

# Report of the Early Childhood and Child Health Care Coordination Team

## Members of the Group

The Early Childhood and Child Health Project Team included representatives from the Department of Job and Family Services, the Department of Health, the Department of Developmental Disabilities, the Department of Mental Health, The Department of Alcohol and Drug Abuse, the Department of Education, the Office of Health Transformation, and Family and Children First. Members of the group are listed in Attachment A.

## Purpose of the Early Childhood and Child Health Care Coordination Work Group

The purpose of the group is to

- Create a single point of care coordination that links the child and family with the appropriate medical, mental/behavioral health and social services in the most appropriate environment for the child,
- Look at the current system through a new lens and commit to remove obstacles and to create true partnerships between agencies, providers, and consumers, and
- Consolidate programs and services as needed.

The group agreed on the following statement of strategic direction:

*The Office of Health Transformation will design and implement an integrated early childhood and child health system in order to better and more efficiently identify and coordinate the medical, social, developmental, educational, and mental health needs of high-risk children and their families.*

The system will use contemporary technology and existing resources to

1. Strengthen partnerships between persons providing health and social services for children and their families,

2. Empower families by providing information about resources and services that are available and can address their child's needs,
3. Build or promote multi-disciplinary tools for regional intake and referral, assessment and care planning, and care coordination, and
4. Measure and achieve better outcomes for children and families.

## Definitions

There are many definitions of care coordination in the literature. The most commonly cited are as follows:

- *Care Coordination* – The deliberate organization of patient care activities between two or more participants (including the patient) for the purpose of facilitation/guiding the delivery of the right care in the right setting at the right time. (Agency for Healthcare Research and Quality-AHRQ)<sup>i</sup>
- *Care Coordinator* is the care provider responsible for identifying an individual's health goals and coordinating services and providers to meet those goals.<sup>ii</sup> The care coordination system should deliver health benefits and related supportive services to those with multiple needs, while improving their experience of the care system and driving down overall health care (and societal costs).<sup>iii</sup>
- *Service Coordination* is coordination among multiple agencies to achieve a common goal, a process of organizing services in order to make an impact at the client level.<sup>iv</sup>
- *Case Management Services* are services furnished to assist individuals in gaining access to needed medical, social, educational and other services including taking a client history, identifying the individual's needs and completing related documentation, and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual. (Center for Medicare and Medicaid Services-CMS).

According to AHRQ, "At the heart of care coordination is communication between providers and their families, within the team of professionals, and across teams and settings."<sup>v</sup> AHRQ also cites the need to facilitate transitions in the healthcare settings, connect with community resources, and align resources with population needs.<sup>vi</sup>

## Methodology

The Early Childhood and Child Health Care Coordination Team met five times between April and December, 2011. The group was chaired by Mary Applegate and Anne Harnish.

The group reviewed the following:

1. The current status of care coordination for young children.
2. Trends in the health care environment and Ohio impacting the delivery of health services for children.
3. Models used within Ohio and other states.
4. Strategic direction.
5. Desired system attributes.
6. Recommendations.
7. Next steps.

The group developed a statement of strategic direction and desirable attributes for a future care coordination system. We also constructed an inventory of the key characteristics of each program that conducts care coordination activities. This inventory was supplemented by interviews with the responsible managers in Mental Health, Medicaid Managed Care, and Special Education.

The following section summarizes some of the key lessons learned and background on care coordination from the literature, the current status of care coordination in Ohio, trends in the health care environment in Ohio and nationally, a summary of the models we reviewed, and desired systems attributes.

## General Background and Lessons Learned

According to AHRQ, there are documented benefits to care coordination:<sup>vii</sup>

- Primary care, defined as coordinated comprehensive first contact care, is strongly associated with improved health and health system functioning.
- Well-designed, targeted care coordination interventions delivered to the right people can improve patient, provider, and payer outcomes.
- Targeted care coordination can be effective in several different settings such as primary care offices or outside, with strong linkages, or through empowering families at times of transition.
- Most successful models of care coordination have incorporated some (and often a high degree of) face-to-face between patients and care coordinators to establish and maintain personal relationships.

