

CARE COORDINATION:

Improving Children's Access to
Health Services

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About the Child Health and Development Institute of Connecticut:

The Child Health and Development Institute of Connecticut (CHDI), a subsidiary of the Children's Fund 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, particularly those 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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INTRODUCTION

Policy makers, patients, providers and researchers recognize the value of care coordination in ensuring the most effective and efficient delivery of health services as well as the linkage of health to other service sectors. Care coordination helps patients access and use services by providing them assistance with scheduling, transportation, and synchronization of recommendations across different providers and settings. Health care providers also benefit from care coordination provided to their patients. Providers often are unaware of the many services that exist for their patients and do not have time to make phone calls, arrange appointments and assist patients with accessing services. Care coordinators can do this for them and provide a valuable service to families. The concept of medical home,¹ which describes care that is accessible, coordinated, family-centered, culturally competent and serves as a usual source of care, requires coordinated care for linking patients to services that the medical home itself does not provide.

CARE COORDINATION AND CHILDREN

Care coordination is especially important for children, as they benefit most when their needs are detected early and they receive intervention services.² In addition, children's care frequently involves utilization of many service systems, including health care, early care and education, and community services. The primary care medical home is an ideal venue for detecting children's problems at the earliest possible age and connecting families to helpful interventions and supports outside of the primary care site, and often beyond the boundaries of the health care system to early education and family support services. It is important then that all children have a medical home, from which they can receive preventive health services and be connected to other services to ensure their healthy development.

Despite the proven effectiveness of care coordination services, their provision in pediatric practices is often less than optimal. Barriers to providing care coordination services include: lack of time, reimbursement, and practice staff; lack of medical specialty and community services to which children can be connected; lack of integrated data systems to support care linkage of patients to services and to inform providers about services their patients use outside of the medical home; and lack of integration across the many systems that serve children and families.^{3,4} When these barriers can be overcome, evidence supports the provision of care coordination from the medical home.⁵

It is important that all children have a medical home from which they can receive preventive health services and be connected to other services to ensure their healthy development. Despite the proven effectiveness of care coordination services, their provision in pediatric practices is often less than optimal.

There is much evidence that Connecticut's children often do not receive coordinated care when needs are identified:

- A 2002 analysis of state Medicaid data revealed that “relatively few children received timely office or clinic visits following an emergency visit for treatment of asthma (20%) or a hospital discharge (40%). Follow-up rates have not improved in recent years and are well below treatment guidelines.”⁶
- Almost half of the children referred to the state's Early Intervention services are found not eligible and require linkage to other services through Help Me Grow.⁷ **This linkage requires seven contacts on average for successful connection of at-risk children to services.**⁸
- According to surveys of parents of Children & Youth with Special Health Care Needs (CYSHCN) in Connecticut, 76% indicate that their primary care provider does not work with them to create a written care plan for their child. Half of the responding parents said that they did not have an identified person at their child's medical home to assist with referrals, help locate needed services, and assist with communication among all of their child's care providers.⁹



From 2007 through 2009, the Hispanic Health Council and the Connecticut Children’s Medical Center partnered to develop and implement H.O.M.E. and provide outreach and care coordination for patients in the Charter Oak Health Center at Connecticut Children’s Medical Center (the Primary Care Center), who were insured by HUSKY.

- **Fewer than 25% of Connecticut-based pediatric and family medicine practices report that they engage in formal care coordination activities.** Almost half of practices state that care coordination is done on an as-needed basis without a formal mechanism.¹⁰
- Connecticut pediatricians overwhelmingly report problems in accessing behavioral health services for their patients.¹¹
- In 2006, 40% of children in HUSKY were seen in emergency care settings. One-third of these children sought care for a condition that is amenable to treatment in primary care.¹²

Outreach is also essential to ensuring that children receive all of their needed services, both from the medical home and from other service sectors. Outreach includes direct contact with families in their homes and communities to link them to services. Outreach that brings children into primary care services improves the likelihood that children’s health problems and development delays will be detected and that they will be linked to helpful services.

