just actionable items.) • Identify Agenda for first CFT meeting taking into account any sensitive information and areas of difficulty. • Schedule first meeting.	Documents to complete/update: • Intake o Member Choice Conflict-Free Form o ROIs • CANS Resources for family/team: • Handout- CANS Orientation • YES and Praed websites • Handout - YES System of Care Resources for TCC: • Handout - YES System of Care • Flowchart – Accessing TCC • Phases of CFT and description of TCC Tasks (this document) • Tip Sheet – CFT Facilitation Skills
Planning and Assessment	• TCC facilitates CFT meetings geared towards developing the Person-Centered Service Plan (PCSP) from the CANS in collaboration with the master's level clinician and any other CFT members:	Documents to complete/update: • Person-Centered Service Plan • CANS Resources for TCC:

Targeted Care Coordination (TCC) - Phases of Child and Family Team (CFT) and Description of TCC Tasks

Phases	Tasks	Documents/ Forms
	○ Introduction/Agenda ○ Informed consent/confidentiality ○ Ground rules ○ Review family's vision/goals for the future and identify goals of the whole team ○ Identify plan to address conflict within the team ○ Review the updated CANS and choose/review priority actionable items ○ Develop goals or outcome statements ○ Identify strengths that can be used by the team to address goals/actionable items. ○ Identify plan to address conflict within the team ○ Facilitate development of the person-centered service plan ○ Identify crisis plan ○ Assign action items to team members ○ Facilitate consensus from all CFT members and assist in resolving disputes • Follow up with youth/family and team members between meetings (at least every 30 days) to check on assigned action items and monitor the youth's status. • Link youth/family to identified and agreed upon services : ○ Note: The youth and family should be offered more than one option of providers for each service needed. There may not always be multiple options for certain services and in those cases, please note on the PCSP. • Distribute copy of PCSP to family.	• Person-Centered Service Plan form and instructions • Handout - YES System of Care • Phases of CFT and description of TCC tasks (this document) • Tip Sheet – CFT Facilitation Skills
Monitoring and Adapting	• Implement the person-centered service plan • Follow-up CFT meetings based on need of the member/family. Meetings are prompted when: ○ A parent or youth requests a meeting. ○ The identified strengths and needs change. ○ The existing services and supports are	Documents to complete/update: • CANS • Person-Centered Service Plan • Progress notes from meetings Resources for TCC: • Person-Centered Service Plan

Targeted Care Coordination (TCC) - Phases of Child and Family Team (CFT) and Description of TCC Tasks

Phases	Tasks	Documents/ Forms
	not working as expected. o New resources are available. o The progress towards a goal is slower than expected. o The goals are met and new goals need to be identified. o There is a decrease in safety or a risk of crisis. • CANS updated every 90 days. • Create a way to track CANS score changes. • Share changes to CANS score with the team. • Address CANS scores that the team chooses not to prioritize. • Update plan every 90 days including changing strategies that have not been effective and also adjusting services based on progress. • Celebrate successes. • Ongoing Coordination and monitoring of services identified on the PCSP. • Ensure the medically necessary services are accessed, coordinated, and delivered in line with the YES Principles and Practice Model. • Continue to meet with the family and/or coordinate services and complete daily and weekly tasks outside of the CFT meeting. • Ensure that the plan is aligned and coordinated across the youth-serving systems and youth is being served in their community in the least restrictive setting. • Ensure all documentation is up to date (treatment plan changes, IEP, etc). • Collect team minutes and conduct regular progress reports/notes.	form and Instructions • Handout - YES System of Care • Phases of CFT and description of TCC Tasks (this document) • Tip Sheet – CFT Facilitation Skills
Transition	• Improved CANS scores inform the team and plan of nearing transition (for example when action items (needs 2-3) become non-action (needs 0-1.) • Transition occurs after discussion and consensus among team members. • Develop plan of transition with the CFT in a meeting that describes: o How ongoing services will be accessed	Documents to complete/update: • CANS • Person-Centered Service Plan o Transition plan reviewed and agreed upon • Discharge Summary

