

# CARE COORDINATION IN THE PEDIATRIC SETTING:

Linking Children and Families to Services



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## **About the Child Health and Development Institute of Connecticut:**

The Child Health and Development Institute of Connecticut is a not-for-profit organization established to promote and maximize the healthy physical, behavioral, emotional, cognitive and social development of children throughout Connecticut. CHDI works to ensure that children in Connecticut who are disadvantaged will have access to and make use of a comprehensive, effective, community-based health and mental health care system.

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Jared is two years old. Born 15 weeks before his official due date, he spent his first two months of life in the newborn intensive care unit. In addition to several ongoing health issues related to his premature birth (chronic lung disease, hypertonia, and retinopathy), Jared has not met many typical development milestones for his age. He cannot walk or feed himself, and he has severe speech and language deficits. Jared sees medical sub-specialists, including a pediatric pulmonologist and an ophthalmologist, for ongoing management of his medical conditions. He also receives speech services and physical and occupational services from the state's early intervention program, both at his home and at his day care center.

Managing all these services would be a challenge for any family, but Jared's family has the support of a nurse in the primary care physician's office where he receives ongoing care. This nurse coordinates the many services that Jared receives, all of which are outlined in his formal care plan. The coordinator has periodic telephone calls with his family to discuss breathing and oximetry readings. She enters this information into the medical record, ensuring that the physician can be up to date on how Jared is doing. When the primary care physician receives reports from sub-specialists, the coordinator ensures that recommendations, modifications in care, and updates are reflected in Jared's care plan, and informs the child's parents of any changes.

The coordinator also maintains contact with the early intervention therapists and day care center to ensure that all services are in place for Jared. She convenes a team conference at least twice a year for Jared's family and providers to review the child's care plan, document his progress, and agree on modifications.

As a result of this coordination, Jared's family has a single point of contact for the many services that he requires. This keeps them informed on what they need to do at home for Jared, as well as the many other services that he uses, and it also ensures that Jared receives all the services he needs in the most efficient way, with no duplication or unnecessary visits and tests.

## INTRODUCTION

The effective execution of child health services frequently depends on connecting children and their families to services and supports outside the primary health care system, or even beyond the boundaries of the health care system to other service systems, such as schools, child care settings, and social services. Care coordination connects children to the services and supports that are needed to ensure optimal health and development.<sup>1</sup> Effective care coordination ensures that children receive all the services that they need, and use services efficiently to avoid duplication and unnecessary visits, which are generally inconvenient and stressful for families and unnecessarily increase health care costs.

Care coordination is especially important for children.<sup>2,3</sup> When children need medical sub-specialty or social and other support services, it is important that they receive them as soon as possible. Children also grow and learn within a variety of settings that affect their long-term development. These include families, child care settings and schools, and public and private programs designed to promote children's health and development. If health services are to be effective in ensuring children's health and development, they need to identify children in need of supports and services early, when intervention can be most effective, and then link them to available services and continue to monitor health and development in coordination with other services. Care coordination helps meet these needs.

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The primary care health setting provides an excellent starting point for connecting children and families to the larger arena of health and community services. Pediatric and family medicine providers, including physicians, nurse practitioners, and physician assistants supply the majority of well child care services and are often the first and most frequent service with links to the broader spectrum of health and other services for parents and caretakers in the first few years of life. The health system's role in early identification of need and referral to services is critical. In fact, care coordination has been identified as one of the most important skills to teach to future pediatricians.<sup>4</sup>

The importance of families as partners in effective care coordination cannot be over-emphasized. Children cannot actuate health or other services without parental involvement, which includes permission, transportation, payment, and follow-through on care recommendations. Families and caretakers, then, need to be collaborators in the implementation of care coordination services.

This report discusses the various forms of care coordination currently supporting families and children within the health care system. The evidence for the effectiveness of care coordination is reviewed in light of its potential to improve the overall effectiveness of health and other systems of care for children. Barriers to providing care coordination services and the current systems in place in Connecticut to connect children to services are reviewed. The report concludes with an analysis of the critical elements of an effective care coordination system and the potential for their implementation in Connecticut.