IDENTIFYING THE NEED FOR OUTREACH AND CARE COORDINATION IN HARTFORD

In 2003, the Children’s Fund of Connecticut supported two pediatricians, Marilyn Sanders and Paul Dworkin, to undertake a needs assessment for outreach and care coordination services for Hartford

children insured by HUSKY A, the state’s Medicaid program for low-income children. Systemwide concerns identified in the needs assessment included:

- Lack of timely outreach, which results in children falling significantly behind in use of well-child services;
- Separation of outreach services from the health care provider sites caring for children, thereby limiting opportunities to engage families in primary care, where their children’s needs might be identified and connection to services might occur;
- Inadequate outreach efforts by the four managed care organizations that were participating in HUSKY, leaving many barriers to care, such as transportation and scheduling, unaddressed. The project leaders identified a pressing need for resources to locate hard-to-reach families, link them to primary care health services, and to provide support in connecting them to other health and community services based on needs identified in primary care. Resulting recommendations clearly indicated the need for a systemic solution that would be well integrated into both the clinical provider sites and the communities that they serve. In response to this identified need, the Health Outreach for Medical Equality (H.O.M.E.) model was designed to bring new expertise into pediatric primary care.

THE H.O.M.E. PROJECT

With a blend of public and private funding, including support from the Children's Fund of Connecticut, the Hartford Foundation for Public Giving and the Connecticut Department of Social Services, Dworkin and Sanders designed H.O.M.E. to test an enhanced primary care-based model of outreach and care coordination for disadvantaged children and their families. From 2007 through 2009, the Hispanic Health Council (HHC) and the Connecticut Children's Medical Center (CT Children's) partnered to develop and implement H.O.M.E. and provide outreach and care coordination for patients in the Charter Oak Health Center at CT Children's (the Primary Care Center (PCC)), who were insured by HUSKY.

The PCC is a partnership between a Federally-Qualified Community Health Center and CT Children's. The site is staffed by 18 board-certified pediatricians and eight nurse practitioners, along with several nurses, medical assistants and support staff. Pediatric residents from the University of Connecticut School of Medicine complete primary care continuity and ambulatory care rotations at the PCC. All but three of the 78 providers at the PCC referred patients to H.O.M.E. at some time during the project period. Throughout the three years, PCC providers made an average of two referrals per month to the care coordinators.

The HHC served as the administrative base for H.O.M.E.'s care coordinators and provided the project director and manager. HHC hired and supervised two care coordinators based at the PCC and two care coordinators who worked in the community, locating families in need of well-child services and building relationships with community-based service providers. Care coordinators had a variety of educational credentials and professional experience, mostly in the social service field.

The PCC provided a medical director and social worker/supervisor. A H.O.M.E. internal leadership team was established, comprised of H.O.M.E. leadership and key staff from HHC and PCC, who developed intake assessments, care plan templates, care coordination protocols and data collection tools to gather and maintain data throughout the initiative. Patients eligible for referral to H.O.M.E. were children 16 and younger who were receiving services at the PCC and were insured by HUSKY or uninsured. In addition, they had one or more of the following risk factors:

- pattern of missed primary care appointments, as needed given the child's age, health and social risk
- significantly delayed in receipt of immunizations or screening procedures as defined by professional standards
- transferred care among provider sites more than twice in the previous 24 months

Care coordinators performed standardized intake assessments, developed care plans with families, linked children and families to needed services and facilitated communication between families and providers.

An 11 year old missed an appointment at the primary care center because her mother was ill and did not have transportation to the clinic. A H.O.M.E. care coordinator was able to identify a physician for the mother, arrange transportation for both the mother and child to their health care appointments, and show the mother how to access health and transportation services.

- special circumstances indicating the need for outreach/care coordination services, such as children in foster care and high-risk newborns
- identified with an urgent need for an appointment at the PCC due to medical test results or other emergent situation

Care coordinators performed standardized intake assessments, developed care plans with families, linked children and families to needed services and facilitated communication between families and providers. Much of this work could be completed during families' visits at the PCC. When PCC providers referred families to H.O.M.E. outside of the PCC visit, the care coordinators conducted outreach by telephone and with home visits when telephone contact was not possible and/or follow-up was either time-sensitive or very intensive.

Over three years of operation, HHC care coordinators served 1,873 children, or approximately 6% of the clinic's total patient population each year. Reflecting the PCC's population, 84% of the children were Latino, mostly from Puerto Rico (66% of Latino children). The HHC was successful in hiring care coordinators fluent in Spanish who were able to communicate with families in their primary language. Almost half of the families receiving services from H.O.M.E. were Spanish speaking.