Targeted Care Coordination (TCC) - Phases of Child and Family Team (CFT) and Description of TCC Tasks

Phases	Tasks	Documents/ Forms
	○ Crisis plans that include a communication plan in case of emergency ○ Follow-up phone numbers for all team members that may be contacted ○ Effective use of natural supports and community resources ○ Indicators that a youth may need to return to the CFT/TCC ○ Formal discharge plan that describes strengths of the family, successful interventions, and ineffective interventions • Ensure youth/family have a way to access services in the future • TCC is also responsible for linking the youth to higher and lower levels of care throughout the duration of treatment. • If youth transitions, for example, to a higher level of care during or after a crisis, the TCC coordinates between systems as youth transitions to higher and lower levels of care. This includes updated CANS/PCSP as needed.	

Targeted Care Coordination (TCC) -
Tips for Facilitating a Child and Family Team (CFT) Meeting

Facilitation Components	Tips
Family and CFT Orientation (Prior to first official CFT meeting)	• Be diligent in reaching out to youth and families in ways that are welcoming and comfortable for them. • Take time to listen to the family's story and perspective. • Use language and body language that demonstrates a non-judgmental approach to understanding the family's situation. • Be open and honest about mandated reporting requirements, the role of systems, mental health, and regulations, and choices about sharing of information among team members. • Encourage and support the participation of children and families in identifying their individual treatment and services. Ensure that they understand what is and is not in their control. • Take the time to explain the CFT process, CANS assessment, and answer questions. (Provide handouts and resources if family and team members want to learn more, for example; youthempowermentservices.idaho.gov/, praedfoundation.org).
Introduction and Review Agenda	• TCCs should have a discussion with youth/family before the meeting about what to expect, who will be there, and potential topics being addressed. • Be attentive to who sits where. Some facilitators find it helpful to use name markers, assign seats, and have the youth and family arrive prior to the rest of the team. • Asking the family/youth to introduce themselves first is one way to put family-centered and youth voice and choice principle into practice. • Have each team member introduce themselves and identify their role/responsibility • Provide a copy of the CFT meeting agenda. • Remember to refer team members to where on the agenda their concerns will be addressed, if it is not the right time in the meeting. • Use "ice breakers," or creative ways to help the team members get to know each other.
Ground Rules	• Come to the meeting with a framework of ground rules in mind. • The term "ground rules" may need to be explained. • Encourage "balanced" participation from all members. Encourage quiet members to speak/contribute so the process is collaborative and team-based. • It may be helpful to ask the team how some of the rules tie to the YES Principles of Care. • Help "shape" the rules to be applicable to the entire team rather than singling anyone out. • Positively framed rules are preferable to negatively framed rules. • Review ground rules in every meeting and adapt as needed. • Use a whiteboard or bring a big poster notepad to record ground rules and use for brainstorming throughout the meeting.
Reviewing Strengths and Needs- (CANS)	• Identify and discuss strengths first, before identifying needs. • Reference and share the useful strengths identified in the CANS. • Gently re-frame deficit-based language and inappropriate language.

Portions of this Document have been adapted from Clark County Department of Family Services: https://www.childwelfare.gov/pubPDFs/NV_CaseManagementTrainingFacilitator.pdf and San Diego State University School of Social Work: CalSWEC link: https://calswec.berkeley.edu/child-and-family-team

Targeted Care Coordination (TCC) -
Tips for Facilitating a Child and Family Team (CFT) Meeting

