The Children's Partnership

California Children's Trust

CARING FOR KIDS THE RIGHT WAY:

Key Components of Children's Care Coordination

JULY 2022

The Children's Partnership (TCP) is a California advocacy organization advancing child health equity through research, policy and community engagement. We envision a California where all children—regardless of their race, ethnicity or place of birth—have the resources and opportunities they need to grow up healthy and thrive. For more information, visit www.childrenspartnership.org.

California Children's Trust

The California Children's Trust (The Trust) is a statewide initiative to reinvent our state's approach to children's social, emotional, and developmental health. We work to transform the administration, delivery, and financing of child-serving systems to ensure that they are equity driven and accountable for improved outcomes. The Trust regularly presents its Framework for Solutions and policy recommendations in statewide and national forums. For more information, visit www.cachildrenstrust.org.

This report is part of a larger body of work known as the **Equity Through Engagement project**, a partnership between The Children's Partnership, the California Children's Trust and the Georgetown Center on Poverty and Inequality. Funded by the Robert Wood Johnson Foundation, the partners are conducting policy-relevant quantitative and qualitative research and analysis to highlight opportunities for California to integrate community partnerships and interventions into its Medi-Cal health care financing and delivery systems in order to advance child health equity. Support for this brief was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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Introduction

California's Medi-Cal program has developed several models of whole-person care with comprehensive care coordination for the elderly and those with complex health care needs, such as the Program for All-Inclusive Care for the Elderly (PACE), which has become a national model; the Coordinated Care Initiative (CCI); Whole-Person Care pilots; and, most recently, CalAIM's Enhanced Care Management (ECM) benefit with community support services for "populations of focus" including those with complex health conditions or "high utilizers."[1] While some children will be included in the ECM benefit, the needs of the general population of children enrolled in Medi-Cal do not fit into this current "high-utilizer" framework as most children are less likely to use health care services in the same way as adults.

Children's health needs may not always manifest as complex health conditions at the outset. For children, a more relevant framework would be a "high need" one that would capture social and emotional conditions that have a profound impact on children's healthy development. Due to the relational nature of childhood development, children's health care needs should focus "upstream" to assess the social conditions in which children and their families live.

Children are the most racially and ethnically diverse age group in California, with children of color facing the greatest gaps in health outcomes and delivery of care in the state.[2] With three-fourths of Medi-Cal children being children of color, Medi-Cal has an opportunity to play a critical role in advancing child health equity by cultivating a whole-person health care approach for all Medi-Cal children that integrates their health care with social support needs and creates a bridge across multiple systems that serve them and their families.

Care Coordination Briefs: Part of Our Equity Through Engagement Project

This report is part of our Equity Through Engagement (ETE) project—a partnership with The Children's Partnership, the California Children's Trust and the Georgetown Center on Poverty and Inequality. Funded by the Robert Wood Johnson Foundation, the ETE project examines opportunities for Medi-Cal managed care to partner with community collaboratives, CBOs and families to advance child health equity. This report focuses on care coordination services as a pivotal component in whole-child health care, and is a companion to our issue brief, Care Coordination for Children in Medi-Cal. Also, as part of this project we released a Family Engagement Report in which we asked parents themselves about their experience with Medi-Cal and what they need to engage with Medi-Cal and managed care plans.

"Due to the relational nature of childhood development, children's health care needs should focus 'upstream' to assess the social conditions in which children and their families live."

Whole-Person Care for All Children

"Care coordination is one of the critical pillars of a whole-child care approach in that it is the connector to the array of services and interventions to meet a child's needs."

The research on Adverse Childhood Experiences (ACEs) shows how important safe, stable and nurturing environments are to preventing adversity and supporting children and families in responding when adversity does occur, which in turn can mitigate the longer-term health care impacts of ACEs. Children of color are more likely to experience ACEs compared to their white peers due to "**stressful environments, socio-economic inequalities, and lack of systemic support and resources for families of color"**—issues that are more likely to persist into adulthood if they are not addressed early on and could then manifest into health conditions, including mental health issues and emotional distress.

In order to adequately promote child well-being, what is needed is a whole-person model *designed specifically for children*, applicable along a continuum of needs for all Medi-Cal children. Aligned with the goals of advancing whole-person care for populations of focus, all children enrolled in Medi-Cal require a **whole-child approach** to health care. (Notably, this approach is distinct from DHCS' specific program called the "California Children's Services (CCS) Whole Child Model,"[3] which applies to CCS-qualified children with specific health conditions and aims to integrate CCS specialty care services into Medi-Cal managed care plans' package of services for those children.) A whole-child approach applies to all children and centers on the whole-child experience, including family and social environment and recognizing that children are dependent on the adults in their lives. Such a model would emphasize well-child preventive care and provide the full spectrum of health, dental, mental health, and social and family services based on identified needs. In doing so, a whole-child approach offers a coordinated system of care that fully actualizes the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit to which all Medi-Cal children are entitled, coupled with social and family support services.