The most successful programs appear to target a high-risk subset of the population and address multiple psychosocial and emotional issues, not just physical health. Our team felt

strongly that these other factors may heavily influence the health care outcome of an individual or child and need to be included in an integrated care coordination approach.

According to Institute for Health Improvement,

*CMS's failed case management of the late 1990's initially showed huge reductions in cost and dramatic improvement in health outcomes through aggressive case management.... Follow up analysis has shown that a few (of the projects) that did succeed – and the successful pilot projects- all had one key element in common: first-name, caring, personal relationships in which the case manager was an advisory friend who got to know the individual and connected with him or her at a personal level.<sup>viii</sup>*

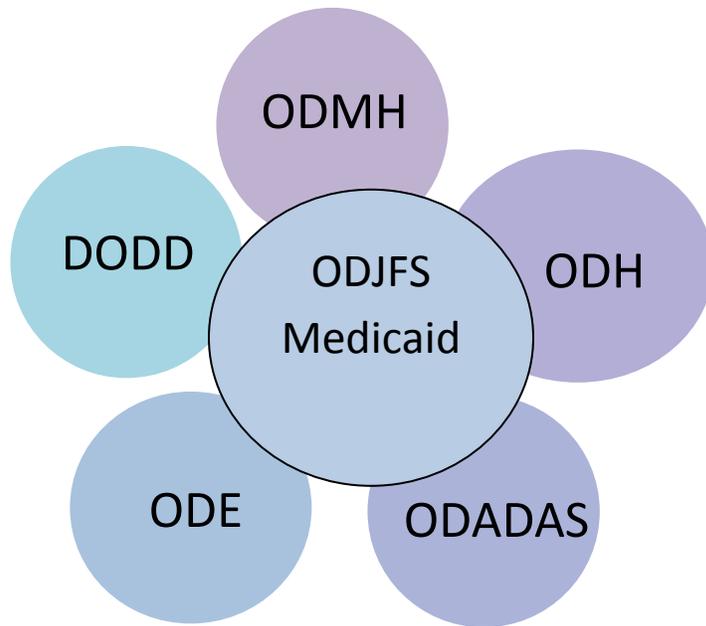
Just as important as the potential successes are lessons learned about what does not work. Some of these are: <sup>ix</sup>

- Disease management services provided primarily by telephone have not been effective for Medicare beneficiaries.
- Targeted care coordination services provided to low-risk Medicare patients have not been shown to improve the quality or utilization of care and at times, have increased overall costs.”
- Targeted care coordination interventions are frequently and most likely to succeed with high-risk/high-need patients.”

The consequence of sub-optimal systems for linkage and referral are serious. For example, in the US, the average time between the first indications of concern about a child's development and enrollment in Early Intervention (Part C) is 8 months –some of the most critical months for a child's language, mobility, and cognitive development.

### **Current Status of Care Coordination in Ohio**

Ohio has six cabinet agencies providing health services.



Over the past twenty years, systems of care for high risk children have evolved separately for the various populations served. Consequently, there is inconsistency in the state’s approach to care coordination for high-risk children including:

- Inconsistent definitions of high-risk.
- Varying client-to-worker caseload ratios.
- Different qualifications for care coordinators.
- Inconsistent outcome and accountability standards and reporting.
- Disconnected IT systems.
- Varying reimbursement structures.
- Different geographic organizational structures.

In some cases this variability is justified; however, it often results in inequitable availability of services and an inability of clients to understand where they may seek help. In addition, accountability for results is limited, and it is likely that the state is paying for duplicated services.

The following chart summarizes the major programs in Ohio providing care coordination activities. Family and Children First Agencies in every county are responsible for managing community priorities and cross- system initiatives for children aged 0-21.

