

Care Coordination

About Technical Assistance Briefs. The MCH Evidence Center provides ongoing technical assistance (TA) to Title V agencies related to the emerging evidence base, strategies, and measures related to many topics interconnected with National Performance Measures and other critical topics in MCH. *Technical Assistance Briefs* are an outcome of these TA sessions that are designed to act as *conversation starters* in thinking about programs that can be developed to address issues that affect women, infants, children, adolescents, youth, families, and communities. These briefs are not meant to be comprehensive; full analyses of the NPM topic areas are provided in [Evidence Analysis Reports](#).

The Center makes these customized briefs available during TA and on the program website to identify evidence-based/informed strategies, promising practices, examples of ESMs from the field and peer-reviewed resources. Please [contact us](#) if you would like us to develop a similar report for topics that you are working on.

Initial Query for this Brief. Identify measures and best practices around Care Coordination.

Evidence-Based Strategy Measures

ESM: Program Integration. These ESMs have been chosen by other states. You can review the ESMs to see if any resonate with your goals. Evidence Center staff are available to talk through how you could modify select ESMs to serve your needs.

State	ESMs
AZ	ESM 13.1.1: Number of inter agency partnerships implemented to coordinate dental services for pregnant women and children.
AK	ESM 12.4: Number of School-based Health Center Coordinators that complete a Title V Health Care Transition Readiness Assessment Survey with questions regarding the school district's health center
DE	ESM 15.1: Establishment of Cross-Agency Coordination Committee between DPH and Medicaid
IN	ESM 11.1: Percent of families who received effective care coordination.
IA	ESM 13.1.1: Number of medical practices receiving an outreach visit from an I-Smile Coordinator
LA	ESM 11.1: Number of health care providers trained on Medical Home, Care Coordination and Youth Health Transition
MD	ESM 11.1: Number of CYSHCN who receive patient and family-centered care coordination services
NE	ESM 11.1: The number of CYSCHN families who have contact with a Parent Resource Coordinator.
NM	ESM 11.1: The number of medical providers who have participated in a Quality Improvement initiative to improve coordination of care for CYSHCN.
OK	ESM 11.1: Number of CYSHCN who received care coordination services from Title V CSHCN contract providers in the past year.
PW	ESM 11.1: Increase the number of children with special health care needs and their families with a care coordination plan who are linked to primary healthcare services and community support
PR	ESM 11.1: Percent of families at the CSHCN Program who report that they "always" have a care coordinator assigned to help them find the services they need.
PR	ESM 11.2: Percent of families at the CSHCN Program who agree that their child has a better health status thanks to the efforts of the care coordinator to help them access the needed services.
RI	ESM 11.2: Percent of pediatric practices trained on care coordination

SC	ESM 13.2.1: Number of new partnerships to improve coordination between oral health services and well child visits
SD	ESM 11.1: % of families enrolled in care coordination services who report an improvement in obtaining needed referrals to care and/or services
TN	ESM 11.8: Number of CYSHCN who receive CHANT/CSS care coordination
TX	ESM 11.1: Percent of families receiving professional care coordination for their child
UT	ESM 11.3: Percent of children with special health care needs population served by the Bureau who have documented care coordination follow up as part of a medical home model of care.
VA	ESM 15.2: Number of Managed Care Organizations (MCO) and Care Connection for Children (CCC) Care Coordinators that attend statewide meeting

Evidence-Based Strategies – What Works for Health

The following programs have been identified as effective models related to care coordination:

Title	Link	Category
Medical homes	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/medical-homes	Scientifically Supported
Chronic disease management programs	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/chronic-disease-management-programs	Scientifically Supported
Patient navigators	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/patient-navigators	Scientifically Supported
Social service integration	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/social-service-integration	Some Evidence
Grady Memorial Hospital Interpregnancy Care Program	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/grady-memorial-hospital-interpregnancy-care-program	Expert Opinion

Evidence-Based Strategies – Innovation Hub

The following programs have been identified as effective models related to care coordination:

Title	Link	Category
Developing, Testing, and Scaling “Coordinated Intake & Referral”	https://amchp.org/wp-content/uploads/2021/05/CIR.pdf	Promising
Oregon Care COOrdination Program (CaCoon)	https://amchp.org/database_entry/oregon-care-coordination-program-cacoon/	Promising
Kern County (CA) Medically Vulnerable Care Coordination Project	https://amchp.org/wp-content/uploads/2021/05/MVCCP_CA.pdf	Promising
Cultivating Connections through Coordinated Referral Networks	https://amchp.org/wp-content/uploads/2021/05/Cultivating-Connections_Practice-Handout_Promising.pdf	Promising
Minnesota Care Coordination Systems Assessment and Action Planning	https://amchp.org/database_entry/minnesota-care-coordination-systems-assessment-and-action-planning/	Emerging

Resources from the MCH Digital Library & The Peer Reviewed Literature (2017-2019)

National Title V children and youth with special health care needs program profile. *Annotation:* This report provides a snapshot of Title V Children and Youth with Special Health Care Needs (CYSHCN) programs across the United States. Contents include background and history of CYSHCN programs, recent changes affecting CYSHCN programs, and methods and results from an electronic survey of Title V CYSHCN directors to assess key characteristics of each state's CYSHCN program. Topics include program structure and strengths, roles in systems of care, CYSHCN program partnerships, financing of care for CYSHCN populations and emerging issues for CYSHCN programs.

http://www.amchp.org/programsandtopics/CYSHCN/Documents/CYSHCN-Profile-2017_FINAL.pdf

How states use the national standards for CYSHCN to strengthen Medicaid managed care for children with special health care needs. *Annotation:* This fact sheet provides examples of state actions to use the National Standards for Children and Youth with Special Health Care Needs (CYSHCN) to strengthen their managed care systems for CYSHCN. Topics include analyzing and enhancing specialized managed care plans, providing a framework to design and strengthen care delivery systems, strengthening contract language to address the needs of CYSHCN, and improving care coordination and transition to adult care.

<https://nashp.org/how-states-use-the-national-standards-for-cyshcn-to-strengthen-medicare-managed-care-for-children-with-special-health-care-needs/>

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Incorporating health care transition services into preventive care for adolescents and young adults: A toolkit for clinicians. *Annotation:* This toolkit for clinicians provides suggested questions and anticipatory guidance specific to adolescents' transition to adult health care, and is meant to be used alongside Bright Futures. It covers early adolescence (11-14 years) through early adulthood (22-25 years), and includes transition and preventive health care guidance.

<https://www.gottransition.org/resourceGet.cfm?id=468>

Wisconsin care coordination for children and youth mapping project. *Annotation:* This report describes a project that aimed to increase the number of children and youth with special health care needs (CYSHN) served within a medical home by 20% and specifically a mapping project that examined how care coordination is being implemented for CYSHN currently in Wisconsin, what gaps exist, and what assets can be built upon and shared.

<https://www.dhs.wisconsin.gov/publications/p01840.pdf>

Care Coordination: Technical Assistance Brief

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Access other resources at <https://www.mchevidence.org>

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