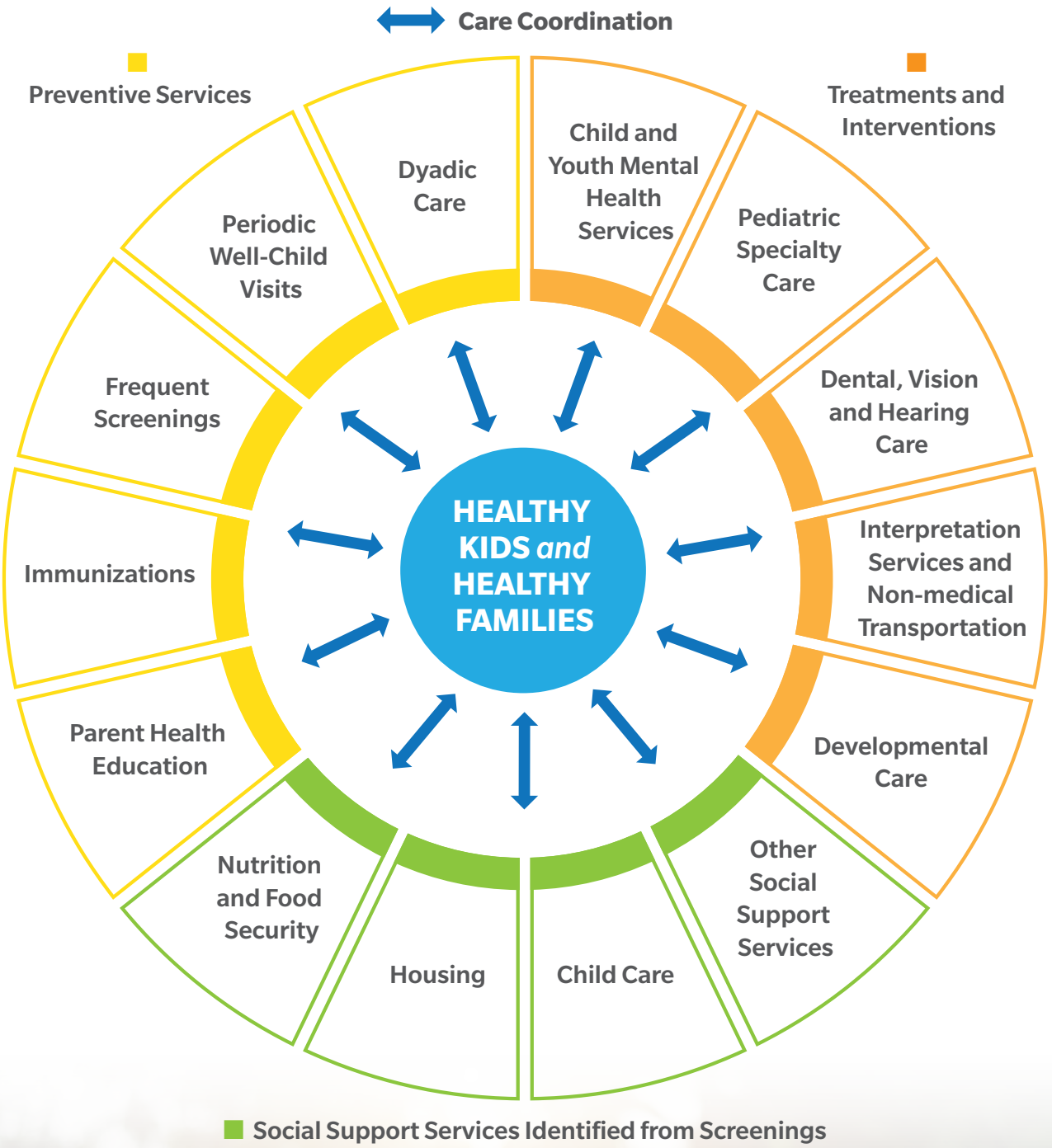
Although Medi-Cal has had a comprehensive child health care program through the EPSDT benefit for decades, the delivery has been underwhelming:

- Only half of Medi-Cal children had preventive care visits.[4]
- Only 25% of Medi-Cal children received recommended screenings.[5]
- California ranks 48th in the nation in access to mental health services for children.[6]

The challenge lies in making the promise of EPSDT a reality while also integrating social support services to children's care.

California's Medi-Cal program has an opportunity to deliver on this promise for children by actualizing proactive promotion of preventive care and building the infrastructure for a continuum of care coordination. Care coordination is one of the critical pillars of a whole-child care approach in that it is the connector to the array of services and interventions to meet a child's needs. As Medi-Cal embarks on reinvigorating its required continuum of care coordination through CalAIM's Population Health Management Program, **this report will focus on the care coordination functions that support the interventions and services within a whole-child approach to children's health care.**

Whole-Child Care Approach



What Is Care Coordination?

Care coordination is a service that ensures children and adolescents get the right care at the right time and in the right setting by creating a bridge across multiple systems that serve children and families.[7] Successful care coordination for children requires effective communication among providers, patients and families across the health system and also among the multiple systems that serve children.[8] Navigating the right support among the fragmented systems of children's medical care is difficult enough for families, with managed care plans, mental health plans, regional centers and school-based services all playing a supporting role in a child's developmental, mental and physical health.

Care coordination is foundational for all children—not just for those with emerging or complex health conditions—to ensure early preventive care is provided. Again, because so much of children's health is determined by conditions that shape where they live, learn, develop and play, particularly in the early stages of their brain development, children and their families' needs should be *assessed early* and educational resources and supports should be provided in a *timely manner* to enable them to be healthy and thrive.[9] For whole-child care models to be effective for children and their families, it is necessary to integrate care coordination functions that not only bridge the multiple systems of health care, but also weave in the child's and their family's social drivers of health.[10] Family (and youth) engagement is at the heart of the function of care coordination: Families are the experts on their child and their voice must be included in their child's plan of care.