Facilitation Components	Tips
	• If the team struggles to identify strengths, point out strengths you have seen while working with the family. • Discuss needs identified on the CANS with the family prior to the first meeting and have agreement with the family on which needs represent the family's current challenges. This will help you come to the first meeting with a prepared list of needs to begin forming goals and brainstorming strategies.
Defining and Prioritizing Needs/Goals	• Use SMART goals (Specific, Measurable, Achievable, Realistic, and Time-Limited). • Positively framed goals are preferable to negatively framed goals. • Goals must be individualized and fit within the family's culture. • Choose just a few goals to start. Plans with too many goals can lead to complicated plans that are hard to follow. You can move on to new goals/needs after some have been addressed later in the process.
Resolving Conflict	• Identify a process to resolve conflicts at the initial meeting and make sure it is documented on the coordinated care plan. • Clarify areas of agreement and disagreement and focus on areas of agreement. • Help team members look at all the options and see their choices. • Find and remind the team members of the common goals. • Allow breaks for de-escalation, if needed.
Brainstorming Strategies	• Lead the team in brainstorming multiple strategies for one outcome/goal at a time. • Record all strategies identified; even if far-fetched (try not to let the team judge the ideas). • Strategies should help achieve goals and meet needs. • Allow the youth and family to select the strategies that work best for them and fit with the family culture. • Include strategies that draw from the strengths of the youth and family. • Make sure each strategy includes a specific action step that is assigned to a specific team member(s). • Have the team pick the top 1-3 strategies for each need/goal.
Action Steps	• Assign action items to specific team members based on strengths identified. • Follow up with assigned tasks in between CFT meetings.
Summarize and Agree on Person-centered service plan	• Make sure the Person-Centered Service Plan (PCSP) honors the 11 YES Principles of Care. • Summarize the PCSP (strengths, needs, actionable items, goals, owners of tasks, and ultimate vision for the family's future).
Schedule Next Team Meeting	• Schedule the next meeting at the beginning of the meeting to ensure all members are present. • When considering time, dates, and locations for meetings, ensure family-centered, youth voice and choice, and cultural/linguistic needs are put into practice.

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TCC Requirements and Billing

Service Definition: The Targeted Care Coordinator (TCC) is responsible for coordinating and facilitating the Child and Family Team (CFT) interdisciplinary team meetings for the purpose of developing an outcome-focused, strengths-based Person-Centered Service Plan (PCSP) that includes both formal and informal services and supports. The TCC will be responsible to ensure that services are accessed, coordinated, and delivered in a strengths-based, individualized and relevant manner, and that services and supports are guided by family voice and choice. TCC must reflect the YES Principles of Care and be consistent with the YES Practice Model. The TCC will serve as a care navigator for the family and will be responsible for promoting integrated services, with links between child-serving providers, systems and programs.

Targeted Care Coordination occurs through face-to-face or telephonic contact and must not be duplicative of any other service. Targeted Care Coordination cannot be provided by the same individual who provides other direct care services to the member nor can they be supervised by another member of the CFT. Targeted Care Coordination can be delivered as a community-based service or in the outpatient clinic setting.

Requirements

- CANS certified Bachelor's level TCCs can only UPDATE the CANS for a member they are providing TCC for. They cannot complete CANS updates for members they are not working with as TCC. The CANS certified primary treating master's level clinician must do the initial CANS.
- The primary treating master's level clinician must be present for a Child and Family Team (CFT) to occur and a PCSP to be developed.
- CANS certified TCCs bill the Targeted Care Coordination code (T1017) while facilitating CFT meetings and also while serving other TCC functions outside of facilitating CFT meetings. The other providers at the CFT meeting may bill the CFT code (G9007).
- Bachelor's level TCCs bill the CANS code with the appropriate modifier (H0031 HN) when updating the CANS for their member engaged in TCC.
- TCCs do not bill the case management code (T1016) for the coordinating/linking tasks of a family engaged in Targeted Care Coordination. They would bill the Targeted Care Coordination code (T1017) for these functions.
- The member/family must be present in order for TCC to occur.
- The CANS must be updated at a minimum of every 90 days, or more often when clinically indicated.
- TCC must follow up with the family outside of CFT meetings at least every 30 days to monitor the youth/family's progress.
- PCSPs must be updated annually and/or more often as clinically indicated.

Billing

A TCC will use the codes and modifiers on the table below for Targeted Care Coordination activities.