## WHAT IS CARE COORDINATION AND HOW IS IT PROVIDED TO CHILDREN?

Care coordination can be accomplished in many ways but usually includes the same basic set of activities. Insurance companies, which often provide and pay for care coordination, have defined payable care coordination activities. These are outlined in Figure 1.<sup>5</sup> Medical providers, health insurance organizations, state agencies, visiting nurses associations, and public health programs can all provide care coordination for children. Often, care coordination services are available only for children and families who meet specific eligibility requirements. For example, many managed care organizations provide care coordination for enrollees who meet criteria such as:

multi-system involvement, significant impairment in functioning level, or the need for three or more providers or levels of care (i.e., home care, school services, early intervention, family therapy, medical management, individual treatment, and group therapy). It is estimated that 11% of children with special health care needs receive care coordination from their primary health insurance plan.<sup>6</sup> These organizations use care coordinators who are employed by the health plan and usually work by telephone from centralized sites.

**Figure 1. Care coordination activities**

- Contact via phone or face to face
- Face to face meetings with community-based agencies and organizations, such as state child welfare, schools systems, in which children receive services
- Formal telephone conferences with organizations and agencies serving children
- Assessment/intake with family and/or children
- Review of assessment/intake with other treatment providers
- Addressing barriers to services, including scheduling appointments, exploring payment and reimbursement options, securing referrals (shelters, health care, educational, mental health, and early intervention), arranging transportation, interpreters, and special equipment that children and families need to access health and community-based services
- Meeting with agencies and organizations to review resources for addressing children's functioning
- Written reports/evaluation of reports that contribute to children's treatment plans
- Follow-up contacts with family, school, and treatment providers as required for the evaluation of the treatment interventions

Several publicly funded systems provide care coordination services for children. These include the following:

- 1. State child protection agencies** often provide care coordination to meet the needs of children living in out-of-home settings, such as foster care. These services integrate health services into the variety of supports that these children need. The services provided are usually accomplished by caseworkers, who work face to face with children and with the various providers of services and supports they need. The starting point for this type of care coordination is child protective services and is only available to children within that system.
- 2. The Title V program for children with special health care needs** is another state program that typically provides care coordination services. These care coordinators are particularly focused on connecting children with highly complex medical and developmental needs to medical sub-specialty services, respite care, and medical equipment suppliers. Care coordination in Title V is central to the provision of “medical home” services, which also should be accessible, comprehensive, continuous, family-centered, and culturally competent.<sup>1</sup>
- 3. Care coordination under the label of “service coordination”** is also mandated for children receiving early intervention services under Part C of the Individuals with Disabilities Act. Children ages birth to three, with or at risk for developmental delays, qualify for Part C services according to state eligibility guidelines. Federal regulations require that service needs for these children, which include such things as speech and language, occupational and physical therapies, and educational interventions are outlined in an Individualized Educational Plan (IEP). In some states, including Connecticut, primary care physicians are required to sign the IEPs developed for their patients who qualify for Part C services. This is designed to facilitate the integration of community-based early intervention services with medical primary care services.

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For the general population of children, including those with less complex health care needs, care coordination services are provided in a less formal way. If children receive health services within a setting that has access to care coordinators, they can be linked to supports through that mechanism. For example, hospital-based primary care and specialty clinics usually employ social workers to facilitate patients' access to needed services beyond the clinic. In private practice child health settings, and particularly in smaller practices, care coordination is provided by a variety of professionals within the practice, including nurses and referral managers. Parents themselves do much of the coordination for their children's care across the spectrum of medical and community-based services. The most comprehensive view of care coordination services in private practice settings was published in 2004.<sup>7</sup> This study of care coordination activities in one large practice identified five categories of staff that performed care coordination, including: physicians, nurse practitioners, registered nurses, medical assistants, and clerical staff.

The development, implementation, and monitoring of a written care plan is central to providing care coordination services. A written care plan outlines, for each child, all of the services needed, who will provide them, when they will be provided, the expected outcomes, and the plans for follow-up. It is important that the family be involved in developing, implementing, and monitoring the care plan in collaboration with the care coordinator. Care plans formalize everyone's role in providing services and hold providers accountable for care and outcomes. A sample care plan is featured on Page 17.

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## THE BENEFITS OF CARE COORDINATION

Care coordination has been shown to be cost-effective and to result in improved health outcomes. An investment of \$400 per child over one year to ensure care coordination in six pediatric practices<sup>8</sup> resulted in a significant decrease in the number of parents of children with special health care needs missing more than 20 days of work and a significant decrease in children's hospitalization rates. When asked about their experiences working with a nurse practitioner who served as a practice-based care coordinator, parents in this study reported that it was easier to set goals for their children (52% responded "easier"), get letters of medical necessity (67% responded "easier"), and to have the same nurse with whom to talk (68% responded "easier").