The H.O.M.E. External Leadership Team, including project leadership from CT Children's and HHC, funders and evaluators, defined several

goals for H.O.M.E. that allowed for measurement of the impact of the initiative on the following: 1) care for families, 2) care provision by providers and 3) the child health system. In addition, an evaluation consultant, Dr. Joseph Telfair, developed a comprehensive evaluation plan for H.O.M.E.,

with input from project leadership and funders.¹³ Project and evaluation staff used several strategies to answer questions about the impact of H.O.M.E. on families, providers and the health care system. Figure 1 provides key information about the data source for each evaluation strategy.

Figure 1: Evaluation Objectives and Data Sources

Evaluation Component	Data Source
Reasons why children need care coordination services	Audit of 326 randomly selected PCC medical charts of H.O.M.E. participants
H.O.M.E.'s success in helping families keep their well-child appointments as scheduled	Audit of 326 randomly selected medical charts of H.O.M.E. participants
Family satisfaction with H.O.M.E. services	Random sample survey of 142 parents
Availability of information on services used by H.O.M.E. participants provided to primary care provider	Audit of 326 randomly selected medical charts of H.O.M.E. participants
Provider satisfaction with H.O.M.E. services	Survey of 28 providers in the PCC
Utilization of primary care, emergency department, dental and mental health services by H.O.M.E. participants and the general HUSKY child health population in Hartford	Medicaid claims from 2008 for children served by H.O.M.E. prior to 2008 and for all Hartford children

The leading reasons for referral were: needing subspecialty medical services (62%), well-child services were not up-to-date (42%) and needing a follow-up appointment (21%).

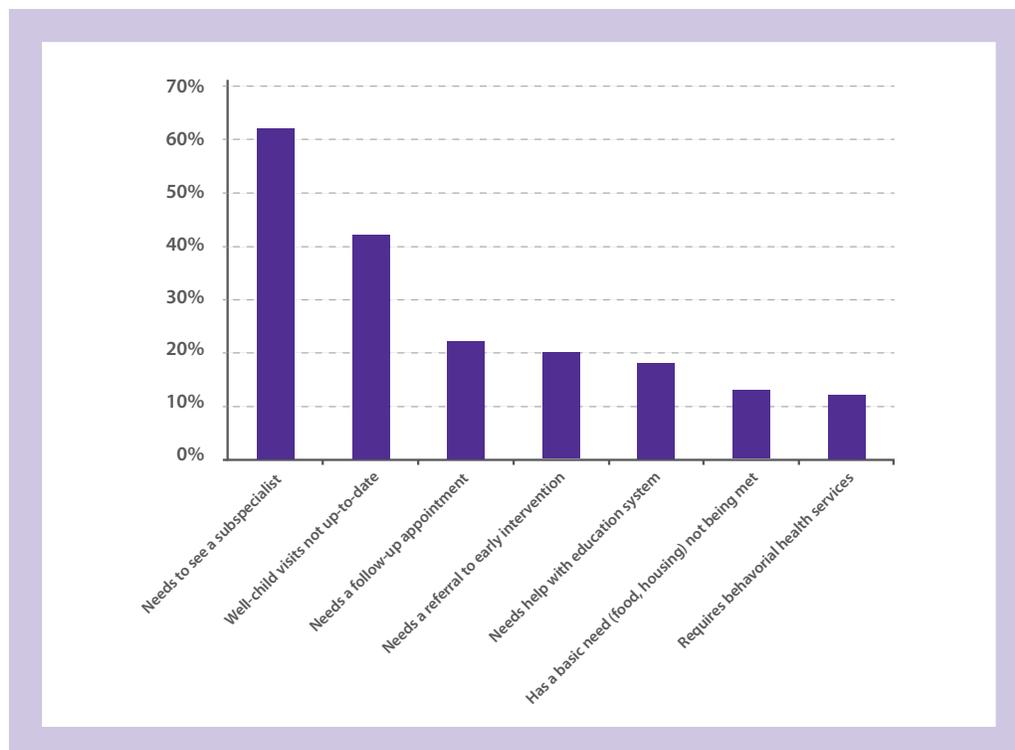
RESULTS

Serving Families

The primary goal of H.O.M.E. was to connect children to pediatric primary care, medical specialty and other community services. Outreach was critical in bringing families into the primary care system, from which their children's needs could be assessed and they could be linked with helpful services. Based on chart audits from a random sample of 326 H.O.M.E. participants, Figure 2 shows the most frequent reasons that primary care providers referred patients to H.O.M.E. The leading

reasons for referral were: needing subspecialty medical services (62%), well-child services were not up-to-date (42%) and needing a follow-up appointment (21%).