Code	Mod 1	Mod 2	Description	Unit
T1017			Targeted Care Coordination – face-to-face	15 min
T1017	**UA**		Targeted Care Coordination – Telephonic	15 min
T1017	**U2**		Targeted Care Coordination with CCM certification – face-to-face	15 min
T1017	**U2**	**UA**	Targeted Care Coordination with CCM certification – Telephonic	15 min
H0031	**U2**		CANS update by TCC with CCM certification – face-to-face	15 min
H0031	**HN**		CANS update by TCC without CCM certification – face-to-face	15 min

T1017 – Targeted Care Coordination service

Providers would bill this code for facilitation of a Child and Family Team (CFT); check-ins with the Member; meetings or calls between the Member, the TCC and the provider outside of a CFT, etc. This code can be used face-to-face or telephonically, but the Member must be physically present or on the phone.

H0031 – CANS

Providers would bill this code for the time spent completing a CANS update. When billed by a Bachelor's level TCC, this code is to be used when the member is physically present. The CANS updates cannot be done via telephone or telehealth by a Bachelor's level provider. Please note that Targeted Care Coordinators are only permitted to do the 90 day CANS updates as coordinated and agreed upon by the primary treating master's level clinician. The Targeted Care Coordinator may not completed the initial or annual CANS. The initial/annual CANS must be completed by the primary treating master's level clinician.

Modifiers

UA – This modifier is used to indicate that the service was provided telephonically.

U2 – This modifier is used to indicate that the Targeted Care Coordination service was provided by a Certified Case Manager (CCM) that has also completed the Optum Idaho Endorsement: Targeted Care Coordination and the TCC Toolkit Training.

HN – This modifier is used to indicate that the service was provided by a bachelor's level provider. In the case of the CANS, the bachelor's level provider that is permitted to provide the service is a CANS Certified Targeted Care Coordinator with the Optum Idaho TCC Endorsement (or with a CCM Certification, however, those with a CCM Certification would bill using the U2 modifier rather than HN).

Other Notes

Please note that prior to June 1, 2019; T1017 was used to bill BH Case Management services. After June 1, 2019, all Behavioral Health Case Management services (not TCC) are to be billed under T1016.

Qualifications

- Bachelor's level or higher under supervisory protocol with an Optum Idaho Endorsement: General Foundation and Optum Idaho Endorsement: Targeted Care Coordination.
  OR
- Bachelor's level or higher with National Certification from Commission for Case Manager Certification (CCMC) who has completed the Optum Idaho Endorsement: Targeted Care Coordination and the TCC Toolkit Training.
  AND
- The Targeted Care Coordinator must complete CANS training and must be CANS Certified if completing CANS updates.

Authorization/Limits:

- No prior authorization is required.

Facilitation and Child and Family Team (CFT)/Person Centered Service Plan (PCSP) Development

- If you still have questions that are not answered below, please reach out to your Regional Network Manager.
- If member/family responses are limited, try using open ended questions when possible.
- Be conscious of applying a trauma informed lens to CFT meetings and PCSP development. For example, if there is a history of trauma and/or Oppositional defiant Disorder(ODD) diagnosis, develop goals tied to emotions and mental health symptoms vs "the child will follow directions" or "the child will do what they are told"
- When documenting, ensure the plan does not incorrectly list another child's or sibling's name.
- The primary treating master's level clinician must be present for the CFT meeting and PCSP development to take place. However, Targeted Care Coordination (TCC) discussions can take place without a master's level clinician present.
- Please ask the family all required questions on the form. "None identified" or "Family declined to answer" are acceptable responses if the question doesn't apply to that particular family's situation.
- If you are making a change to an existing PCSP, it must be signed and dated by the participants who are responsible for implementing the change.
- Suggest reviewing the PCSP process document before completing the member's PCSP, as the process document contains ground rules for the CFT meeting and resolution strategies for conflicts within the CFT, both of which are essential for effective facilitation. It may be helpful to discuss these components toward the beginning of the meeting vs end.
- If the family needs the PCSP translated to another language in order to understand it, please make those arrangements prior to submitting the PCSP to Optum for Code of Federal Regulations (CFR) review. The PCSP submitted to Optum for review must be in English.
- Optum only needs to review the PCSPs for YES members, and not traditional Medicaid. This can be checked the same way your check a member's eligibility on Provider Express. Please refer to a separate document called: Member YES Eligibility.