One study of care coordination in a private practice setting in Massachusetts<sup>7</sup> found that telephone contact with a care coordinator decreased the need for office visits when their children were sick. Avoidance of an office visit resulted from 26% of telephone consultations between the care coordinator and families of children with complex health care needs. When this study was replicated across six pediatric practices, 32% of care coordination encounters resulted in avoidance of utilization of some other medical service, including emergency department (ED) visits, lab tests, x-rays, and hospitalizations.<sup>9</sup>

When one large pediatric practice extended office hours, opened a new office site, and added a care coordinator, the average per member per month emergency department cost for children covered by Medicaid decreased by \$1.36.<sup>10</sup> In South Carolina, when a full-time care coordinator was placed in a two-provider pediatric practice, the number of children being admitted to the hospital if they did use the ED decreased dramatically, from nearly 10% to less than 1% after 18 months.<sup>11</sup>

***Care coordination has been shown to be cost-effective and to result in improved health outcomes.***



## CARE COORDINATION IN THE PEDIATRIC SETTING:

Three years after implementation of a care coordination system in 16 private practices in Pennsylvania, parents were more likely to report that their children's primary care provider "often or always" used a written care plan,<sup>12</sup> which is considered critical to successful care coordination.<sup>1</sup> Practices that were part of this demonstration project achieved higher scores than practices that did not implement care coordination on Medical Home Index Measures (organizational capacity, chronic care management, community outreach, data management, and quality improvement) after three years of using a practice-based care coordinator.<sup>12</sup> In this same study, practices that relied on care coordination services from a community agency also improved their Medical Home Index scores, but not as much as practices that implemented care coordination themselves.

Studies of care coordination services for specific medical conditions also report beneficial outcomes. Service coordination for pregnant women covered by the Medicaid program and deemed high risk decreased the number of newborns who required admission to the neonatal intensive care from 107.6 per 1,000 live births to 56.7 per 1,000 live births over a five-year period.<sup>13</sup> Children with asthma who had written care plans were half as likely to be hospitalized or have an ED visit for asthma as children who did not have care plans.<sup>15</sup> One study from Rochester, New York, showed that hospital admissions, lengths of stay, and inpatient costs were reduced significantly when children with chronic illness received practice-based care coordination services.<sup>15</sup>



## THE CURRENT PROVISION OF CARE COORDINATION SERVICES TO CHILDREN

Despite the proven effectiveness of care coordination services, their provision in pediatric practices is still less than optimal. A survey of 1,632 American Academy of Pediatrics (AAP) members<sup>16</sup> (57% responding) found that 71% of pediatricians responding reported that they or someone in their practice coordinates care for patients. When asked about specific care coordination tasks, however, only 23% reported always contacting schools about a child's health, only 19% scheduled time with the child's family to discuss the results of a visit to a specialist, and only 24% reported meeting with a discharge planning team if a child were hospitalized.

Pediatricians in this study did not report that the children with special health care needs in their practices were more likely to receive care coordination services than the children without special health care needs. Pediatricians reported that their practices are less likely to have someone from the practice staff serve as the care coordinator for children with special health care needs than they are for other children. However, it may be that coordination of services for children with special health care needs largely happens through funded programs for this special population, such as the Title V block grant.<sup>6,17</sup>

The AAP survey also revealed variation between practice types in providing care coordination services, suggesting that receiving care coordination is dependent on the practice environment.<sup>16</sup> Pediatricians practicing in rural areas are more likely than their urban counterparts to be in contact with schools. Pediatricians working in hospital clinics and solo practices are more likely than pediatricians in group practices or health maintenance organizations to report that they integrate their patients' care plans with those developed by other medical practices and/or community agencies or services. In general, however, the integration of patient care plans across service sites is low with 41% of pediatricians reporting that their practice does this for all patients and 49% reporting that they integrate care plans for children with special health care needs.

In a survey of families with children with special health care needs<sup>18</sup> almost half reported that their child had a case manager. Seventy percent of those with case managers felt that their case manager had a "good understanding" of their child's health care needs and services. Many parents also reported that they coordinate their children's care and utilization of numerous systems of services themselves.