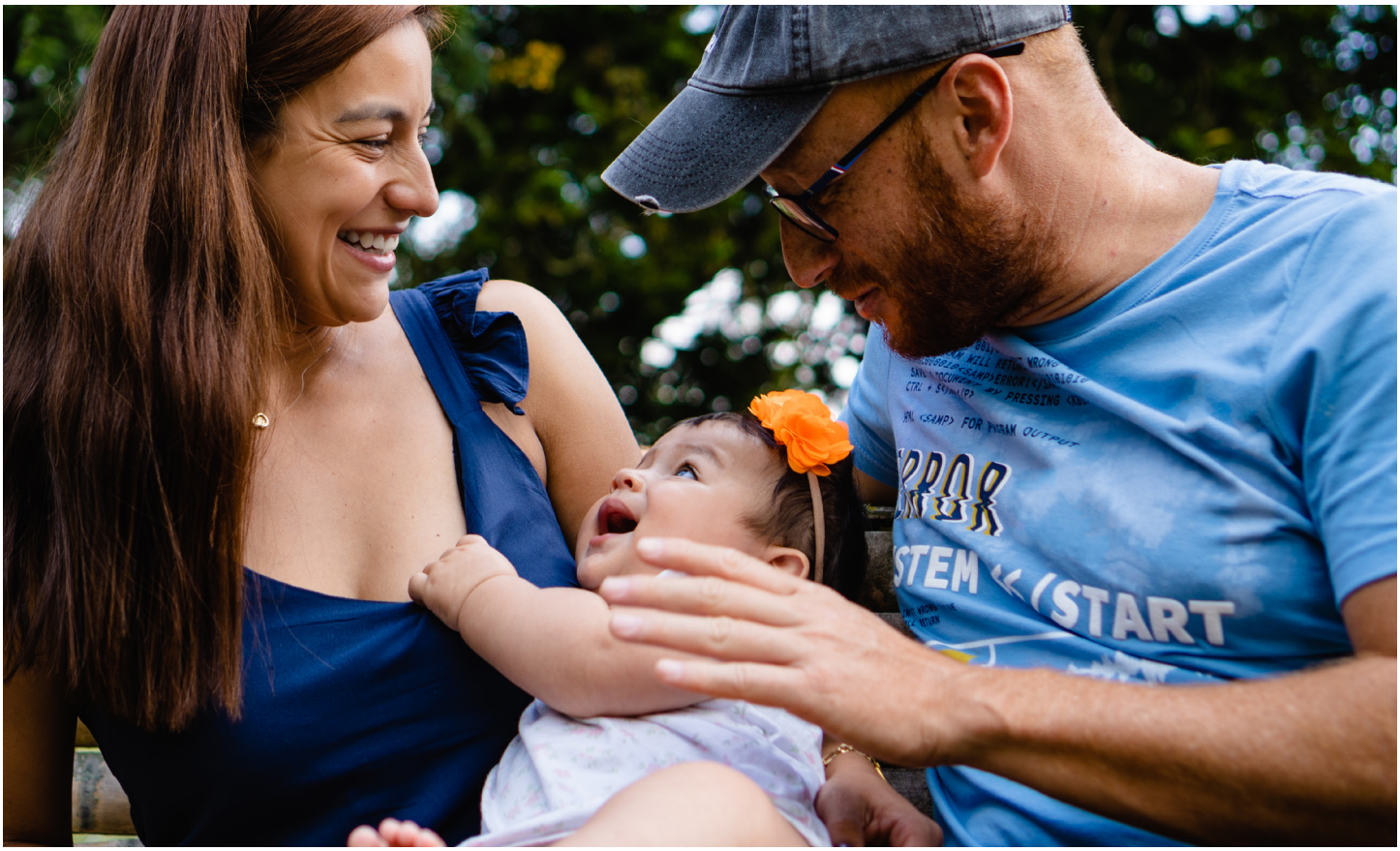
Care Coordination in Children's Health Care

Pediatric "Care Coordination"—one of the core pillars in child-centered primary care approaches—is the communication and organization of a child's care across all child-serving care settings to ensure indicated care is delivered in a timely and culturally and linguistically appropriate manner.

"Case management" or "care management" (Medi-Cal terminology) is a specific higher-intensity level of care coordination, usually shorter-term to address a complex condition.[11]

As we outlined in our previous brief, Care Coordination for Children in Medi-Cal, Medi-Cal managed care plans are currently required to provide a spectrum of coordination of care for "…all medically necessary EPSDT services delivered both within and outside the MCP's provider networks," building upon a comprehensive array of preventive care and screenings. However, there is very little known about the extent to which children enrolled in Medi-Cal are currently receiving care coordination because managed care plans are not required to report standard measures of care coordination. Survey data indicate there is a problem: About 40% of children in California are not getting care coordination when needed, as compared to 31% of children nationally.[12]

"There is very little known about the extent to which children enrolled in Medi-Cal are currently receiving care coordination…"



Reinvigorating Attention to Care Coordination and Preventive Care

CalAIM's Population Health Management (PHM) program—to begin in 2023—aims to further define managed care plans' responsibility beyond cost and utilization management to a continuum of care coordination across multiple systems, which is grounded in preventive care, population needs assessments, and related health services and social supports.[13]

The PHM program outlines three levels of case management: 1) care coordination as part of a basic population health management program that is available to all Medi-Cal beneficiaries and aims to connect them to primary and preventive care; 2) complex care management, which is available to those who are assessed for "rising risk" and may need a temporary case manager to assist them with accessing services across multiple systems; and 3) enhanced care management.[14]

This new Medi-Cal PHM requirement, however, is not a new requirement for Medi-Cal children. In fact, the PHM program is intended to apply to all Medi-Cal beneficiaries and serve as the preventive care model envisioned as part of children's EPSDT benefit. The question is whether this new Medi-Cal PHM program will bring greater focus and accountability to developing a more deliberate care coordination strategy and infrastructure for children—a model of health care delivery that connects to child-specific settings and systems and promotes preventive care and screenings for children.

Understanding what makes care coordination effective for children will help DHCS and Medi-Cal managed care plans implement the PHM program—through standards, partnerships, and infrastructure—in a way that better serves children and fulfills the vision of EPSDT.

Children's Care Coordination

Effective care coordination—as a pillar within a whole-child care approach—should identify where children can best be served and make those connections with a "warm handoff" to those supports, creating a bridge between the services provided by pediatricians, other health professionals, community-based organizations, and child-serving agencies. Given each child-serving system may have its own care coordination structure, care coordination across multiple systems may mean connecting among these various systems of care coordination.

Importantly for children, strong care coordination also builds trusting relationships and partnerships with children's families. This means that parents/caregivers understand their options, are part of their child's care team of decision-makers, and their choices are meaningfully communicated across all systems, service providers and child-serving settings.[15] Additionally, to ensure compliance with care coordination obligations under Medi-Cal, performance metrics for care coordination should also be devised to track compliance with care coordination standards.[16]

The hub or setting of a whole-child care approach may vary from a child-serving medical home, Early Intervention Regional Center or school-based mental health program.

The following section offers a few local examples that illustrate how effective care coordination for children can work. These examples from child- and family-serving programs illustrate the fundamentals of effective care coordination for children, which are further described below.

Key Components of Effective Care Coordination[17]

1. **Screenings and Assessments**
2. **Communication Within a Multidisciplinary Team**
   a. Designated Care Coordinator
   b. Parent/Caregiver (and Youth)
   c. Clinical Team
   d. Legal Partner
3. **Family Communication and Feedback Loops**
4. **Social Support Networks and Partnerships**
5. **Case Management Systems**
6. **Sustainable Financing Mechanisms**

Examples of Children's Care Coordination Models

California has many exemplary primary care child health sites that have integrated effective care coordination through integrating care coordinators, family navigators or community health workers into their practices to support and strengthen families. Below are descriptions of four existing examples of programs and interventions with effective care coordination functions as part of child-serving models of care: **Developmental Understanding and Legal Collaboration for Everyone (DULCE), Help Me Grow (HMG), HealthySteps (HS), and Wellness Together (WT).** Most of these examples are affiliated with early childhood primary health care with the exception of Wellness Together, which is a mental health model of care centered around the school setting. These programs illustrate how care can be centered around a child or child's family, based on the totality of their needs regardless of the care setting or hub.