Department	Program	Program Description	Number of Participants	Budget
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ODMH	CPST	Assessment, achieving independence, facilitation w/ADL's, coordination of ISP, symptom monitoring, crisis management, advocacy, family education, MH intervention, positive environmental interaction	1225(0-3) 18,564 (3-6)	
ODJFS	Healthchek (EPSDT)	Screening, diagnosis, medically necessary treatment	1.32 mil.	\$4 mil.
ODJFS	Managed Care	Access to medically necessary services for plan members. Plans have criteria for care management for high risk/high cost/special needs.		
ODH	BCMH	Disease specific hospital based care teams with a designated services coordinator. (Ages 0-21)	1,703	\$\$603,000
ODH	BCMH	Community-based nurse consultants in local health departments who coordinate care for children with special health care needs.	42,470	\$5.5 mil
ODH –Lead DODD	Help Me Grow	Children at-risk for developmental delay	8,800 Home Visiting 14,500 Early Intervention (Part C)	31 mil. GRF for both HV & EI/Part C 14 mil. Fed. Part C
ODE	Pre- School Special Education	Identify, Locate, evaluate children with disabilities to provide, if they qualify, a free and appropriate public education	23,000	12.2 mi.
Family and Children First	Service Coordination for Children in some counties, Care Coordination for children in some counties	Children aged 0-21	NA	Funding included in other programs.
ODADAS	Services for Pregnant Women & Substance Abuse			

## Changes in the Health Care Environment

The discussion of the future of care coordination is taking place in an environment which is changing rapidly, largely due to changes resulting from the Affordable Care Act. These changes will impact the design of a new care coordination system. The following chart summarizes the major changes which are taking place.

Moving Away From	Moving Toward
Boutique information systems for health information	Electronic Medical Records (EMR) and meaningful use
Managed care high risk	Stronger high risk criteria and requirements
Six agencies relating separately to Medicaid	Coordinated and integrated leadership of Medicaid
Budget reductions and stress on local governments	Shared services approaches
Payments for encounters and volume	Value based purchasing and pay for performance
Fee for Service and opt outs of managed care	Disabled and blind children in managed care
Coordinating Medicaid and insurance benefits	Insurance Exchanges and universal coverage

The variability in the early childhood health and human services system is a source of duplication and higher costs. If addressed, it will provide potential for greater value, better outcomes, more consistent use of technology and information, better linkages with the medical and human services communities, better transitions between systems, and more consistent standards and training for care coordinators.

## Description of Models Reviewed

### Public Health Nurse Care Model –Ohio\*

This is a model designed around children with special health care needs, ages 0-21 in Ohio. *Public Health Nurses*, based in local health departments, are contracted to provide community based care coordination for children with special health care needs and their families. *The Public Health Nurse* works collaboratively with the hospital based team service coordinator and the *Help Me Grow (HMG)* service coordinators based on the needs of each child. The model seeks to provide service coordination while a child is in the hospital (by hospital based team service coordinators). Additionally, the model provides transition of infants to community-based services (utilizing the Public Health Nurses at local health districts in collaboration with *Help Me Grow* service coordinators). When the child turns age three, the *Public Health Nurse Care Model* manages the comprehensive care

coordination activities for a child qualifying for diagnostic, treatment or service coordination programs. These activities include managing care coordination related to medical, social, and specialized nutritional needs, and providing education to the family while working in tandem with primary care medical home and medical sub-specialists until the child is 21 years old. At the state level this model is supported by the state office of Bureau of Children with Medical Handicaps (BCMh), which provides medical care coordination, retrospective utilization review, comprehensive benefits coordination, quality assurance, clinical supervision, and technical assistance to service providers. There were approximately 42,470 children managed through this program during SFY 2011. The major diagnoses represented in the *Public Health Nurse Consultation* model are Hemophilia, Myelomeningocele, Retrolental Fibroplasia, Cerebral Palsy, Cystic Fibrosis, and Cleft Lip and Palate.