***Despite the proven effectiveness of care coordination services, their provision in pediatric practices is still less than optimal.***

## BARRIERS TO PROVIDING CARE COORDINATION

Time and lack of practice staff are the two most common barriers to providing care coordination services.<sup>16</sup> The realities of pediatric practice cause providers to spend most of their time on activities for which they can derive reimbursement. It has been estimated that it costs between \$23,000 and \$28,000 per year for a practice with 5,800 patients to provide care coordination services.<sup>7</sup> This estimate is derived from an analysis of the time practice staff spent on telephone calls, in meetings, completing and reviewing correspondence with a variety of community services, medical consultants, and parents for other than routine medical needs. Although Current Procedural Terminology (CPT), the numerical coding system used by providers when submitting claims to health insurers, contains codes for several aspects of care coordination (such as care plan oversight, team conferences, and telephone consultation), they are not uniformly reimbursed by public or private payers.<sup>17, 19</sup>

In an effort to improve care and lower costs for children with special health care needs, demonstrations are under way in some states to reimburse providers for care coordination services. Illinois<sup>20</sup> and Ohio<sup>21</sup> have developed educational and documentation requirements to guide physician billing for care coordination to the state Title V program. It remains to be determined if reimbursing providers for care coordination can lead to a sustainable system change within pediatric practices.

The personnel challenges in providing care coordination are also related to reimbursement. Traditionally, insurers only reimburse for care provided by physicians and nurse practitioners. Many care coordination activities are done by RNs, LPNs and office staff. CPT documentation stresses that the only time that can be included when using the billing codes is the time a nurse or other staff member spends reviewing patient information with the physician.

The practicality of designating one staff member to serve as the practice's care coordinator is questionable. On the one hand, it is ideal for practices to use their own staff members to serve as care coordinators, as they are familiar with the families and children for whom they are coordinating services and can meet needs in collaboration with families. On the other hand, a practice-based care coordinator needs to serve a large enough population so that it is worthwhile for a practice to maintain the position. The reality is that a variety of staff members provide care coordination, as evidenced by an analysis of six community-based pediatric practices.<sup>9</sup> This unsystematic approach to care coordination makes it difficult for insurance companies that pay for care to identify and recognize a set of services that can be documented and that require substantial time commitment to qualify for reimbursement.

***Time and lack of practice are the two most common barriers to providing care coordination services.***

An alternative to practices hiring their own care coordination staff is to have community-based entities provide care coordination services on a more regional basis. These individuals can develop relationships with families and practices, maintain a good understanding of the community resources for children and families, and simultaneously serve a number of practices. In Pennsylvania, however, practices had difficulty obtaining care coordination services for children with special health care needs from community or government agencies.<sup>16</sup>

The lack of information about and availability of community resources hinders effective care coordination. Care coordination requires an array of medical specialty and community services to which children can be connected and served, and from which the practice will receive appropriate feedback. Care coordination is not a service that practices can provide in isolation of the larger health care, social, educational, and community service environment. Pediatric providers may be reluctant to identify needs in children if they are not confident that extensive evaluation and treatment options can be accessed or if they cannot easily connect children with services.

A lack of integrated data systems also stands in the way of effective coordination. Data systems that support care coordination not only can help link patients to services, but they also inform providers about services their patients use outside of the medical home. For example, cross-site electronic medical records alert providers about when patients are hospitalized, use the emergency department, or see specialists. Electronic transfer of service utilization information helps primary care practices provide appropriate follow-up and efficient ongoing care.

The final barrier to implementing care coordination for children is the lack of integration across the many systems that serve children and families. These systems include: health care, education, social service, early intervention, mental health, child care, and still others. Propelled by separate funding streams and eligibility criteria, these systems often don't work together in the best interests of the children they each serve. Critical to the provision of effective care coordination is the bridging of services across sectors in terms of access, information flow, and responsibility. In sum, collaboration across systems needs to happen at the state service system level to optimize care coordination.

## TOOLS FOR IMPROVING CARE COORDINATION

Several tools exist to help practices provide care coordination services for their patients and monitor their effectiveness in doing so. The National Center for Medical Home Initiatives for Children with Special Needs, part of AAP, offers several templates for care plans,<sup>23</sup> job descriptions for care coordinators,<sup>24</sup> and coding guidelines for care coordination services.<sup>25</sup> AAP also provides a tool that practices can use to determine the extent and outcome of their care coordination activities.<sup>26</sup> Utilization of these resources helps practices to systematize care coordination and continuously monitor their processes and outcomes.

Despite the availability of resources for practices, it is doubtful that providers will implement and systemize care coordination activities within their practices without support. Demonstrations and models that are in use have been developed through state initiatives and grant-funded projects. These initiatives are described on pages 18 and 19.