Figure 2: Reasons for referral of patients to H.O.M.E.



Care coordinators determined at intake that 43.6% of children referred to H.O.M.E. were not up-to-date on well-child services. Care coordinators scheduled appointments for 673 of these children and then tracked the receipt of services with data from the medical chart audit of the 326 randomly selected charts for children receiving H.O.M.E. services. Results showed that 82.5% of the sample tracked kept their subsequent well-child appointment.

In addition to consistent use of primary care services, H.O.M.E. was dedicated to improving care coordination through the development of a written care plan for children served. The chart audit review showed that for all but six children in the entire group of H.O.M.E. recipients, care plans were included in the medical record.

In an effort to assess family satisfaction with H.O.M.E. services, care coordination staff distributed a satisfaction survey to a random sample of 406 families. Of the 142 parents who responded (34% response rate):

- 84% (119) found that the care plans were helpful
- 50% reported involvement with the creation of a written care plan or discussion regarding a plan for the child
- 84% of those who were actively involved in development of the plan and had a copy of the written care plan, found that the care plan was helpful in understanding their child's needs and made it easier to get help for the child

- 84% of respondents expressed satisfaction with service care plans
- 86% of respondents expressed satisfaction with services provided
- 74% responded positively that they felt more confident in their own abilities to obtain health services for their children as a result of their work with H.O.M.E. care coordinators
- only 17% (24) claimed that they had problems trying to get an appointment with a medical specialist



Providers and H.O.M.E.

Several aspects of H.O.M.E. helped PCC providers improve their care to children and families. In addition to having care coordinators available who could work with families to schedule appointments and ensure that children obtained needed services, other support components included: development of written care plans in collaboration with families, communication of follow-up information on services used by patients and assurance of continuity in patient utilization of the PCC for ongoing care.

The H.O.M.E. chart audit evaluation tracked information flow for 319 children and found:

- 66% (219) of medical records included information about services utilized as a result of participation in H.O.M.E.
- for more than 90% (287) of patients H.O.M.E. care plans were available to providers when families came in for subsequent visits

PCC providers, then, had access to information about their patients' interactions with the H.O.M.E. care coordinators and the actions resulting from the care coordination provided.

Nearly all of the 28 PCC providers (93%) completed surveys about their experiences with H.O.M.E. Survey results showed that:

- H.O.M.E. was a valuable service for the PCC

and contributed to providers' ability to provide comprehensive care to patients (93%)

- providers (92%) expressed satisfaction with care coordination and outreach services provided by H.O.M.E.
- providers (85%) received copies of care plans all or most of the time

Across all age groups, H.O.M.E. children (other than one year olds) were significantly more likely than Hartford children in general to use mental health services.

H.O.M.E. and Children's Utilization of Services

A central goal of H.O.M.E. was to improve children's utilization of health care services so that 1) families used primary care services for their children according to the schedule promulgated by the American Academy of Pediatrics and endorsed by state and federal policy, 2) refrained from unnecessary use of expensive emergency departments, and 3) were connected to other commonly needed services. To determine the extent to which H.O.M.E. had this impact, project evaluation staff from the Child Health and Development Institute (CHDI) obtained data from the Medicaid program on health services utilization for 620 H.O.M.E. participants who were enrolled in the H.O.M.E. program prior to 2008, the first full year of operation.¹⁴ Utilization rates for the comparison group were provided by Connecticut Voices for Children, a research-based public education and advocacy organization that conducts independent performance monitoring of the HUSKY population.¹⁴ Comparative results for utilization of primary care services could not be computed due to different billing codes used by the PCC, which billed as a Federally Qualified Community Health Center.

