Care Coordination within a Medical Home

What is Care Coordination Within a Medical Home?

Care Coordination for children within a medical home is a service that connects children and their families to comprehensive health care and community resources.[1]

What Are the Key Elements of Care Coordination?

Key Elements:

- Identified lead coordinator
- Partnership with the family that meets the child's needs
- Collaborative, coordinated, with ongoing process
- Culturally competent at every step
- Assures smooth transitions between systems and services

Care coordination within a medical home is essential to effectively and efficiently manage the medical needs of children and families.[2] The components of a medical home (comprehensive, coordinated, family-centered, continuous, culturally-effective, accessible, and compassionate) support effective care coordination.

How Does Care Coordination Help Families?[3]

Care Coordination:

- Helps families understand the possible health outcomes for their children.
- Identifies and builds on child and family strengths.
- Reinforces families' skills and abilities.
- Validates parents' participation in their children's care.
- Understands children's conditions and involves children, when appropriate, in their care.
- Transitions care tasks to children whenever possible.
- Reduces stress and identifies parents' and families' self-care needs.
- Assists with finding financial support.
- Assists with finding support for parents and siblings.

What Are the Benefits of Care Coordination?

There are many benefits of effective care coordination including:[4]

- Reduced hospital admissions.
- Reduced length of hospital stays.
- Reduced inpatient charges.
- Reduced emergency department visits.
- Improved patient satisfaction.
- Enhanced opportunities for clinical improvement.

Who Can Provide Care Coordination?

A variety of professionals such as nurses, social workers, or medical assistants can provide care coordination in a medical home. Parents who receive special training may also act as care coordinators. All rely on community partners such as Early Intervention Family Resources Coordinators, public health nurses, school nurses, and health plans to ensure comprehensive coordination among all health care providers. The process of coordinating care can occur outside the

[1] This statement was developed in July 2007 in partnership with the Department of Health (DOH), the Washington State Financing Care Coordination Workgroup, and the participants in the May 2007 Washington State Medical Home Leadership Network conference.

[2] November 2005 AAP Policy Statement, Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children with Special Health Care Needs

[3] Adapted from Washington State Medical Home portal: http://www.medicalhome.org/physicians/coordinating_care.cfm

[4] November 2005 AAP Policy Statement, Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children with Special Health Care Needs

medical home by community service providers and health plans and may be referred to as “resources coordination” or “case management.” The source of funding may dictate the type of care coordination that occurs and who provides it. Families prefer having one lead care coordinator or “go-to” person at a time rather than multiple care coordinators.[5]

What Does a Care Coordinator Do?

A Care Coordinator:

- Assesses and identifies short and long term needs and goals- with the child and family.
- Develops a written care plan-that includes identified goals and desired outcomes. The care coordinator decides with the family which action steps will be addressed and who will be responsible for addressing them. Other providers may be contacted to support the family in accomplishing goals.
- Implements the care plan along with the family and other service providers. The care coordinator assists the family in accessing needed resources and services, making referrals, and coordinating with specialty providers, a dental home, schools, and other agencies.
- Ensures continuity of care- by following-up with the family and by ensuring communication between providers.
- Conducts evaluations to assess the plan of care to identify and address new needs.[6]

What Are the Opportunities for Improving and Promoting Care Coordination?

There are many opportunities to improve and promote care coordination in Washington State. These include:

- Emergence and promotion of medical homes in Washington State: Multiple agencies, health plans, community groups, provider organizations, and others are acknowledging and promoting the importance of having a medical home. Care Coordination is an essential element of a medical home.
- New legislation: Governor Gregoire signed Second Substitute Senate Bill 5093, concerning access to health care services for children, in March 2007. The new law directs the state to collaborate with parents, schools, communities, providers, and health plans to improve outcomes for children, including linking children with a medical home and identifying performance measures indicating a child has a medical home.
- Financing care coordination: Current Procedural Terminology (CPT)[7] codes are already in place to support billing for elements of care coordination, including the development of care plans and developmental screening. However, many public and private insurers do not pay for these services.
- While care coordination within a Medical Home has been typically associated with children, many of the facets of Medical Home can be readily applied to adults, especially adults with chronic illness.

What Are the Challenges to Providing Care Coordination?

Challenges of providing effective care coordination include:

- Reimbursement: Care coordination requires consistent and adequate reimbursement processes and rates so that health care professionals can provide care coordination as part of a medical home.
- Cost of care coordination: Although there are considerable long-term fiscal benefits for care coordination within a medical home, up-front costs are often borne by the medical providers and not currently reimbursable. One study estimates the annual cost of nonreimbursable care coordination in a pediatric practice would be $6600 for each primary care provider FTE (National Physician Fee Schedule Relative Value File Calendar Year 2000, Centers for Medicare and Medicaid Services).[8]
- Limited access to technology resources: Some providers have limited or no access to health information technology to facilitate care coordination. Health information technologies are not coordinated across different medical sites.
- Increasing cultural diversity: Washington State’s increasingly diverse population requires providers to become well versed in cross-cultural communication and care.

Contact the Department of Health’s Children with Special Health Care Needs Program for more information at (360) 236-3571.

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[5] Washington Integrated Services Enhancement Grant, 2001-2005.

[6] Adapted from Utah Medhome Portal: http://medhome.med.utah.edu/about/aboutCare.cfm and November 2005 AAP Policy Statement, Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children with Special Health Care Needs

[7] Current Procedural Terminology (CPT) is a list of terms and codes for medical services and procedures designed to provide a uniform language that accurately describes medical, surgical, and diagnostic services…" See http://www.ama-assn.org/med-sci/cpt/template.htm) CPT is trademarked by the American Medical Association (AMA).

[8] Antonelli, R., et al. (2004). Providing a Medical Home: The Cost of Care Coordination Services in a Community-Based, General Pediatric Practice. *Pediatrics*. 113:5. (1522-1528).