The program reports improved coordination of services and enrollment of children with medical conditions into needed program(s) at younger ages. *Ohio's Public Health Nurse Care Coordination* model is built on a strong foundation of community-based Public Health Nurses with extensive medical knowledge of pediatric-conditions and the services and supports for social, therapeutic, habilitative, and financial needs of families and their children with special health care needs.

### **Help Me Grow – State of Connecticut<sup>xi</sup>**

The *Help Me Grow* program in Connecticut is designed to detect and refer children (Aged 0-8) with developmental problems early. This model has been adopted in about 6 states. It is based on a single point of access using a call center approach staffed by nurses or professionals who understand typical and atypical child development. Some design attributes are:

1. Strong partnerships across child serving systems responsible for helping identify children with potential delays.
2. One-stop shopping.
3. Connection with the 211 system.
4. A family focus.

### **The Community HUB Pathways Model (Richland County, Lucas County), developed by the Community Health Access Project (CHAP)<sup>xii</sup>**

This model focuses on geographic areas of high risk essentially a “hot spotting” model. The underlying premise of the model is that health and social needs are intertwined, and both

must be addressed in order to have a successful outcome. It uses a three step tool to find, coordinate, treat and measure health outcomes based on evidence-based practice. Because one client may have several issues or “pathways” that need to be addressed for a successful outcome, the *Pathways Model* functions using a *Pathways/HUB* which permits agencies to act as a team. For example, if the outcome desired is the birth of a healthy, normal birth-weight infant, barriers which may need to be addressed include (1) a lack of prenatal care, (2) smoking, (3) homelessness, (4) depression, and (5) lack of education. Through the HUB, the client is assigned one community care health worker who serves as a care coordinator. Services are not duplicated from agency to agency, and results are both financially rewarded and measured. Research conducted by ODH and the OSU Department of Biostatistics found *CHAP* clients enrolled in *Pathways/HUB* from 2001-2004, had a one-third less chance of having a low-birth weight infant in a case matched sample.

### **Project Launch (Athens, Hocking, Vinton, and Meigs counties)<sup>xiii</sup>**

*Project LAUNCH* for Appalachian Ohio was created by a federal grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, awarded to the Ohio Department of Health (ODH). The sub-grantee and local partner is Ohio University. Ohio University administers this grant locally and contracts with a number of community organizations for the development of local infrastructure that serve young children and their families in Athens, Hocking, Vinton and Meigs Counties. The local partners include Ohio University’s College of Osteopathic Medicine and Voinovich School of Leadership and Public Affairs, and Integrating Professionals for Appalachian Children (IPAC). IPAC is a community-consumer-university rural health network and non-profit organization serving as the Local Council for *Project LAUNCH*. Its members are parents, university administrators, and professionals from many disciplines partnering with many community organizations that serve children (aged birth through eight) and their families in Southeastern Ohio.

The goal of *Project LAUNCH* is to create a shared vision for young child wellness that builds a solid foundation for sustaining effective, integrated services and systems to support and promote the wellness of young children and their families. To achieve that goal, Ohio has two objectives: (1) to build our infrastructure and (2) to enhance and expand service delivery by coordinating physical and behavioral health services for young children across systems. This will involve developing and implementing an appropriate physical and behavioral health services coordination model for Ohio’s Appalachian region.

Like the *Pathways Model*, it depends heavily on community involvement. The model uses a *Nurse Family Navigator Model*. *Project LAUNCH* has just completed its second year and it is too early to have reportable outcomes for the *Family Navigator* component of the program.