Analysis of Medicaid claims data for the three other types of services showed:

• Dental care

- Expectation: H.O.M.E. children as a result of care coordination would have a higher rate of dental service utilization than children in Hartford insured by HUSKY
- Finding: H.O.M.E. children younger than 2 were significantly more likely than Hartford children in general to use dental services. Thirty-four percent of children 2 and younger in H.O.M.E. received preventive dental services compared to 25% of Hartford children overall.

The youngest and oldest H.O.M.E. children were significantly more likely to receive preventive dental services than the general population of children insured by HUSKY in Hartford. This finding suggests that primary care-based care coordination services can be more effective in linking families to early dental services than routine referral by primary care providers and is particularly important for the youngest children, for whom early dental services can have a significant impact on health in later years.¹⁵ However, even with care coordination services, H.O.M.E. participants' rates of dental service utilization still remained far below the universal participation promoted by the American Academy of Pediatrics and Academy of Pediatric Dentistry.

¹⁴ Based on the data provided by DSS, we estimate that 92% (572/620) of H.O.M.E. participants utilized any services in 2008. To ensure comparability with available data on other children in Hartford, we limited the utilization analysis to children who received H.O.M.E. services in 2007 and were enrolled in Medicaid for all 12 months of 2008. This yielded 466 children for comparison with children ages 0-17 living in Hartford who were insured by HUSKY A for the entire 12-months of 2008 (n= 17,472).

- **Mental health**

- Expectation: H.O.M.E. children as a result of care coordination will have a higher rate of mental health service utilization than children in Hartford insured by HUSKY.
- Finding: Across all age groups, H.O.M.E. children (other than one year olds) were significantly more likely than Hartford children in general to use mental health services.

Connecting children with needed mental health services is an ongoing challenge: as many as 20% of American children have an identifiable mental health disorder, yet 80% of those who need behavioral or mental health care do not receive appropriate services.¹⁶ Children who received H.O.M.E. services accessed behavioral and mental health services at a significantly higher rate than the overall Hartford HUSKY population. One concern in interpreting these data is the need for behavioral/mental health services in each population: did H.O.M.E. participants have a greater need for behavioral/mental health services than the general HUSKY population? H.O.M.E. reason for referral data show that only 11.7% of H.O.M.E. participants were referred to the program specifically because they were in need of a behavioral or mental health service. In addition, even if 100% of H.O.M.E. participants needed behavioral/mental health services, H.O.M.E. children realized a higher utilization rate for mental health services than would be expected for children in the HUSKY program who need mental health services.

- **Emergency department services**

- Expectation: H.O.M.E. children as a result of outreach and connection to a medical home (the PCC) will have a lower rate of emergency department (ED) utilization than children in Hartford insured by HUSKY
- Finding: H.O.M.E. children were more likely to use ED services

Utilization of ED services was significantly higher for children in the H.O.M.E. program compared to children in the overall Hartford HUSKY population in two age groups: 6-8 years (39% vs. 32%, $p=0.00$) and 15-17 years (62% vs. 37%, $p=0.00$). This finding is concerning, as a goal of the H.O.M.E. project was to decrease avoidable ED utilization. We believe that this high rate of ED utilization may be related to the fact that most of the H.O.M.E. participants received their primary care services at CT Children's ED as an extension of the PCC, or utilized the ED due to the limited capacity at the PCC. Another explanation for higher ED utilization among H.O.M.E. participants might be their higher risk status, which accounts for their referral to H.O.M.E., and reflects the more high-risk patient population at PCC compared to those who use other Hartford services.

H.O.M.E. has shown that a community collaboration to bring care coordination to the primary care site is feasible and beneficial as evidenced by the experiences of families and providers.

The Primary Care Center identified an 18 month old who had missed several follow-up appointments and subspecialty visits. This family resided in Massachusetts and had difficulty finding transportation to Hartford and obtaining early intervention services in Massachusetts. A H.O.M.E. care coordinator arranged transportation and developmental services in Connecticut, where the family stayed for the next few months. She also ensured that early intervention services would be continued in Massachusetts when the family returned home.

DISCUSSION OF EVALUATION FINDINGS

Evaluation of the H.O.M.E. project yields important findings that support the value of care coordination in primary care services. H.O.M.E. has shown that a community collaboration to bring care coordination to the primary care site is feasible and beneficial as evidenced by the experiences of families and providers. Families receive connection to important services, such as subspecialty, dental and mental health services. Almost three-quarters of the parents with children served by H.O.M.E. express greater confidence in obtaining health services for their children in the future. Pediatric providers also recognized the value of having care coordinators in their clinical setting. They reported that having their patients' care coordinated through H.O.M.E. enhanced their ability to provide comprehensive care.