## DEVELOPING A SUSTAINABLE CARE COORDINATION SYSTEM FOR CONNECTICUT

Effective care coordination connects children and families to the services that they need. This should happen within an ongoing system of care that includes all providers of services and monitors progress collaboratively with providers and families. Four components are essential to ensure this:

- 1) community or practice-based care coordination services
- 2) ongoing financial support for care coordination services
- 3) data systems
- 4) collaboration across systems that serve children

As substantiated above, care coordination is most effective when delivered from or in collaboration with a primary care practice. Ideally, care coordination personnel should be based at the child health practice site, or locally enough to establish relationships with families and inform them about the availability of and mechanisms for accessing community resources.

Care coordination needs to be sustainable in order to embed it into ongoing care. Funding and support for care coordinators needs to be provided as part of health services. Examples of innovations in financing that have supported care coordination include Illinois' medical home initiative<sup>20</sup> and Iowa's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.<sup>29</sup> A visiting nurses association in Iowa connects all families to primary and other services as soon as they become eligible for Medicaid. The visiting nurses' services are reimbursed by Medicaid on a fee-for-services basis. Provider accountability needs to be built into systems to ensure that tangible services are being provided and that the needs of families are being met. In Illinois, primary care child health providers need to complete an online medical home educational course in order to qualify for Medicaid reimbursement for care coordination services.<sup>20</sup> Other auditing strategies include care periodic parent surveys, chart audits, and billing audits to review case management activities.

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Data systems comprise the third necessary element for comprehensive care coordination provided from or in collaboration with the care site. Electronic mechanisms are needed to link patients to services, as described in the Child Development Infoline discussion on Page 18, and to inform providers about services their patients use outside of the medical home. Some large primary care practices, such as the site of the HOME project (also on Page 18), do collect and maintain point of care data to track and monitor patient utilization and clinical information. The challenge remains to implement wider use of such tools by primary care providers. Although several primary care sites in Connecticut are using or considering electronic medical records, the extent to which these systems help connect providers beyond their own practices to coordinate care with medical specialists and community-based services is unclear.

Linking care across sectors that provide services to children is the fourth necessary component of an effective care coordination system. Data sharing and data transfer are two obstacles that hinder collaboration among service providers. The larger issue, however, is bridging services across state programs so that children can benefit from care coordination and direct services without meeting specific program eligibility criteria, such as children with special health care needs or children under the care of state child welfare services. Care coordination needs to span services rather than address needs within a single system of services.

Connecticut is in an excellent position to test a comprehensive model of community-based care coordination. Practice-based and regional models of care coordination are being implemented by DPH, CCMC, and the Charter Oak Health Center. Both of these models provide care coordinators to serve practice sites. The DPH medical home support center model described on Page 18 serves children with complex special health care needs with regional care coordination services. Evaluations of these programs will provide insight into how the location of care coordination services affects patient utilization of health and other services and family satisfaction with care. Both models, however, require substantial financial support in grants or contracts.

The 2006 legislative initiative will provide a first look at reimbursing practices for care coordination and extending the two models under way to explore sustainable methods of supporting these services. The legislative initiative is also noteworthy in its call for collaboration between DPH and DSS in the implementation of a pilot project to coordinate care. The development of data systems to support care coordination remains a challenge. But substantial federal and state resources have been committed to data connectivity in medical practice, so it is likely that primary care practice will experience a revolution in data capabilities in the coming years.

Finally, initiatives to promote collaborations at the state and practice levels will enhance efforts to coordinate services for children.



## CONCLUSION

Care coordination is a critical element of primary care practice that contributes to children's health and development. The evidence supporting care coordination as a cost-effective service with health benefits indicates that it is worthy of serious consideration in the health policy and system spheres. Little care coordination is provided to children now, but models for delivering these services in community-based settings, including pediatric practices, have been tested. Lack of time, reimbursement, personnel, community-based services for children, data systems, and collaboration across sectors of care currently impede the delivery of care coordination services from primary care sites. In Connecticut, however, several initiatives are under way to explore promising models of providing care coordination services that address identified barriers. It is reasonable to expect that Connecticut can support a sustainable care coordination system for children.

