

Care Coordination in Medicaid and CHIP Medical Home Initiatives

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NASHP

- 22 year old non-profit, non-partisan organization
- Academy members
 - Peer-selected group of state health policy leaders
 - No dues—commitment to identify needs and guide work
- Working together across states, branches and agencies to advance, accelerate and implement workable policy solutions that address major health issues

Support for Changing Practices

Care Coordination: *Integration of care across all of a patient's conditions and health needs*

- Within the practice
 - First contact care
 - Team-based care
 - Information to practices
- Outside the practice
 - Other providers and settings
 - Patient, family, or caregivers

Care Coordination: *within the practice*

Access: First contact care

1. Designated medical home (CO, LA, NH, NC, OK, PA, RI, VT)
2. Provider / patient agreement (LA, OK)
3. Same day / open scheduling (CO, OK, LA, NH, PA, RI, VT)
4. Expanded hours (OK)
5. 24/7 voice contact with health professional (CO, OK, LA, NH, PA, RI, VT)

Care Coordination: *within the practice*

Team-based care

1. Practice teams
2. Learning collaboratives (NC, MN, OR, PA, RI, VT, WA)
3. Practice coaches / on-site technical assistance (CO, PA, OK, NH, RI, VT)
4. On-site care coordinators (MN, RI, VT)
5. Off-site care coordinators (CO, NC, OK, VT)

Care Coordination: *within the practice*

Information to practices

1. Support / technical assistance for HIT/HIE
 - Registry or EHR (AZ, CO, LA, NH, PA, VT)
 - eRx (NH)
2. Data to providers
 - Patient needs & utilization (AL, OK, VT)
 - Provider performance (AL, ID, NH, OK)
3. Learning collaboratives/webinars (NC, MN, OR, PA, RI, VT, WA)

Care Coordination: *outside the practice*

Coordination with other providers and settings

1. Health Information exchange (AL, AZ, ID, VT)
2. Care coordinators on site (MN, RI, VT) and off site (CO, NC, OK, VT)
 - CO (children) added more EPSDT Outreach and Case Management staff
 - OK Medicaid Care Management Department added RNs & LPNs for complex cases
 - VT Public Health Specialist
3. Referral tracking systems: paper/electronic

Care Coordination: *outside the practice*

Coordinating care with patient, family, or caregiver

1. Patient education
2. Self-management programs (NC, RI, VT)
3. Informed decision-making tools (WA)
4. Consumer web access (ID, NH)
5. Care teams / care plans (MN)
6. Personal Health Records (WA)

Evaluation and feedback

Examples of Care Coordination strategies in 3 State-led Multi-payer Collaboratives

Pennsylvania

- Chronic Care model training + \$ for lost revenue time
- EHR or registry
- Practice coaching

Rhode Island

- Chronic Care model training
- EHR or registry
- Practice coaching
- Care management nurse at each practice

Vermont

- Chronic Care model training
- \$ for expanded EMR/ /registry
- Practice coaching
- Care Integration Coordinator at each practice
- Community care teams

For More Information

E-mail mtakach@nashp.org

www.nashp.org

*2008 medical home 50 state scan,
webcasts, and issue briefs*

Forthcoming Products

Report: ***Building Medical Homes in State Medicaid and SCHIP Programs***

(Supported by The Commonwealth Fund)

Report: ***The Role of FQHCs in State-led Multi-payer Medical Home Collaboratives***

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