## Partners for Kids (PFK)<sup>xiv</sup>

*Partners for Kids (PFK)* is based on a Physician Hospital Organization concept. In 1994, Nationwide Children's Hospital incorporated *PFK* focusing on Franklin County. *Partners for Kids* now contracts with three Medicaid Managed Care Plans in 37 central and southeast Ohio counties. *Partners for Kids* utilizes 350 primary care physicians and 210 pediatric specialty physicians to provide services to 290,000 children on Medicaid. Eight of *PFK*'s practices are Patient Centered Medical Homes (PCMH), including Pediatric Associates, one of the state's largest PCMHs. *Partners for Kids* uses Medicaid Managed Care to pass capitation on to *PFK*, less an administrative fee for claims payment, reporting, and member services. The Physicians that are contracted with Nationwide Children's are paid a per month capitation, community physicians are paid on a fee for service basis which is above the Medicaid rate, and non-members are paid the Medicaid rate. Participating practices which expressed an interest were recruited. They are all pediatric providers. While individual practices have an Electronic Medical Record (EMR), *PFK* does not have a commonly used standard EMR system among all providers.

*Partners for Kids* has focused on specific diagnoses in order to gain quality improvements and cost savings. For example, they have reduced readmissions after 30 days for asthma by 8.6 % using quality improvement protocols. They piloted an intervention with the *Special Supplemental Feeding Program for Women, Infants, and Children (WIC)* and have reduced the percentage of children who are not immunized to less than five percent. They have reduced Neo-natal Intensive Care lengths of hospital stays from an estimated nine percent to five percent and reduced pre-term births through collaboration with the birthing hospitals by four percent. They have also increased remission rates for Inflammatory Bowel Disease patients by sixty percent, and reduced preventable harm for patients in the Nationwide Children's Hospital by almost fifty percent.

## Other State's Models<sup>xv</sup>

### North Carolina

North Carolina has piloted a developmental screening and surveillance program for children receiving EPSDT visits in pediatric and family practices. The project was designed to improve linkages to community service, assist primary care practices, and improve early identification efforts. While it began as a pilot, the effort was regionalized using networks of providers in each of the state's nine regions. Primary Care Providers who are network members receive a monthly payment to ensure that the child has a medical home and coordinate referrals to specialists. They provide 24 hour coverage, case management, disease management, and quality improvement activities. The care coordination efforts in this model are supported by a per patient per month fee.

## Illinois

Illinois has launched a full-fledged medical homes initiative, enrolling 5000 practices. Providers receive \$2 per child per month as a fee, above normal payments. Services which are to be provided for the additional PCMH payments include referrals, communication with other care providers, and twenty-four hour a day, seven days a week coverage. Illinois is not alone. At least fourteen states report using Medical Homes in some way to promote coordinated care for children.<sup>xvi</sup> Illinois has a model data sharing system which facilitates the sharing of information among providers and feeds into their decision support system. They are also typing information into their Electronic Data Exchange system.

## Vermont

In 2003 Vermont launched an all-payer system called, *Blueprint* in conjunction with Catamount Health (2006), a program that provides health insurance to uninsured Vermonters. The original intention of the Vermont *Blueprint* was to address the increasing costs of caring for people with chronic illnesses, but it has transitioned over time to a broadly defined health reform initiative. The model builds on Patient Centered Medical Homes and locally-based, regional, community health teams, called *Integrated Pilot Projects*. Of late there have been several significant developments which may serve to inform our efforts to improve care coordination in Ohio. In 2009 Vermont launched an Accountable Care Organization pilot. The Vermont Legislature expanded the goals for PCMH's to the entire state, and expanded the support of these practices with community health teams in 2010. Interestingly enough, due to a re-organization prior to the passage of *The Blueprint*, the Department of Children and Families, had already created county integrated service teams which were associated with the pediatric practices in Vermont. At present the integrated pilot projects serve adults, and the integrated service teams serve children. These teams coordinate early intervention, home visiting, and *Healthy Babies, Healthy Kids*. The state may have created a single administrative structure had both sets of teams been initiated at the same time. A Vermont official commented that the teams, and in particular the adult teams, have a heavy emphasis on human service functions which are not medical in nature, such as housing, transportation, and SNAP. Vermont believes that after ten years, their system is still developing. In particular, the electronic medical records technology and data exchange are still being developed. The Community Health Teams are responsible for approximately 20,000 enrollees per team and cost about \$350,000 per service region (12 regions). All payers support the teams.