DULCE[18]

Developmental Understanding and Legal Collaboration for Everyone (DULCE) is an intervention based in health, legal, and early-childhood-related settings that assists parents in overcoming the challenges of caring for children from birth to six months of age by addressing social determinants of health and providing families with support for any unmet legal needs, age-related information on child development, as well as ongoing friendly support. These services are organized as an Interdisciplinary Team comprised of a Family Specialist, a medical provider, a legal partner, an early childhood systems representative, a mental health representative, a project lead, and a clinic administrator. Through its Interdisciplinary Team and relational engagement with families, DULCE works to address the accumulated burden of social and emotional hardship of each family served. Because DULCE is part of a patient-centered medical home, the program benefits extend beyond the new baby and parents to include the entire family.

Help Me Grow[19]

Help Me Grow is a national model built at the local level to improve developmental screening rates, educate parents about developmental milestones, and link children to services as quickly and efficiently as possible. HMGs play a valuable role in California's early identification and intervention systems. HMGs help to bridge the multiple entities providing developmental and behavioral support and interventions for young children, including mental health, regional centers, early care and education, school districts, and community-based providers. HMGs operate call centers in nearly half the counties in California providing developmental screening, referral, and care coordination; educating and providing outreach to parents and providers; training pediatricians and other providers; collecting data and building data systems; and convening partners so they can collaborate effectively.

These services for children and their families are provided through a Centralized Access Point, which, at some sites, might be called Help Me Grow Care Coordinators. These HMG staff connect families to the services they need, provide them with support around specific developmental or behavioral concerns or questions, and help them identify and provide a "warm handoff" to partner organizations for community-based supports that can help overcome barriers to service. Although the primary method of communication between HMG staff and families is through telephone, communication also includes email, secure video conferencing, and telehealth. HMG staff collaborate with health care professionals to ensure that children receive developmental assessments and to identify gaps in service and prospects for enhanced collaboration and improvement.

HealthySteps[20]

HealthySteps is an interdisciplinary pediatric primary care program that ensures young children receive nurturing parenting and have healthy development. HealthySteps Specialists, as part of the primary care team, connect with families during well-child visits at the pediatrician's office and help them identify whether children are reaching developmental milestones, assist in connecting families to additional services, and answer families' questions about child development and well-being. HealthySteps operates according to three levels of service:

Tier 1: Universal Services, including screenings for children and all family needs, and child development support.

Tier 2: Short-term supports for families with mild concerns which include child development and behavior consultations, care coordination and system navigation, parenting guidance and early learning resources, in addition to all Tier 1 services.

Tier 3: Comprehensive services for most-in-need families which include ongoing, preventive team-based well-child visits (WCV) in addition to all Tier 1 and Tier 2 services.

Wellness Together[21]

Wellness Together partners with K-12 school districts to provide mental health services for students, families, and educators regardless of their Medicaid or insurance requirements. The program works in collaboration with site district leadership to evaluate which programs will be most beneficial for students and families. Wellness Together provides services at schools through Mental Health Specialists (MHSs) who collaborate with existing school counselors to provide evidence-based interventions. Multi-Tiered System of Supports include:

Tier 1: Social-emotional learning and family workshops.

Tier 2: Group and school staff consultation.

Tier 3: Individual counseling, family engagement, and crisis intervention.

Care Coordination Components in Action

As part of the selected child-serving programs we described above, this section covers each of the major components of successful care coordination for children's health and includes examples of each component in action. The following table compares the selected child-serving program's care coordination activities relative to the key components that we have identified as part of effective care coordination.

Child-Serving Programs and Their Care Coordination Components

DULCE

INTERVENTION: Birth–6 months; early childhood education; family, social, and legal supports

TYPE OF SETTING OR HUB: Patient-centered medical home setting

COMPONENTS OF CARE COORDINATION				
Screening and Assessment	**Communication Within a Multidisciplinary Team**	**Family Communication and Feedback Loops**	**Local Networks/ Partnerships**	**Case Management Systems**
Parental resilience, social connections, concrete supports, knowledge of parenting and child development, social and emotional competence of children.	Pediatric clinician, mental health specialist, a legal partner, and an early childhood system representative DULCE Family Specialist	Parent/caregiver part of the health care team	Local medical-legal partnerships	

Help Me Grow

INTERVENTION: Promote developmental screenings and early interventions

TYPE OF SETTING OR HUB: Call Center Web

COMPONENTS OF CARE COORDINATION				
Screening and Assessment	**Communication Within a Multidisciplinary Team**	**Family Communication and Feedback Loops**	**Local Networks/ Partnerships**	**Case Management Systems**
Train, educate, conduct outreach and developmental screenings	Communication among players in an early identification and intervention system Centralized access point; contact point varies by county	Continue collaboration with parent/caregiver to ensure access to referred resources	Regular community outreach to maintain local support directory	System reporting to follow up on referrals and outcomes

HealthySteps

INTERVENTION: 0–3 years program; promotes the health, well-being and school readiness of babies and toddlers

TYPE OF SETTING OR HUB: Pediatric primary care settings

COMPONENTS OF CARE COORDINATION				
Screening and Assessment	**Communication Within a Multidisciplinary Team**	**Family Communication and Feedback Loops**	**Local Networks/ Partnerships**	**Case Management Systems**
Behavior, sleep, feeding, attachment, parental depression, social determinants of health and adapting to life with a baby or toddler	Physician Champion and a child development professional, known as a HealthySteps Specialist HealthySteps Specialist (HS Specialist)	A child's caregivers are incorporated into the care team as experts in their child's care to cultivate their strengths and assets as integral to the team's decision-making for their child's health care plan	Partnerships with pediatric primary care	Welly, HIPAA-compliant, mobile-friendly, web-based, care coordination platform

Wellness Together

INTERVENTION: Mental health services for K-12 students

TYPE OF SETTING OR HUB: Pediatric primary care settings

COMPONENTS OF CARE COORDINATION				
Screening and Assessment	**Communication Within a Multidisciplinary Team**	**Family Communication and Feedback Loops**	**Local Networks/ Partnerships**	**Case Management Systems**
Behavioral Emotional Ratings Scale-2 Youth Rating Scale (BERS-2 YRS)	Mental Health Specialist (MHS), social worker, parent/caregiver, and anyone else the student wants to be involved	Family engagement services that bring together families and students (K-12)	Partner with local Graduate Social Work programs to hire mental health specialists who are supervised by more experienced Wellness Together MHS	HIPAA-secure platform to coordinate care with school staff and collect, analyze, and create data reports for school partners

Key Components of Effective Care Coordination

1. Screenings and Assessments

Child well-being involves a wide array of child-specific services that also encompass family-centered services, including those beyond clinical care. Medicaid's EPSDT benefit entitles all Medicaid children to a comprehensive regimen of preventive care and screenings, treatments or interventions to address identified conditions and areas of concern. In our information brief, Caring for Kids the Right Way, we have outlined the array of services and interventions for which care coordination is needed for children.