PCSP Form Instructions & Key Fields

- Form content must be keyed into the fillable PDF. Handwritten forms will not be reviewed.
- Fields which help the PCSP meet the Code of Federal Regulations (CFR) are indicated below as "(CFR)"
- Ensure the member's Medicaid ID, first name, last name, and DOB are completely correct as well as the TCC's contact information (CFR)
- "Is there anything about my ethnicity, faith, language, or culture that we should keep in mind?" (CFR)
- These questions help meet CFR:
    - What do I like to do and what is really important me?
    - What are my talents and strengths?

- What type of things do I enjoy doing with family/ friends, and what are my relationships like with family members/ friends?

- Risk Factors: If there is a risk identified in the body of the plan, ensure it is addressed in this section. (CFR)
- Developing a clear, robust, and realistic crisis plan is an essential tool for families and members. A crisis plan allows the family to maintain some degree of control over a situation that might otherwise feel out of control. It can give families a sense of power and offer options for times when decision making is difficult. Documenting clear strategies in advance can assist families in feeling prepared and supported when it is most imperative to the well-being of the member.
- "Who should be contacted when I'm having a crisis?" Please list at least one person outside of the household. Consider also adding the Optum Member Line (1-855-202-0973) as an option.
- Functional Assessments: Needs to be completed, include CANS date. If the CANS was updated since the original PCSP was created, include the most recent CANS date and information. (CFR)
- "What does my CANS and other assessments say about me?" Include at least one strength and one need. (CFR)
- Goals and outcomes (CFR)
- Use the "Select a Service" field which corresponds with each identified goal. You may select more than one service for each goal. Use the "Other" option to write in informal services, e.g. karate class, church group, etc.
- Do not include services and a provider if that provider is not aware of the member's need for them. If the CFT decides that a service may be appropriate, the referral to a provider for assessment may be documented within the PCSP, but the service would not be included in this section, nor does that provider have to sign the PCSP before it can move forward for CFR review. Rather revisit that service at the next CFT meeting.
- Transition Plan: A transition plan can assist families in strategizing for changes in levels of care - whether planned or unplanned. Transition plans can aid members transitioning from one phase of life to another (e.g. from childhood to adulthood). They can help families anticipate upcoming changes. Proactively planning for transitions in advance can benefit families by creating predictability, stabilization and safety during times of change.
- First three Yes/ No questions on the page (CFR)
- Signatures (CFR)
- If a provider attended by phone or missed the CFT meeting, they should email or provide in writing (email acceptable) their agreement with the PCSP to the TCC. The TCC's signature represents their agreement they have all applicable CFT team members' approvals on file.

Person-Center Service Planning Process Document

- Last 2 pages of the PCSP file
- Resolution strategies for the CFT meeting itself, including any conflicts of interest **(CFR)**
- Service and provider options that were offered to the member: The member should be offered more than one option of providers for each service needed. We understand that in some areas, there may not be multiple provider options for certain services. In those cases, please note accordingly in this section.

- Facilitator's signature: Just like the PCSP, this document should be updated each time there is a PCSP developed and signed/dated accordingly.

Sending the PCSP to Optum

- Optum and Targeted Care Coordinators (TCCs) will interact using a tool called Optum Supports and Services Manager (OSSM). There is an OSSM Tutorial available on **Relias**.
- There is an OSSM Instruction Manual on OptumIdaho.com > For Network Providers > Targeted Care Coordination (below the location of this TCC Toolkit

How Members, Treating Providers, and Other CFT Members Access PCSPs

- Once the youth/family provide permission (see PCSP Consent form under "Forms" on Optumidaho.com > For Network Providers > Targeted Care Coordination), the TCC goes into OSSM to grant other CFT members access to the PCSP document.
- All other CFT members (except the TCC) may access read-only PCSPs on the Optum Idaho website once consent has been given..
- To ensure all members' protection of health information, all CFT members accessing the portal, will need an Optum ID, which can be done on Provider Express. Please see separate instructions on creating an Optum ID for more details. Informal supports in the youth/family's CFT will be able to access The PCSP through the secure, "read only," side of OSSM called "OSSM Individual and Support Team Portal."

