

**Care Coordination: Trends from Approved Medicaid Health Homes SPAs (as of July 2014)**

**Idaho, Iowa, Kansas, Maine, Maryland, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, Wisconsin**

**Areas of Commonality:**

- Care Coordination Function: For all the states, the care coordination function is development and implementation of a patient's individualized, person-centered treatment plan. Each state is detailed in listing which activities are under the purview of the care coordination role. At a minimum, the care coordination function includes these basic services: development of a person-centered plan based on the needs and desires of the patient, presenting options for accessing care, providing information on care planning and care coordination, managing referrals, coordination, and follow-up to needed services and supports.
- Care Coordination Staffing: All states specify which individual/role within a health home is responsible for the care coordination function. In most cases, states specify a care coordinator but some states are much more specific. For example, MO requires a nurse care manager, and RI requires a licensed clinician. KS requires a licensed BSW, a BS/BA in a related field; or a MH (Mental Health), an I/DD (Intellectual/Developmentally Disabled), or a Substance Use Disorder (SUD) Targeted Case Manager (TCM).
- Adherence to Treatment/Medication Management: 8 states (IA, ME, NY, OH, RI, WI, KS, MD) require that care coordinators monitor medication and treatment adherence.
- Tracking referrals: 6 states (ID, ME, MO, NC, OH, OR) require that care coordinators not only coordinate referrals but also track the outcome of a referral to ensure that the patient actually received the services he/she was referred to. (Note: many of the states include this information in the care management service definition as well).

**Areas of Variation:**

- Patient Choice: Although most states consider the input of the patient when making health home assignments, two states in specific (ID and OR), specify that care coordinator should assign health homes as well as care coordinators based on patient's choice in order to improve the continuity of care.
- Tracking Test Results: 3 states (ID, OH, OR) also require that coordination services include tracking the results of any tests conducted on the patient. Idaho also requests that specialist referral reports and notes be provided to care coordinators.
- Specific Services:
  - Developmental disabilities: OH and OR require that health homes also coordinate development disabilities services.
  - Housing assistance: RI (Community Mental Health Organization SPA) and NY both include housing assistance as part of care coordination services.
  - Coordinate mental health and substance abuse diagnosis: 5 states (ID, OH, OR, NY, KS) detail the need to coordinate mental health and substance abuse services for patients with either of these diagnoses.

- Discharge Summaries: 5 states (ID, MO, NC, OH, KS) require the receipt of a patient's discharge summary upon release from the hospital or emergency department.
- Written Policies & Procedures with External Providers: ME and NY both require written policies and procedures to support collaboration among health homes providers and the entities with whom they are coordinating care.
- General Education on benefits/services available: IA mentions general education on available benefits and services, wellness education and lifestyle modification in its care coordination services.

**Best Practices:**

- Care Coordination: The care coordinators work with patients in a variety of settings, including in the home, long-term care facility, hospital, and substance abuse facility or at a doctor's office. Despite the location, the care coordinators are meeting with patients face-to-face to help a patient navigate their care.
- Use of case conferences: Communication is a key part of the care coordination role to ensure that a patient's care is continuous and integrated among all the various service providers. 2 states (ME and NY) encourage the use of case conferences to help coordinate information exchange among a patient's providers, including health providers, social workers, specialists, wellness coaches to name a few. They also specify that practitioners should use technology conferencing tools in order to conduct the sessions (as opposed to face-to-face meetings).

**Table 1: Care Coordination Service Matrix**

	ID	IA	KS	MD	ME	MO	NY	NC	OH	OR	RI- CMHO	WI
<u>Adherence to Treatment/Medication Management</u>		X	X	X	x		x		x		x	X
<u>Tracking Referrals</u>	x				x	x		x	x	x		
<u>Patients Choice</u>		X										
<u>Tracking Test Results</u>	x								x	x		
<b><u>Specific Services</u></b>				X	x			X			X	
Developmental disabilities			X						x	x		
Housing assistance							x				x	
<b><u>Discharge Summaries</u></b>	x		X			x		x	x			
<u>Written Policies &amp; Procedures with External Providers</u>					x		x					
<u>Use of case conferences</u>					x		x					