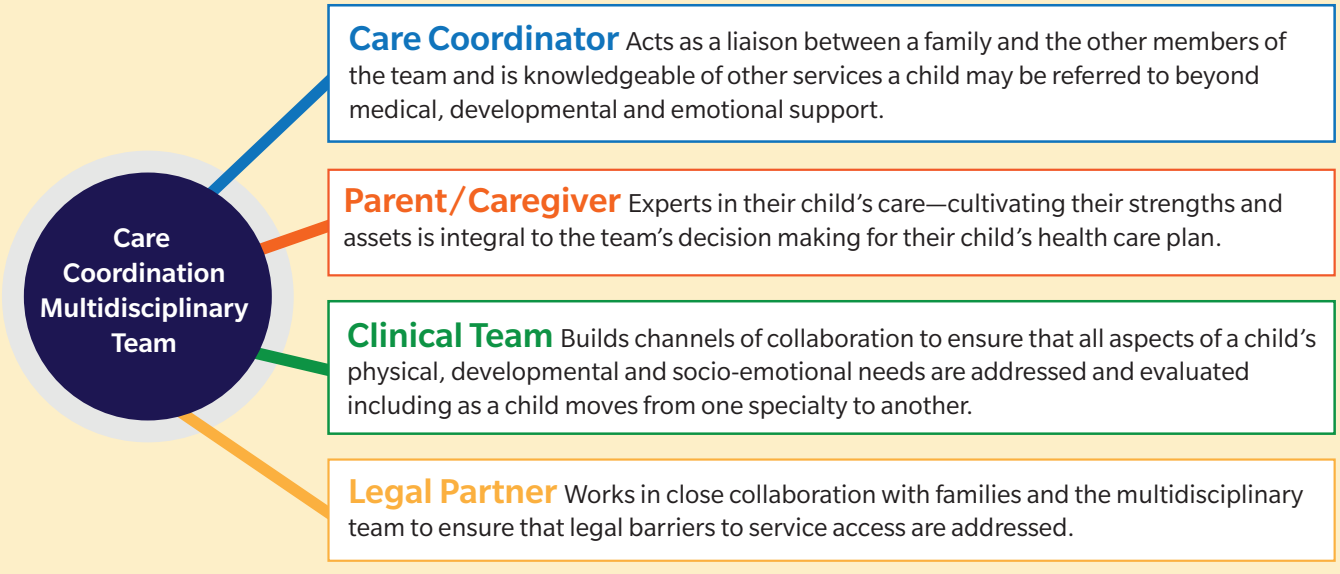
Care coordination also serves to promote and educate families about preventive care, such as Help Me Grow promoting (and providing training) on early and frequent developmental screens for children. In addition, one of the major functions of DULCE and HealthySteps is to assess and identify what supports the parent/caregiver needs. Notably, starting in January 2023, Medi-Cal will be implementing a behavioral health prevention benefit for dyadic care, linking the caregiver's mental health with their child's health.[22] Recognizing dyadic care as a reimbursable service supports pediatric practices and programs like DULCE and HealthySteps, which assess and integrate relational health care.

2. Communication Within a Multidisciplinary Team

Care coordination knits together a child's various treatments and support services with and for a child's family: This entails shared information, communication and feedback loops, and collaborative decision-making among a multidisciplinary team. **A team should always include family members themselves and communicate among the various providers serving the child, within both clinical and community settings.**

Depending on the program and its capacity, the clinical setting may be where children's social, emotional and developmental needs are assessed and identified, while other providers outside the clinical setting provide the services to address the indicated needs or community partners that connect families to services that do.[23] How that team coordinates and communicates may vary—whether they are ongoing partners within the same health home, or various providers, agencies and/or CBOs connected through a central care coordinator. The objective is that the team is collaborating on serving the various needs of the child and that those services and providers are working in coordination with each other.

The members of the team collaborate with each other to 1) determine what supports would benefit the child and their family; 2) decide how to connect them with those support services; and 3) provide ongoing follow-up and feedback on the impact of the services received.



An effective multidisciplinary team is comprised of a designated care coordinator, multiple clinical providers (physical, mental, dental and vision), other child-serving agencies (schools, early intervention regional centers), community-based organizations, and, most importantly, the family member and youth themselves. Often, team members are in different agencies or programs and/or in separate settings, thus, the means of communication are what make a team functional. Communication may be facilitated by a single point coordinator, group discussions or both. While shared data systems would be ideal, this is often difficult to operate across varying agencies, each with its own data systems.

Wellness Together communicates with the existing school team—counselors, in-school nurses, teachers, coaches—and also connects and communicates with other mental health providers, local programs and behavioral health agencies, and other health clinicians serving the youth. In some local HMG programs, the HMG staff communicate among the multiple agencies of the local early identification and intervention system, such as the clinician, regional centers, early child care, schools, home visiting programs, CBOs and county mental health agency.

The multidisciplinary team should be comprised of:

☑ Care Coordinator Staff

The DULCE, Help Me Grow, HealthySteps and Wellness Together models acknowledge that to fully support all of a child's needs, there must be a designated person to serve as a care coordinator. This person acts as a single point of contact for the family and assists in communication among the various providers. This person should also be knowledgeable of other services a child may be referred to beyond medical, developmental and emotional support. Effective care coordinators can be social workers, community health workers (see sidebar), nurses or others who are trained in childhood development and assisting families, and optimally they are culturally concordant, sharing lived experience with the families they serve.