Patient utilization of services suggests that H.O.M.E. was successful in addressing children's oral health, with enhanced connection to preventive dental services for young children, which can be very cost effective in the long-term. In addition, analysis of Medicaid claims data has shown that children in H.O.M.E. are more likely to receive mental health services than children in the Hartford HUSKY population. This, too, may have implications for long-term mental health outcomes and cost savings as problems are addressed earlier when they are more amenable to intervention. The H.O.M.E. evaluation also suggests that providing care coordination within a pediatric primary care setting may improve children's utilization of primary care services, although it may not decrease ED visits.



IMPACT

Expansion of practice-based care coordination with an outreach component is clearly warranted and can be assured with improved policy and system opportunities.

SUPPORTING CARE COORDINATION IN PRIMARY CARE PRACTICE

The H.O.M.E. experience provides insight into new models of care coordination that can support the medical home model of care. The experience with H.O.M.E. also supports recommendations for care coordination made in *“A Framework for Child Health Services: Supporting the Healthy Development and School Readiness of Connecticut’s Children.”*¹⁷

The *Framework* recommends the provision of “care coordination services for children and their families to increase the early detection of problems, improve the management of acute and chronic disorders, promote adherence to interventions and treatment plans, and achieve efficiencies and cost savings in health care delivery.” The preceding analyses have highlighted H.O.M.E.’s success in linking children to important services (dental and mental health) and in engaging families in utilizing primary care services. However, there remains a need to further develop and test care coordination models that are feasible and can strengthen pediatric primary care’s role in early detection and connection of children to services. Expansion of practice-based care coordination with an outreach component is clearly warranted and can be assured with improved policy and system opportunities. These include:

1. Expanded primary care capacity to meet the needs of low income children. Throughout the duration of H.O.M.E., limitations of clinical capacity within the PCC compromised the project’s ability to address deficits in the

well-child services adherence for referred children. At the CT Children’s ED, of 1,081 children screened by H.O.M.E during a 46-day period, 334 (31%) were found to be behind in their receipt of such services. Clinical capacity constraints within the PCC prevented H.O.M.E.’s care coordinators from obtaining timely preventive care services for this at-risk population.

2. Stable funding mechanisms must be developed to support care coordination services in support of medical homes. A strength of H.O.M.E. was its blending of public (Department of Social Services) and private (Child Health and Development Institute, Hartford Foundation for Public Giving) funding. Although such funding streams are appropriate for pilot projects, they do not typically enable the long-term sustainability of such programs. **Payment for care coordination services, within both the public and private health insurance sectors, is critical to enable the successful implementation and sustainability of these services and should be a requirement of public and private health plans.** Payment can be accomplished through upfront per member/per month dollars to providers, although this requires stable patient panels. Other payment methodologies that need to be tested include: 1) payment based on time spent coordinating care; 2) enhanced payment across all services

to primary care providers that meet established medical home criteria (which includes care coordination); or per member, per month payments specifically for care coordination. States are currently experimenting with these payment models in the hopes of realizing cost savings as a result of lower ED utilization, less duplication in service provision and fewer hospitalizations. States also hope to achieve improved patient outcomes resulting from ensuring that patients are connected to needed services.

3. States need to consider the blending of administrative and financial resources across departments and agencies to achieve economies of scale, cost efficiencies and a seamless integration of comprehensive care coordination services. Such collaborative arrangements must work in support of all children and their families, regardless of insurance status. Care coordination services within the primary care sites must be effectively integrated with other care coordination services essential to children and their families, such as support to children with special health care needs (e.g., Title V), children at risk for adverse developmental and behavioral outcomes (e.g., Help Me Grow), children with special social circumstances (e.g., foster children in custody of the Department of Children and Families), children with developmental delays (e.g., Birth to Three), and children lacking health

insurance. Care coordinators must have the ability to address challenges and facilitate access to health and other services across the spectrum of family needs (e.g., transportation, food insecurity, fuel insecurity, housing, etc.) and available resources. The shared resource network for providing care coordination services, as described by Highsmith and Berenson, is a promising approach to supporting pediatric primary care sites.¹⁸