## Desired Attributes of a Care Coordination System

The team focused on the attributes of a desirable care coordination system. We developed desired attributes for the following categories: Intake and Referral, Eligibility, Assessment, Care Planning, and Quality Assurance and Monitoring.

**Intake and Referral** – The group recommended a central intake and referral system that is family friendly and easy to navigate. It should have twenty-four hours a day, seven days a week access via the web or telephone, share data with ease of navigation, allow for cultural competence, and support a system of triage during crisis situations. Upon launch of such a system, strong marketing/branding and communication are critical.

**Eligibility**– The group felt that the state needed to be clear about its eligibility policies and that using care coordination should be voluntary. The system should be internet based and closely tied to the assessment process. Intake and referral sites should also be qualified entities for presumptive eligibility for Medicaid.

**Assessment** – Assessment should be done by a trained health and human services professional. The patient and family should play a critical part during the assessment and should participate in the care plan. Assessment tools should be standardized across the range of care settings with language of the tools being easily understood by those receiving services.

**Care Planning**– Care planning should be comprehensive, multi-faceted and uniform using evidence based methods, even in the most complex cases. The care plan should be written by a person well-trained in health and human services, using commonly understood terms, and easily updated in a timely manner. Care plans should promote family/client independence which takes advantage of partnerships with the community. Care planning should include the family and child; and, if needed, a team of professionals accepted by the family. Care Planning should be strength- based, with family choice and voice.

**Monitoring and Quality Assurance** - A single entity should be responsible for monitoring and tracking, possibly at a regional level. The entity (ies) should support learning collaboratives in order to identify trends and solutions and provide a feedback mechanism for the family. In addition, data should be collected on care plan objectives, performance measures, gained incentives and consequences utilizing a centralized data base.

The following is an assessment of the strengths of the models we reviewed against the attributes we would like to see in a new system.

## The State Role in Designing a New System

States have adopted different strategies to improve care coordination for children. These strategies are designed to improve some of the typical barriers to care such as limitations on provider capacity, gaps in service capacity in areas such as early childhood development and mental health, gaps in eligibility for services, insufficient financing, and different cultural practices and customs.

According to the Commonwealth Fund, the three types of strategies being pursued by the states are:

1. Primary care practice-based strategies,
2. service provider linkage strategies, and
3. Systems changes and cross-system strategies.

While all three strategies are used by the states, the principles of Office of Health Transformation align best with primary care practice-based strategies. These roles foster:

1. Medical homes that use care planning and care coordination approaches.<sup>xvii</sup>
2. Assigned staff to assure referrals and linkages, including on-site care coordinators.
3. Efforts to improve quality within clinical practice settings which can address gaps in knowledge, behavior and competence.
4. Adoption of technology such as electronic medical records that facilitate linkages.
5. Practice-based follow-up systems.
6. Individualized care plans used by primary care providers and medical homes.<sup>xviii</sup>

