



**Medical Home: Care Coordination** is a component of [Medical Home](#) (a Universal Measure), one of twenty Maternal and Child Health (MCH) **National Performance Measures (NPMs)** for the Title V MCH Services Block Grant to States Program. This NPM subcomponent is focused on increasing the percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination.

For [Care Coordination](#), there are 17 evidence-based strategies from [MCHbest](#) and 14 field-based practices from [Innovation Hub](#). Strategies for this subcomponent start on p. 3.

The [What Works Evidence Accelerators](#) provide background information and a summary of effective strategies to advance each NPM topic area. The strategies support programs and policies to expand care coordination for children and families, foster partnerships between families, providers, and across systems, and develop and implement tools to evaluate and monitor care coordination efforts.

**Overview.** The American Academy of Pediatrics (AAP) defines [care coordination](#) as the “*deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services.*” It is a key component of the pediatric medical home model and is essential for developing partnerships across settings.<sup>1</sup> To be successful, care coordination must have effective communication between providers, patients, and families across the health system, as well as the multiple systems that serve children, including schools and child care, social services, community-based organizations, and managed care plans.<sup>1,2</sup>

A care coordinator works with and guides the team process, which is driven by the needs of the child and family, and can include functions such as care planning and building partnerships with all medical and nonmedical providers.<sup>3</sup> By centering on the comprehensive needs of the child and family, care coordination can improve the quality of services, reduce health care costs, and decrease the burden on family and other caregivers.<sup>3</sup>

While there are benefits, there are also challenges to implementing care coordination, including staffing requirements and training, different levels of family engagement, payment mechanisms, and care models that are largely adult focused.<sup>4</sup> Promising practices, such as having a designated lead or locus of coordination and new payment reform models,<sup>4</sup> and innovative tools, such as health information technology and integrated health care teams,<sup>3</sup> can be used to improve care coordination.

**Data.** This NPM is measured through data collected from the [National Survey of Children’s Health \(NSCH\)](#). In 2022, among children who needed it, 66.7% of children received needed care coordination.<sup>5</sup> In addition, in 2022, 28.6% of parents or guardians reported *never* getting as much help as they wanted with arranging or coordinating their child’s health care, with 44.9% saying they *sometimes* did, and 26.5% reporting they *usually* did.<sup>6</sup> The rate of *never* getting as much wanted help with care coordination was highest among Other, non-Hispanic and Black, non-Hispanic families (40.1% and 31.2% respectively) and lowest among Hispanic families (23.1%).<sup>7</sup>

### Social Determinants of Health (SDOH).

A comprehensive approach to care coordination requires a cultural shift to address the [SDOH](#) and lived experiences of children and families.<sup>4</sup> Such a shift could occur with collaborative care planning that may encompass finances, employment, housing, food security, transportation, and other social determinants that impact the optimal health, functioning, and well-being of children and their families.<sup>4</sup> Despite widespread acceptance of the role of SDOH in determining health outcomes, screening for individual-level social risk factors in clinical settings remains minimal.<sup>8</sup>

In particular, effective strategies for leveraging care coordination to address SDOH include:

- Utilizing a social risk screening tool to improve identification of social needs and better enable nurses to coordinate needed resources, maximizing all of the programs and services for which children and families are eligible.<sup>8,9</sup>

- Shifting away from fee-for-service reimbursement to a value-based model of payment centered on quality-of-care measures and health outcomes.<sup>10</sup>
- Investing in technological solutions to increase data and resource accessibility and foster connections between systems.<sup>11</sup>
- Developing “one-stop shop” models that collocate multiple pediatric health and human service providers in a single location.<sup>12</sup>

The AAP has [resources](#) to support the implementation of SDOH screening, referral, and follow-up.

