IMPACT

Executive Summary

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Improving Care for Children and Families with Complex Needs:

Enhancing Care Coordination in Connecticut

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CHDI's IMPACT, *Improving Care for Children and Families with Complex Needs: Enhancing Care Coordination in Connecticut*, articulates the need for care coordination to help children and families navigate complex health systems, reviews the evolution of care coordination in the physical and behavioral health fields nationally, provides an overview of existing care coordination programs in Connecticut, and makes recommendations to improve policies, systems, and practices.

Visit www.chdi.org to download a copy of this report or to learn more about integrating systems of care to improve children's health and well-being.

IMPACT Online

Child Health and Development Institute of Connecticut, Inc.

The promise of coordinated care

There are nearly 140,000 children in Connecticut who have complex physical, developmental, or behavioral health needs that require frequent and more intensive services. Their families find themselves working with multiple providers and often serve as the primary source of communication between them. These families want help coordinating services, but 40% report not receiving help. As care systems have grown more complex, care coordination has been put forth as a strategy to not only help families, but also to benefit providers and systems through integration and enhanced communication that can improve outcomes and reduce costs.

There is no single definition of care coordination, and programs that identify as providing the service vary greatly in how they operate and the outcomes on which they focus. In some ways, this reflects the flexibility needed to use care coordination as a strategy across multiple settings and varied situations, but the lack of consensus on what care coordination is makes it difficult to identify best practices that can be implemented widely and consistently. If care coordination is to deliver better experiences and improved outcomes for families, greater precision and consideration of what it is and how it should work is needed.

Care coordination can improve outcomes by broadening the view of health

Care coordination grew out of health navigation in primary care and case management in behavioral health. This parallel development has resulted in similar conversations split across the two fields. There is growing recognition that behavioral health is an important component of overall health in individuals; while the systems delivering services are often separate, the health needs of individuals are intertwined and overlapping. Aligning efforts across physical and behavioral health systems, recognizing the importance of each domain, can improve experiences for children and families.

Care coordination, with its focus on the needs of the family, is well-positioned to address the social, economic, and environmental factors that influence an individual's health. Research on these social determinants of health has increased in recent years and it is estimated that they account for 50% of health outcomes. In addition to these social determinants, racism and trauma exposure negatively impact health. Racism, a component of social and community context, impacts health on multiple levels, with both structural and interpersonal racism resulting in health inequities.

Executive Summary (continued)

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Connecticut has strong examples of care coordination programs

Connecticut has multiple care coordination initiatives, both within and across the primary and behavioral health care systems. Compared to other states, Connecticut has a robust system of care. System level initiatives include the state's Connecticut Network of Care Transformation (CONNECT) Initiative, which, along with the Children's Behavioral Health Plan and its Implementation Advisory Board, works to develop and sustain a network of care across primary care, behavioral health, education, social services, and other child-serving systems.

The Department of Public Health's Medical Home Initiative for Children and Youth with Special Health Care Needs collaborates with the Connecticut Children's Center for Care Coordination, the United Way Child Development Infoline, and others to improve systems-level care, convene regional collaboratives, and provide direct care coordination to children and families. Other examples of programs in Connecticut providing direct care coordination services to children and families with demonstrated positive outcomes are Help Me Grow and WrapCT.

Though Connecticut benefits from these and other strong programs, there are opportunities to enhance care coordination in the state. Care coordination programs are well-positioned to help systems deliver care that is more family-centered, integrated across physical and behavioral health, and able to address the social determinants of health to improve outcomes for children and families.

Recommendations for aligning, expanding, and strengthening care coordination

This IMPACT includes recommendations at the policy, system, and program levels to expand and improve care coordination services in the state, including:

- **Promote policies that directly address the conditions that lead to poor health and health disparities, particularly racial and ethnic health disparities.**
- **Ensure that care coordination services address social determinants of health.**
- **Remove barriers to integrating primary and behavioral health care.**
- **Use Wraparound principles to implement a family-driven approach to care coordination across all child-serving systems.**