In DULCE, HMG and HealthySteps models, designated care coordinators are trained to be responsible for: 1) screening children for health-related social risk factors; 2) identifying and connecting children and their families to the appropriate organizations or agencies with the resources and capacity to meet their particular needs;

Community Health Workers: Providing Families With Relational Health Care[24]

In establishing an intentional, anti-racist health care structure, cultural competency and humility can be enhanced by incorporating staff with lived experience such as Community Health Workers (CHWs). Programs that employ CHWs as part of the medical home find that families are more engaged and more comfortable responding to and establishing connections with staff contacts who have similar life experiences as their own. Because families can quickly build trust with CHWs, these staff also can help improve the relationship between professional health care providers and families.

CHWs can also play a critical role in children's relational health care: Nurturing relationships and intimate bonding are foundational to a child's healthy childhood development—their "relational health." In turn, relational health care recognizes the importance of social connections and fosters and supports a child's relational health by ensuring engagement, trust and partnerships with families.

CHWs, in a care coordination capacity, provide standard functions such as home visits, regular phone check-ins, health care navigation, "warm handoffs" to appointments, and enrollment assistance for social services programs. But CHWs also can offer relational health care coordination, coaching and mentoring, and protective factor strategies. It is estimated that one in every twenty families with a young child receives consistent and ongoing support from a CHW to help them and their child grow, whereas at least one in every five families would benefit from a CHW.

California recently adopted a Medi-Cal CHW benefit, which will cover CHWs' navigation and health education work, two core functions of care coordination.

"When parents have to talk to a different person each time they call Medi-Cal or their provider, they don't get the help they need. Parents expressed frustration about not having a single point of contact that knows their child and their situation. They feel as if they have to tell their story and circumstance to multiple people before they receive support or obtain the information they need."

–TCP Family Engagement Parent Discussion Groups

3) following up with parents/caregivers to ensure they stay connected to the services they need as well as to identify new needs and needed interventions including physical, mental and social-emotional supports;
4) communicating with all parties involved regarding a child's progress, outcomes and concurrent needs; and
5) tracking children's health outcomes based on services received for continued case management improvement that includes personalization of health care needs. While the caregiver (and, in the case of adolescents, the child) is part of the care team, the care coordinator is also a primary contact for the family/caregiver who listens to their input and feedback.

Through the DULCE program, families are immediately connected to a Family Specialist—DULCE care coordinators—who are specialized community health workers (CHWs). These Family Specialists are trained in child development and provide relational engagement by attending well-child visits with families and health care providers to ensure a child and their family's priorities and concerns are addressed as well as by providing home visits and telephone check-ins.[25] A Family Specialist gets to know the families, provides information and education on healthy early childhood development, ensures children access preventive services—such as screenings—and works with the rest of the DULCE Interdisciplinary Team to connect families with existing community resources and needed supports.

"A parent couldn't follow what her child's doctor was saying because the interpreter assigned to them spoke a different dialect of Mixteco than the parent spoke. The parent did not feel comfortable letting the interpreter and doctor know that the dialect interpreted was not her own dialect."

–TCP Family Engagement Parent Discussion Groups

Many county Help Me Grow systems provide an assigned care coordinator that serves as the central point of contact for families. These staff provide a myriad of supports to families: They help identify gaps and barriers to services, connect families with community-based services and programs, provide health education and parenting guidance, educate families about their options and the service delivery system, and assist with developmental screening-related activities such as scoring, sharing results, and linking families to the appropriate developmental services.[26] HMG care coordination staff can be social workers or similar health or human services professionals with training or experience in early childhood development or special education.

A care coordinator provides a trusted relational contact to families who can often serve as an advocate for and with families ensuring that the multidisciplinary team understands the child and family's needs, concerns and objectives. While maintaining a single contact person might be difficult for small programs, coordinator staff with similar lived experience can make the difference between a family's ability to fully engage in their child's doctor's visit and not being able to do so. For example, this consideration may determine whether the coordinator knows to provide the family an interpreter that speaks their specific dialect.

Additional skills HMG affiliates have identified as essential for HMG care coordination staff include: empathy and non-judgment in listening and speaking, trustworthiness, having the ability to adapt their language and approach

to meet families where they are, and having the ability to understand difficult circumstances and responding appropriately to help families.[27] Some counties, depending on resources and capacity, aim to moderate the caseload for HMG care coordinator staff to allow them time to fulfill their family-directed functions, such as listening to family needs; providing education and information on child development, behavior management, and assistance; and providing advocacy and follow-ups with families as needed.

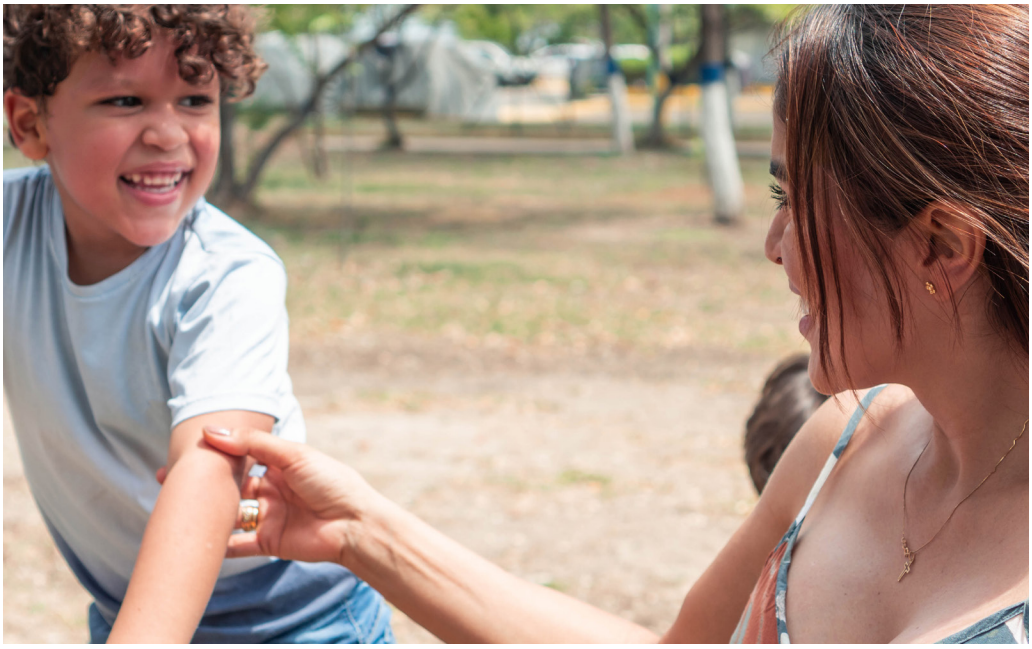
HealthySteps integrates into their health care team a HealthySteps Specialist (HS Specialist) who meets with families at well-child visits to assist them in screening and addressing frequent and complex issues that "physicians sometimes lack the time to address including feeding, behavior, sleep, attachment, depression, social determinants of health and adapting to life with a baby or young child."[28] HS Specialists have been trained to provide care coordination, parenting counseling and support, as well as perform universal screenings, compliance monitoring and quality improvement processes. The minimum requirement to be an HS Specialist is a bachelor's degree, with most HS Specialists having backgrounds as social workers with training in mental health, psychologists, early childhood educators, or nurses with experience in early childhood development.[29]