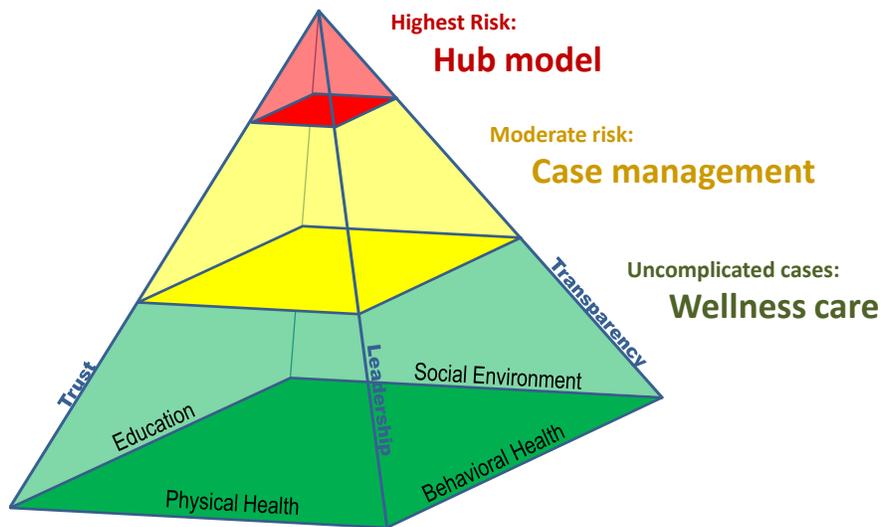
Our reviews found that neither the *Partners for Kids* nor the Managed Care Organizations coordinate care according the Agency for Health Care Research definition, cited on page (2) of this document. This is not to say that care coordination is not occurring at all, but it is not fully integrated into community care. There are some strong attributes of the high cost case identification algorithm used by the managed care plans. Some very good outcomes and savings have been achieved by *Partners for Kids*. Many pediatric practices in the state have an assigned care coordinator who follows up on appointments and makes referrals to community resources. As the state moves to a health homes policy, there will be additional incentives for better care coordination.

## Recommendations

The Office of Health Transformation recommends building upon the Health Homes and Patient Centered Medical Home work that is already under way in the state. The care for most children can be managed through their Managed Care Provider/Primary Care Provider. If the child's needs are more complex, a care coordinator embedded in the

primary care provider’s practice (or a group of practices) can usually help with the support that is needed. For a group of children with most intense needs, specialized services and supports are needed. These groups include at a minimum, first-time low-income parents, children with developmental delays and disabilities, and children with special health care needs and children with behavioral health needs. A schematic of the proposed system appears below:

### Care Coordination Model



It remains to be seen how the Pediatric Accountable Care Organizations (ACO’s) \* will work with Patient Centered Medical Homes. An Accountable Care Organization is an integrated network of providers that are collectively held accountable for delivering coordinated, high-quality, cost-effective care to a group of patients. These organizations tie provider reimbursements to quality metrics and reductions in the total cost of care for a set of patients. Rules for Pediatric Accountable Care Organizations have not been promulgated nationally. Ohio’s General Assembly authorized the promulgation of rules for ACO’s in the biennial budget. The potential role of the ACO will be to promote payment reform that promotes value, (including shared savings), to measure performance using timely and accurate data, and to drive delivery systems changes that promotes integrated organized processes for improving quality and costs. <sup>xix</sup> Six other states in the US that use this model have also identified specific activities that the ACO can perform such as promoting learning collaborative for practices, coaching, registry support, on-line training, and assistance with NCQA standards. <sup>xx</sup>

According to AHRQ, “the two models (ACO and PCMH) can work in tandem, medical home providing the direct coordination of services and ACO’s providing the infrastructure and incentive to facilitate collaboration across different types of providers and organizations.”<sup>xxi</sup> Similarly, the Commonwealth Fund comments, “... states recognize the benefits of PCMH can be enhanced through an ACO model, which can encourage the broader system to coordinate and improve care. Likewise, the ACO model will be more successful in delivering value if built around an evidence-based, high-performing, patient center medical home.”<sup>xxii</sup>

For children with complex needs we recommend a synthesis of the *Pathways/Hub Model* developed by Community Health Access Project and the *Pediatric Partner’s for Kids Model* developed by Nationwide Children’s Hospital. We propose that a regional pilot be launched in Southeast Ohio which includes *Partner’s for Kids*, the Integrated Professionals for Appalachian Children (IPAC) non-profit collaboration, the *Community Hub/Pathways Project*, the Managed Care Plans in the region, and the Office of Health Transformation.