4. The design and implementation of information technology infrastructure to support linkage across child serving systems needs to be a priority. IT supports to enable communication, sharing of data, and compilation of community resources are needed to ensure that care coordinators have real-time access to services that their patients use. H.O.M.E. was successful in keeping providers informed and families engaged with written care plans despite numerous logistical obstacles that would likely be eliminated by facilitative information technology. As electronic health records become more routine in pediatric primary care, it is unclear how the care plan can be integrated, updated and ensure family participation in its development when it is embedded in an electronic health format. Electronic systems also need to ensure that outcomes related to utilization of services can be assessed in an ongoing manner to ensure that care coordination is meeting patient connection and system efficiency goals.

We are hopeful that the success of H.O.M.E. and lessons learned from this initiative will enable child health services to ultimately fulfill their potential for enhancing children’s healthy development. The H.O.M.E. experience demonstrates that care coordination is critical to achieving this goal.

The mother of a 4 year old had problems obtaining speech services for her daughter. A H.O.M.E. care coordinator developed a written care plan with the family and the primary care physician and was able to ensure that the child received speech services. This child also needed dental services, and the H.O.M.E. care coordinator located a local dentist who would take payment from Medicaid. Work with this family increased their utilization of primary care services to appropriate levels as well as ensured that their child receives services outside of the health system.

A NEW MODEL OF CARE COORDINATION

The lessons from H.O.M.E are being incorporated in efforts to further develop a model of comprehensive care coordination for children of the Hartford region that can inform similar efforts in other communities and, ultimately, across the State of Connecticut and nationally. Partners in the H.O.M.E. initiative have committed to strengthening and stabilizing care coordination services in the Hartford region through the design and implementation of a “central utility” (i.e., “collaborative”) model, in which the capacity of a centralized care coordination entity will meet the needs of children and families across the region. The Department of Social Services (DSS), the Medicaid Administrative Services Organization, the Department of Children and Families (DCF), the Hispanic Health Council, United Way/Child Development Infoline (CDI), and the leadership of the region’s Title V Children with Special Health Care Needs support center (the Connecticut Children’s Medical Center Special Kids Support Center [SKSC]), facilitated by leadership from the Child Health and Development Institute of Connecticut and Connecticut Children’s Medical Center, have now set the stage for an integration of administrative and financial resources to enhance care coordination services. Specifically, the SKSC will collaborate with the Medicaid administrative services organization, DSS, DCF, and CDI to create the central utility to provide care coordination services for children and their families. This model

will bring care coordination onsite to child health providers and serve children with public and private insurance and in DCF custody and foster care. CDI and United Way 2-1-1 Infoline will provide an extensive resource inventory to support care coordinators in practices and in partnering agencies. The demonstration of clinical and cost-effectiveness of this central utility care coordination model can inform the advocacy to sustain this model through reimbursement schedules and policies supporting the blending of administrative and financial supports across state agencies.

Finally, the lessons from H.O.M.E. will inform the specific development of care coordination services and capacity. The critical importance of

clinical, cultural, and linguistic competencies; the importance of information technology applications; the need for policies that facilitate, rather than obstruct, communication and data sharing; and the need for unimpeded access to utilization data to continuously document performance must be addressed as the care coordination models are developed and strengthened.

We are hopeful that the success of H.O.M.E. and lessons learned from this initiative will enable child health services to ultimately fulfill their potential for enhancing children's healthy development. The H.O.M.E. experience demonstrates that care coordination is critical to achieving this goal.



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the fact that the \mathbb{Z}_2 -action on \mathbb{R}^n is not free, the quotient space $\mathbb{R}^n/\mathbb{Z}_2$ is not a manifold. However, the quotient space $\mathbb{R}^n/\mathbb{Z}_2$ is a manifold with boundary, where the boundary is the set of fixed points of the \mathbb{Z}_2 -action, which is a hyperplane through the origin.

Let M be a manifold with boundary ∂M . The quotient space M/\mathbb{Z}_2 is a manifold with boundary $\partial(M/\mathbb{Z}_2)$, where the boundary is the set of fixed points of the \mathbb{Z}_2 -action on M .

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IMPACT



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