Wellness Together has Regional Social Work Specialists (in some areas, specialists are from central offices) that maintain a network list of local service organizations and agencies. A Regional Social Work Specialist could help students and families enroll in Medi-Cal, make referrals to navigate their health plans or find local assistance with immigration issues. They provide referrals to families and youth to meet social support needs in collaboration with a WT Mental Health Specialist, and either the Mental Health Specialist or Regional Social Work Specialist maintains communication with the school counselor, other clinicians and a network of local service organizations and agencies to address any identified needs.

☑ Parent/Caregiver Team Member

As part of the multidisciplinary team, families play an important role in determining action plans that will help address their children's needs and improve health outcomes.[30] Effective care coordination is relational and starts with building family trust. Care coordination models such as those used in DULCE and HealthySteps demonstrate a "gold standard" for incorporating a child's caregivers in the care team as experts in their child's care to cultivate their strengths and assets as integral to the team's decision-making for their child's health care plan. (Youth themselves can also be included in decision-making for their own care.)

Other programs such as Wellness Together provide family engagement services that bring together families and students (kindergarten through grade 12) with the school support team and Wellness Together, as well as any other supports the youth or family identifies, which may include a coach or a minister. (For youth ages 12 and over who do not want a family member such as a stepparent involved, that request is met.) Together they develop academic, social-emotional and personal goals for the child or youth over the next 13 weeks, and all commit to those goals and the plan to get there.



In recent conversations with parents of children in Medi-Cal as part of the Equity Through Engagement project,[31] parents often expressed dissatisfaction with the level of communication they receive from health care providers

regarding, among other aspects, information shared across different providers, treatment information, referrals to other services, and updates on Medi-Cal applications and eligibility of services. Parents also expressed a desire for health care providers to take their concerns as parents more seriously and recognize the importance of their role in the understanding and decision-making process regarding their children's needs.

For example, **DULCE's design and execution rely heavily on parental leadership and participation** to ensure that the right interventions and approaches are meeting the needs of children and addressing other family needs impacting a child's healthy development. DULCE also relies on feedback from parents to personalize care and relationships with Family Specialists as well as to improve the overall DULCE structure.

HealthySteps recognizes parents as experts in their children's health care needs. HealthySteps educates parents to become advocates for their children by providing educational resources that help parents understand their children's growth and developmental needs as well as to more effectively communicate with health care providers and other professionals regarding concerns, challenges and milestones through the different stages of their child's development. Additionally, HS Specialists collaborate with parents in problem-solving common parenting challenges such as safety, feeding, discipline and limit setting. Here the parent/caregiver is given the opportunity to receive advice reflecting on their own history and how it impacts their parenting as well as their own parenting style and strengths as a parent.

☑ Clinical Team

A clinical team composed of physicians, mental health professionals, other health care professionals and social workers is established in care coordination models to assist in determining where a child should be referred next in terms of general and specialty health care treatment based on need.[32,33] In order to best assist children, a clinical team builds channels of collaboration, communication and cooperation to ensure that all aspects of care coordination for the physical development and social-emotional needs of a child are addressed and evaluated by the team as a whole and as a child moves from one specialty to another.[34, 35]A clinical team also communicates with the corresponding care coordinator

about concerns, recommendations and treatment options. Coordination between clinical team members and the care coordinator is critical to ensuring that children are referred to and connected with appropriate specialists or other social services, as well as assisting families during transitions and follow through.

For example, DULCE includes a clinical team as part of their care model: a medical leader or pediatric clinician, a mental health professional and a medical legal partner liaison. The primary care or pediatric clinician is housed in the clinical setting. The clinician communicates with the DULCE Family Specialist outside the exam room to identify whether a family has been able to be reached by the clinic as well as to raise other concerns observed. For example, if a clinician knows a mother of a newborn has had mental health issues in the past and is concerned the mom might not be receiving assistance, the clinician communicates with the Family Specialist to reach out to the mom. Subsequently, the clinician and Family Specialist work together to make sure the mom is connected to a mental health professional. Additionally, the mental health professional meets with the Family Specialist on a weekly basis to discuss the number of families that were seen the previous week, how many are in crisis, why they are in crisis, and gather information about parent-child interactions.[36]

The Wellness Together program team consists of Mental Health Specialists (MHSs), which are licensed therapists and associates who work as trainees gaining experience toward clinical licensure. The program partners with graduate schools, giving associates the opportunity to train under licensed therapists and build clinical work hours in exchange for school credits. This clinical team works closely with school counselors to address students' mental health needs.

☑ Legal Partner

Legal partners play an important preventive role within the interdisciplinary team by identifying legal issues before they become serious problems. Children are able to thrive when their families have access to the tools and resources necessary for a healthy and nurturing environment. Integrating a legal partner into the team of providers caring for a child offers a family the concrete support and services that address a family's needs and help minimize stress caused by challenges.[37] These legal partners provide support and training to Family Specialists to screen for legal issues related to social determinants of health, provide legal information, and refer families for legal intake if necessary.

For example, DULCE has partnered with public interest law organizations such as the East Bay Community Law Center. These organizations dedicate a portion of an attorney's time to support DULCE and also deploy paralegals and law students to support DULCE[38] to help identify legal risks and barriers and facilitate remedies. DULCE legal partners may attend weekly team case reviews with Family Specialists to provide legal-problem-solving insight to Family Specialists, as needed, to help determine which families need acute legal assistance.[39]

In Alameda County, where the DULCE program is located at the county's Highland Hospital, 70% of the families served by Alameda DULCE are immigrants. Nearly half of DULCE families are referred for legal assistance through partner East Bay Community Law Center, often for immigration, housing and public benefits issues. Families report decreased anxiety and fear after receiving this legal assistance, directly impacting the mental health of parents.[40]

The other program models also have engaged with legal aid organizations to assist families with immigration or housing issues, although not always as an ongoing partnership as is the case with DULCE. For example, Wellness Together has connected families with legal assistance for immigration issues.