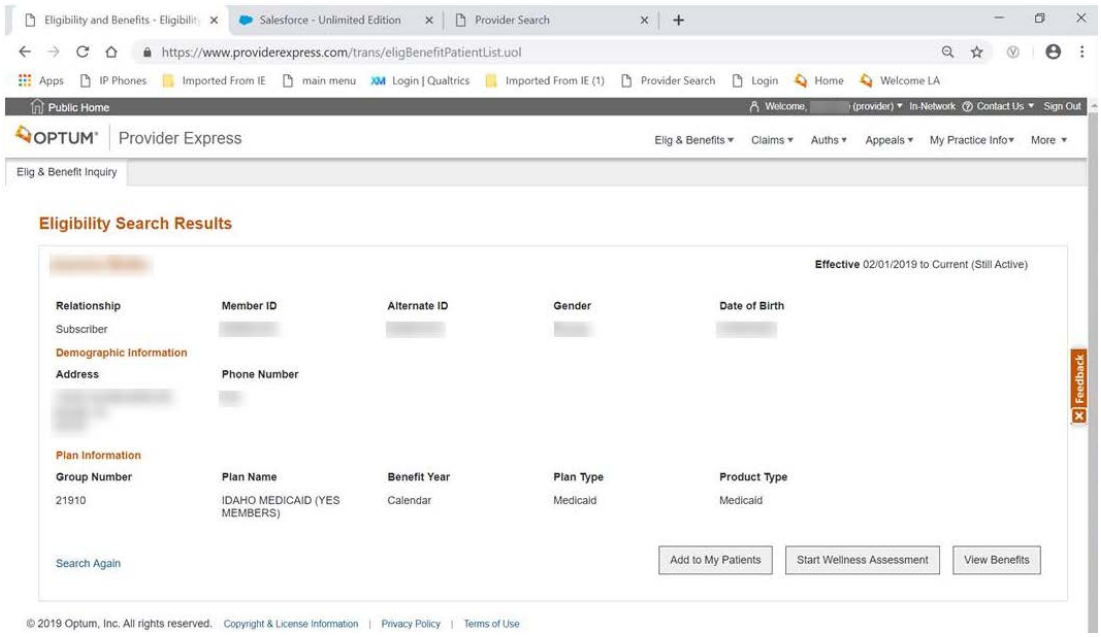
The OSSM Instruction Manual is on OptumIdaho.com > For Network Providers > Targeted Care Coordination (under "forms")