**Health Equity.** Children of color are more likely to experience Adverse Childhood Experiences (ACEs) compared to their white peers<sup>2</sup> due to “stressful environments, socio-economic inequalities, and lack of systemic support and resources for families of color.”<sup>13</sup> With a majority (70%) of children enrolled in Medicaid and the Children’s Health Insurance Program (CHIP) under age 18 identifying as American Indian and Alaska Native, Asian American and Pacific Islander, Black, Hispanic/Latino, or multiracial, state-administered health coverage programs are uniquely positioned to advance [health equity](#) by implementing care coordination strategies that address the needs of children and families of color.<sup>14</sup>

Promising approaches include:

- Employing community health workers and other staff with similar life experiences, including shared ethnicity, culture, or language, as client families to facilitate care coordination and support a child’s relational health by ensuring engagement, trust, and partnerships.<sup>15</sup>
- Integrating a legal partner into the care team to address legal issues impacting the family, such as immigration, housing, and public benefits.<sup>2</sup>

**Children and Youth with Special Health Care Needs (CYSHCN).** [CYSHCN](#) generally require services from a broad range of providers and systems, resulting in a greater-than-average need for high-quality care coordination.<sup>16</sup> This requires parents to navigate multiple complex systems and can place a significant burden and added stress on families: In 2022, 27.5% report spending 1-4 hours per week on coordinating health or medical care, and 5.8% spend more than 11 hours per week on care coordination.<sup>17</sup>

In 2022, the NSCH showed that CYSHCN were *less likely* to have received effective needed care coordination than non-CYSHCN (54.8% vs. 71.7%),<sup>18</sup> with only 22.3% of parents of CYSHCN reporting they *usually* received as much help as they wanted with arranging or coordinating their child’s health care, compared to 33.9% of parents with non-CYSHCN.<sup>19</sup>

Potential strategies for improving care coordination for CYSHCN include:

- Promoting the coverage of care coordination under Medicaid and other insurance schemes.<sup>20</sup>
- Integrating nurse care managers into the medical home model of care for CYSHCN.<sup>21</sup>
- Providing resources and incentives to promote the development of shared plans of care.<sup>22</sup>

**Key Resources.** There is extensive research on the benefits of care coordination for children.<sup>2,9,16</sup> Effective care coordination requires screenings and assessments, communication within a multidisciplinary team, family communication and feedback loops, social support networks, case management systems, and sustainable financing.<sup>2</sup>

Search the [Established Evidence database](#) for peer-reviewed research articles related to strategies for increasing access to care coordination.

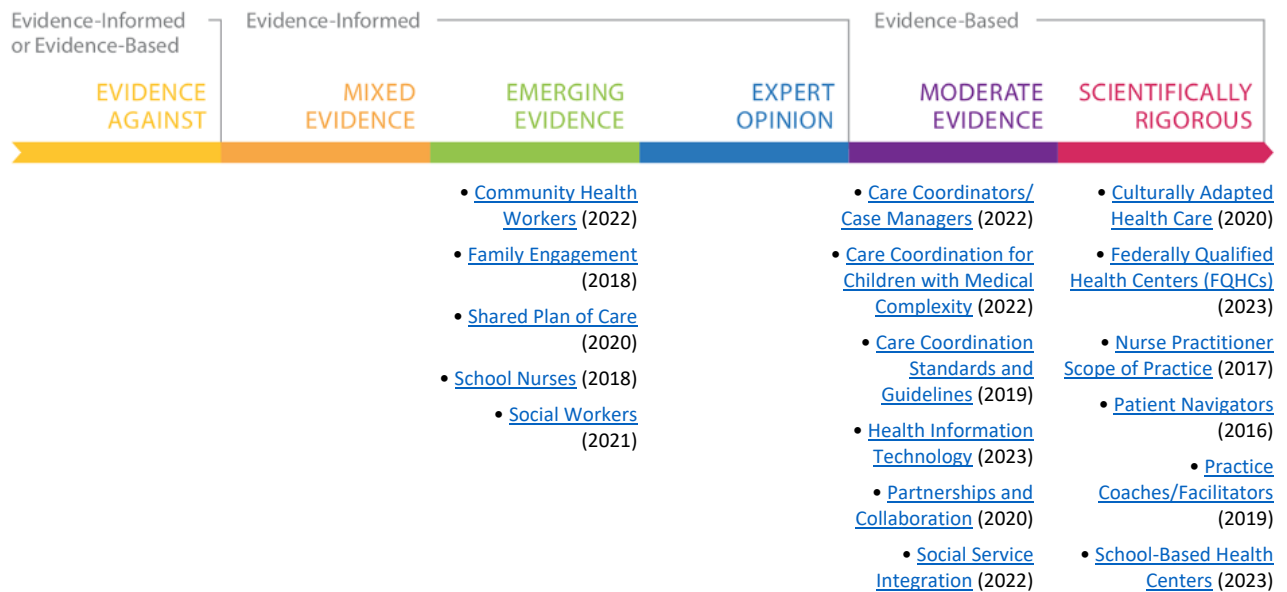
Find [field-based resources](#) focused on increasing access to care coordination relevant to Title V programs in the [MCH Digital Library](#).