## SAMPLE CARE PLAN

Patient Name: \_\_\_\_\_

Practice Staff Contact: \_\_\_\_\_

Date Developed: \_\_\_\_\_

Date Reviewed (complete with each update): \_\_\_\_\_

Date Reviewed: \_\_\_\_\_

Date Reviewed: \_\_\_\_\_

Problem	Service Needed	Responsible Agency	Timeline	Goals	Follow-Up
Speech and language delay	Speech	Public school preschool special education program:  Contact: (name and contact information)	2 x per week in preschool classroom for 2006-07 school year	Refer to Individualized Education Plan	Practice care coordination to talk with school staff prior to next well child appointment (March 2007)
Otitis Media with Effusion	ENT evaluation	Referred to (name of ENT and contact information)	By March 2007	Evaluation for bilateral tympanostomy tubes	Consultation with ENT following evaluation (March 2007) and meeting with parents to discuss recommended plan of action

## CARE COORDINATION INITIATIVES IN CONNECTICUT

### ***Help Me Grow***

In Connecticut, access and linkage to community-based, medical and non-medical services for children at risk for developmental and behavioral delays is coordinated by the Children's Trust Fund's Help Me Grow program. Components of the program include training and support of child health providers in identifying children for referral and how to make referrals. Once a provider makes a referral through Child Development Infoline/211, a child development community liaison works with a 211 care coordinator to identify appropriate services. One call will connect families to the state's Birth to Three system, preschool special education, and Title V services for children with special health care needs in addition to all of the community-based services inventoried through Help Me Grow.<sup>27</sup> This ensures that children who do not qualify for state early intervention or preschool education programs still are connected to services. Sending feedback to primary care physicians regarding all of the services to which their patients are connected facilitates care coordination.

### ***Nuturing Families Network***

The Nuturing Families Network (NFN), another program of the Children's Trust Fund, identifies vulnerable, first-time mothers during the prenatal period or before they leave the hospital with their newborns. By 2007, NFN will offer services through the prenatal clinics and birthing centers in all Connecticut hospitals. The program uses intensive home visiting to support the parent in finishing school, securing a job, and accessing and utilizing child health services. NFN also connects families to WIC and other community services. Participating families' needs are continuously assessed in order to ensure that they are linked to the services that they need to ensure the healthy development of their children. The program has been shown to help families find needed services.

### ***Legislation***

In 2006, the Connecticut General Assembly authorized a pilot demonstration project to reimburse physicians for care coordination, extended care, and combined well- and acute-care visits. To begin implementation of the pilot program, the state Department of Social Services (DSS) has formed a team to develop care coordination performance measures and a system to give child health providers incentives for meeting defined targets. This work is informed by the state's participation in a Medicaid Pay for Performance learning collaborative and is slated for implementation in 2007.

### ***Regional Medical Home Support Centers Program***

Using Title V block grant funds from the Maternal and Child Health Bureau, the state Department of Public Health (DPH) funds five regional medical home support centers around the state through a competitive bidding process.<sup>28</sup> These centers support pediatric practices in connecting children with medically complex needs to services within their regions, such as medically necessary technology and equipment, as well as to respite care.

### ***Health Outreach for Medical Equality (HOME)***

In addition to the initiatives led by state agencies, a demonstration project is under way at the Charter Oak Health Center at Connecticut Children's Medical Center (CCMC), with facilitation from the Hispanic Health Council. *Health Outreach for Medical Equality (HOME)* is a two-year project jointly funded by DSS, the Hartford Foundation for Public Giving, the Children's Fund of Connecticut, and CCMC to provide care coordination and outreach to more than 1,200 Hartford children and families annually.

The program targets children who miss primary care appointments, frequently transfer among provider sites, use the emergency department for conditions that can be handled in the primary care site, and miss appointments for necessary follow-up care. Outreach services bring these families into the primary care site, where care plans are developed in partnership with families. A designated care coordinator links families to other services and monitors implementation of the care plan. The ultimate goal of HOME is to demonstrate that care coordination services that are provided within the health care site promote appropriate use of primary care, result in better health outcomes for children, and save money.

### ***The Behavioral Health Partnership***

Beginning in 2006 the state Departments of Children and Families (DCF) and Social Services (DSS) implemented a collaborative strategy to improve access to and the quality of mental health services for children insured by Medicaid. They retained a third party to manage services and took payment out of the Medicaid managed care system. DSS is also designating a subset of behavioral health providers as Enhanced Care Clinics that are eligible to receive 25% additional reimbursement for billed services if they meet criteria outlined under the partnership. The qualifying criteria address timely access to services and coordination of services with primary care providers.

Three aspects of the Behavioral Health Partnership promote care coordination:

1. Care coordination by behavioral health specialists will be reimbursed.
2. Enhanced Care Clinics are required to develop memoranda of understanding and coordinate services with primary care practices.
3. The partnership formalizes relationships between systems, both at the state (DSS and DCF) and practice levels.



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