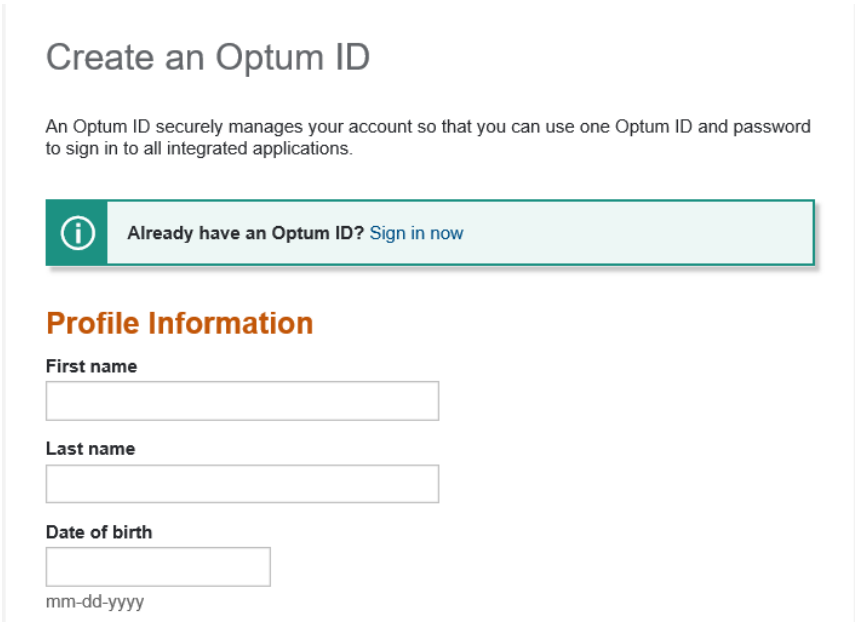
Identifying if a Member is YES

Optum only needs to review the PCSPs for YES members, who will have one of these client codes, as well as "YES" in their Group Name:

Client Code	Cosmos Group	Cosmos Contract/Group Name
N44	21910	Enhanced Child YES 0-18 Non Dual
YN36	21930	YES-Foster Care Title IV-E -ND.
YN52	21972	YES-Aid to the Blind w/o Cash -ND.
YN54	21995	YES-Perm/Term Disabl w/o Cash -ND
YN55	21996	YES-Homecare Disabl Child 133PL -ND.
YN56	21998	YES-Refugee Medical Non Dual
YN61	22000	YES-Foster Care Non IV-E -ND
YN66	22002	YES-Presumpt Elig Pregnant Women Non Dual
YN67	22007	YES-Pregnant Women Non Dual
YN85	22084	YES-Enhanc/Transition MCD - ND.
YN88	22091	YES-Basic Children 1 Non Dual
YN89	22092	YES-Enhanced Children 1 Non Dual
		Total Y.E.S. Non-Duals
YC60	22093	YES-Basic Children A 6-19 CHIP
YC63	22098	YES-Enchanced Children A 6-19 CHIP
		Total Y.E.S. CHIP

Below is how that looks in Provider Express when you check their eligibility

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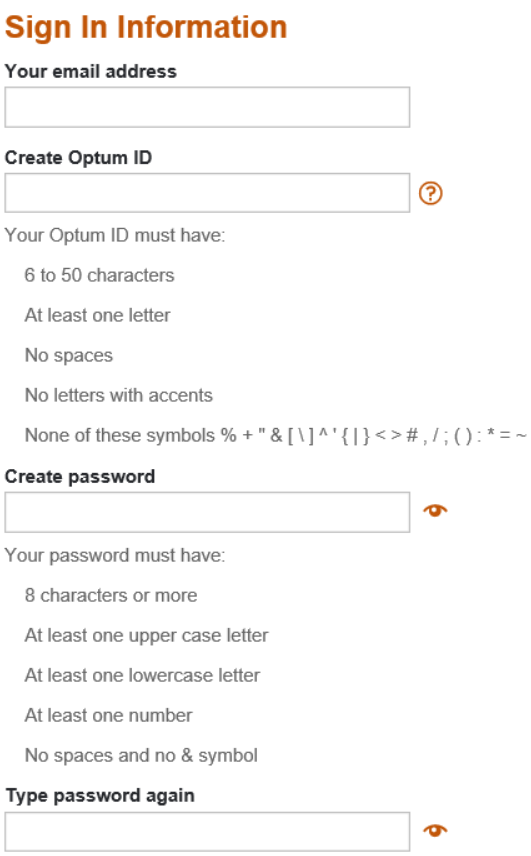
Profile Information
First name
Last name
Date of birth
mm-dd-yyyy


Sign In Information
Your email address
Create Optum ID
Your Optum ID must have:
6 to 50 characters
At least one letter
No spaces
No letters with accents
None of these symbols % + " & [\ ] ^ ' { | } < > # , / ; ( ) : * = ~
Create password
Your password must have:
8 characters or more
At least one upper case letter
At least one lowercase letter
At least one number
No spaces and no & symbol
Type password again

Security Questions and Answers

Security question 1

--Select--

Security answer 1

Security question 2

--Select--

Security answer 2

Security question 3

--Select--

Security answer 3

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