**Partnership and the Role of Title V.** Title V programs and Medicaid agencies are well-positioned to work together to maximize resources and drive improvements in care for children and families, particularly CYSHCN, by:

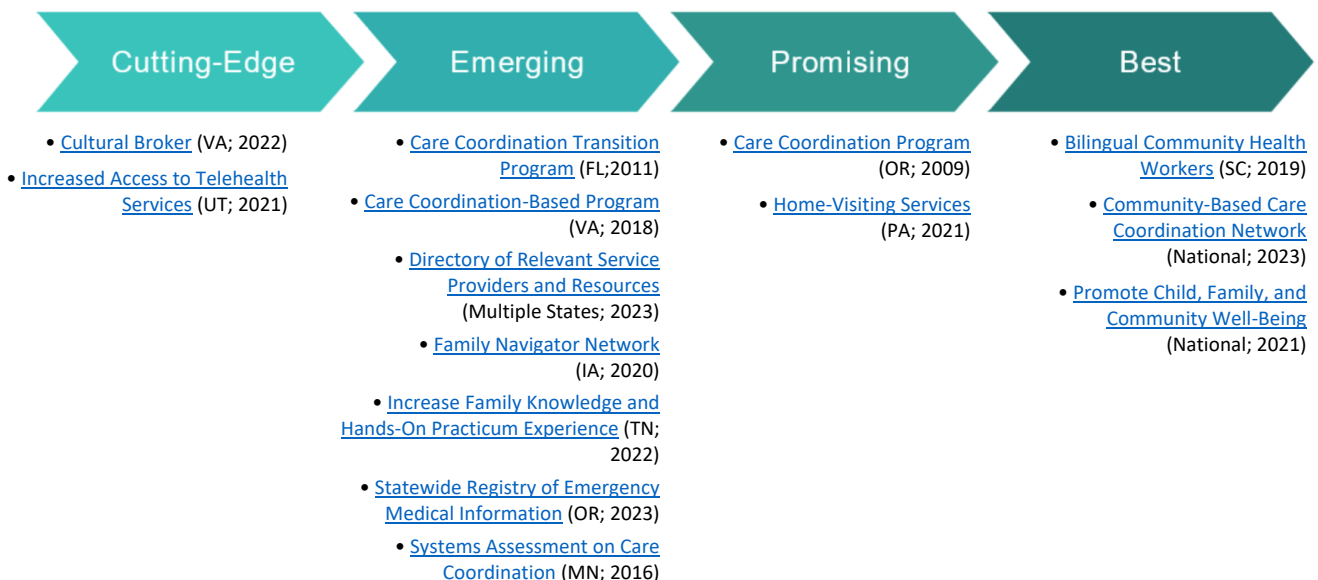
- Ensuring Medicaid managed care (MMC) contract language requires collaboration between managed care organizations and Title V programs to support the coordinated delivery of services for CYSHCN.<sup>23</sup>
- Leveraging services and expertise of Title V programs, which have extensive experience providing care coordination services to CYSHCN.<sup>24</sup>
- Coordinating efforts to measure and promote quality of care for CYSHCN, including engaging families on MMC program design and gathering feedback on how well MMC meets their needs.<sup>2</sup>

**Care Coordination Strategies.** This page summarizes the latest strategies and practices that have emerged as potential approaches for increasing the percent of children with and without special health care needs, ages 0 through 17, who receive needed care coordination. It provides a framework to identify, understand, and implement “what works” in creating new or strengthening current Evidence-based/informed Strategy Measures (ESMs). Use the links below to access strategy and practice details, approaches, supporting evidence, outcomes, and examples of how Title V agencies are either using these strategies directly or adopting components of the intervention that address this NPM.