Goals of the project will be to:

1. Define roles for managed care, the *PFK*, the managed care plans and the *Community Pathways/HUB*, and the Office of Health Transformation.
2. Evaluate the feasibility of employing Community Hubs more widely, and potentially establishing a regional approach.
3. Proposes a methodology for targeting services.
4. Identify how much duplication occurs and eliminate.
5. Identify new pathways that will need to be developed or enhanced.
6. Identify sustainable financing mechanisms for the activities identified in 2.
7. Examine various data systems solutions and determine what can be best adapted to support a coordinated care team.
8. Evaluate information that will be desirable in a health care data exchange and decision support system.
9. Evaluate the feasibility of using this model statewide.

## Considerations and Challenges

There are a number of issues that will need to be considered when this approach is further evaluated:

1. As disabled children move into managed care, there will continue to be a shortage of mental health services for children. Fifty-nine percent of emergency department visits paid for by Medicaid for disabled children have a behavioral health component. There is concern among the provider community about the capacity of the system to meet these needs.
2. If the Patient Centered Medical Home and/or Health Home is used as a base for building the delivery system, more practices will need to become Patient Centered Medical Homes or Medicaid Health Homes.

3. Data systems are a major issue, since we have a number of them and they are not connected through the electronic health records or the data exchange.
4. The Pathways/HUB model was the strongest model connecting outcomes to payment, but it needs to be integrated with the current payment methodologies used by the managed care organizations. In addition, the Community HUB/Pathways model is in various stages of development in only three communities in Ohio. The pilot will need to address the feasibility of expanding this model on a regional basis and for a broader range of early childhood needs.

## Next Steps

1. Review by the Early Childhood and Child Health Care Coordination Group.
2. Devise a governance structure for the project.
3. Involve other stakeholders in the process.
4. Form Teams to Design and Implement the Pilot. Proposed teams are Governance, Quality/Outcomes, Finance, and Data Management, Operations, and Workforce.
5. Create a Care Coordination Communication Plan.
6. Evaluate CPST, DODD, and BCMH financing in more detail.
7. Evaluate financing and legal authority questions for inclusion in the next budget.

Attachment A – Members of the Early Childhood and Child Health Care Coordination Team

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<sup>i</sup> McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination). Rockville (MD): Agency for Healthcare Research and Quality (US); 2007 Jun. (Technical Reviews, No. 9.7.) Definitions of Care Coordination and Related Terms

<sup>ii</sup> Eby, C. E, Whittington J. *Care Coordination Model” Better Care at Lower Cost for People with Multiple Health and Socials Needs*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on [www.IHI.org](http://www.IHI.org))

<sup>iii</sup> Op Cit., p2.

<sup>iv</sup> Bungler, A. J Soc Serv Res. 2010 October 1; 36(5): 385–401. doi: [10.1080/01488376.2010.510931](https://doi.org/10.1080/01488376.2010.510931)

<sup>wv</sup> The Roles of Patient Centered Medical Home and Accountable Care Organizations in Coordinating Patient Care, The Agency for Healthcare Research and Quality Publication No.11-M005-EF, December 2010 p.4.

<sup>vi</sup> The Roles of Patient Centered Medical Home and Accountable Care Organizations in Coordinating Patient Care, The Agency for Healthcare Research and Quality Publication No.11-M005-EF, December 2010 p.5.

<sup>vii</sup> The Roles of Patient Centered Medical Home and Accountable Care Organizations in Coordinating Patient Care, The Agency for Healthcare Research and Quality Publication No.11-M005-EF, December 2010 , 6.

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- <sup>viii</sup> Craig C, Eby E, Whittington J. *Care Coordination Model” Better Care at Lower Cost for People with Multiple Health and Social Needs*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on [www.IHI.org](http://www.IHI.org)) p.3.
- <sup>ix</sup> The Roles of Patient Centered Medical Home and Accountable Care Organizations in Coordinating Patient Care, The Agency for Healthcare Research and Quality Publication No.11-M005-EF, December 2010 p. 6.
- <sup>x</sup> HMG/BCMh, Public Health Nurse Consultative Services, Evaluation Report for Fiscal Years 2007 and 2008, Internal Paper, Ohio Department of Health, 8/22/2008.
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