**Evidence-Based/Informed Strategies.** 17 strategies have emerged from studies in the scientific literature as being effective in advancing the NPM. They can be adopted or adapted to meet your program needs. More information on these strategies can be found in the MCH Evidence Center’s [MCHbest](#) database.



**Field-Based Practices.** 14 practices from state-/community-based programs have emerged as potential approaches for advancing the NPM for specific communities or populations. They can be used as models to meet your program needs. More information can be found in the Association of Maternal and Child Health Program’s (AMCHP’s) [Innovation Hub](#).



**Key Findings.** The following are key findings emerging from the literature:

1. A key component of several effective initiatives is designating a nurse<sup>25-31</sup> or other licensed health professional<sup>22,32,33</sup> to lead care coordination efforts within the healthcare setting.
2. Outside of the healthcare setting, social workers,<sup>34</sup> community health workers (CHWs),<sup>35</sup> and school nurses<sup>36</sup> may be uniquely positioned to coordinate care for at-risk populations, including children in foster care, low-income communities, and underserved schools.
3. Developing tailored care plans in collaboration with families has shown to improve health and family outcomes for CYSHCN and reduce healthcare costs.<sup>37,38,39</sup>
4. Technology can be leveraged to enhance care coordination, including through the early identification of children who could benefit from care coordination<sup>40</sup> and by offering enhanced support for families of CYSHCN.<sup>41,42,43</sup>
5. Structured care coordination models can be effective in improving health outcomes and reducing overall healthcare costs for children with medical complexity.<sup>44,45,46,47</sup>

### Discussion: Research, Practice, Partnership.

**Research.** Multiple strategies are emerging as potential approaches to advance this NPM, but they have not been studied with enough rigor to be included in the evidence-based continuum. Additional research is needed to verify outcomes, but initial studies have shown promise of these strategies in MCH settings:

- Developing reimbursement mechanisms and payment models to incentivize care coordination.<sup>48</sup>
- Promoting smooth transitions and continuity as children move between providers or settings.<sup>49</sup>
- Establishing mechanisms for ongoing quality improvement in care coordination.<sup>50</sup>
- Providing training and education to providers on the importance of care coordination and best practices in delivering coordinated care.<sup>51</sup>
- Fostering data sharing and interoperability among different providers, public health agencies, and community organizations.<sup>52</sup>

**Practice.** The following tools can be used to translate evidence to action to advance this NPM:

- [National Care Coordination Standards for CYSHCN](#) (NASHP). The standards outline core, system-level components of high-quality care coordination for CYSHCN.
- [Interprofessional Education in Care Coordination: An Interprofessional Resource to Effectively Engage Patients and Families in Achieving Optimal Child Health Outcomes, 2nd Ed](#) (Boston Children’s Hospital). This curriculum supports family-centered care coordination in pediatric medical homes.

**Partnership.** The following organizations focus efforts on advancing Care Coordination:

- [AAP National Resource Center Medical Home Care Coordination Resources](#). Houses a collection of tools and resources for Medicaid, Title V agencies, and others interested in care coordination.
- [National Center for Care Coordination Technical Assistance](#). Provides technical assistance focused on pediatric care coordination capacity building and measurement.



### Frameworks and Tools for “What Works.”

Use this accelerator to strengthen current or new programs that align with multiple MCH frameworks across domains and settings. Access toolkits related to these frameworks for additional resources:

- [MCH Evidence Framework](#)
- [Blueprint for Change for CYSHCN](#)
- [Maternal Health Toolkit](#)
- [Life Course and Social Determinants Brief](#)

**Need More Help?** [Contact us for training and technical assistance](#) customized to your needs.

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