3. Family Communication and Feedback Loops

A major issue that parents raised in our Equity Through Engagement focus groups was wanting greater communication with providers about their child's care. While they may be on the team that makes decisions about the care plan, parents want and need to know the progress that is being made with a speech therapist, for example, and know what they can be doing at home. Similarly, the child's pediatrician will need to know when a referred support provider saw the child and what was the result of that visit or service—in other words, a feedback loop. Care coordination would include a protocol for communication and feedback among providers and organizations as well as with parents/caregivers.

While Wellness Together is centered around school-based mental health services, the program still communicates regularly, with consent, with the youth's family physician and the school counselor providing relevant information about their progress. The program regularly communicates with parents/caregivers about their child's progress as well as the parent's/caregiver's needs. For children over age 12, they are given agency to serve as their own spokesperson, setting their own goals with the program and choosing who will be part of their team.

Help Me Grow has a data system that tracks initial contact through follow-up from referrals to ensure the families' needs were met and serves as a single point of contact for the parent/caregiver as a person to turn to for asking questions or for assistance.

Using a technology called Welly, HealthySteps is able to keep track of information about families and close referral feedback loops. Welly is a web-based care coordination tool that is HIPAA-compliant and mobile-friendly. It is meant to optimize the skills of the HS Specialist while also smoothly recording data. HS Specialists may capture data for the whole family, organize care, manage referrals and follow up.

"A major issue that parents raised in our Equity Through Engagement focus groups was wanting greater communication with providers about their child's care."

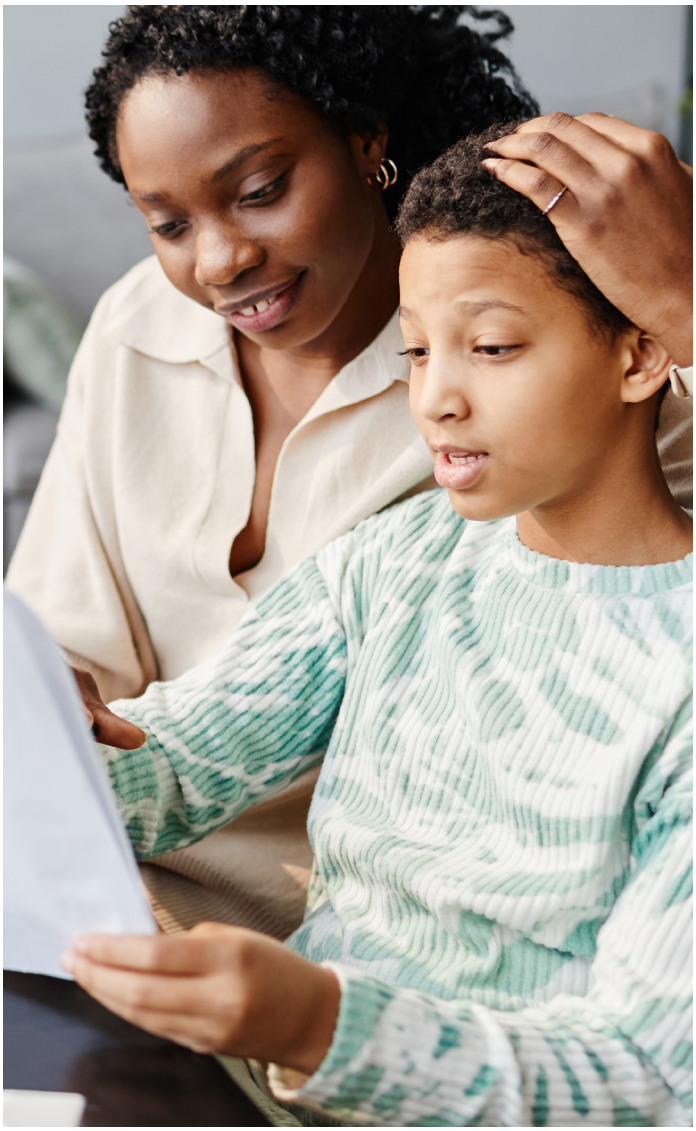
4. Social Support Networks and Partnerships

Critical to effective care coordination models are their networks, relationships and partnerships with child-specific providers, such as schools and regional centers, and support services in the community through local CBOs and agencies. The network is more than a list of available specialists and organizations in the area. It includes organizations where there are established relationships (and optimally, partnerships) with providers who have demonstrated quality of care and respect for the families they serve. Established relationships more effectively help overcome barriers families face in trying to secure appointments, to access services, or to enroll in benefits, as well as ensuring follow-up and outcomes from those supports.

In some cases, local community-based or family-run organizations can themselves serve as a coordinator of care or the linkage from medical care to social and emotional supports in the community, particularly those that have the trust of community members to reflect and respect the cultural experience of the families served. Such organizations can also provide for families problem-solving and goal-setting support and decision-making assistance for needed treatments.

HealthySteps programs collaborate with community partners and other local, evidence-based programs such as home visiting and Reach Out and Read. HealthySteps programs also partner with onsite programs that include Medical-Legal Partnerships, Positive Parenting Program (Triple P), and Help Me Grow.[41] Additionally, in order to assist parents navigating a variety of systems, HS Specialists and other HS staff partner with community-based organizations who provide close follow-ups and assistance when necessary.

Help Me Grow cultivates its network by keeping an up-to-date directory of available services from reliable and trusted organizations and by linking service providers to one another to establish an integrated and strengthened support network for families. The success of HMG is also dependent on the ability of communities where HMG sites are located to come together around a shared goal of "helping children grow healthy and with the resources they and their families need."[42] For example, Health Me Grow Orange County partnered with 2-1-1 Orange County



(211OC)—a 24-hour emergency hotline that connects OC residents to thousands of local health and human services resources. Through this partnership, families and children, child care providers, early educators and health care providers have access to a specific toll-free number where they can obtain resource information.[43,44]

For each district, Wellness Together updates local directories of community resources, including housing, transportation, Medi-Cal, clothing, employment and food security. These lists are approved by the district and amended based on input from partners and families. The program ensures the youth or family receives a warm handoff connection to any organization in the directory.

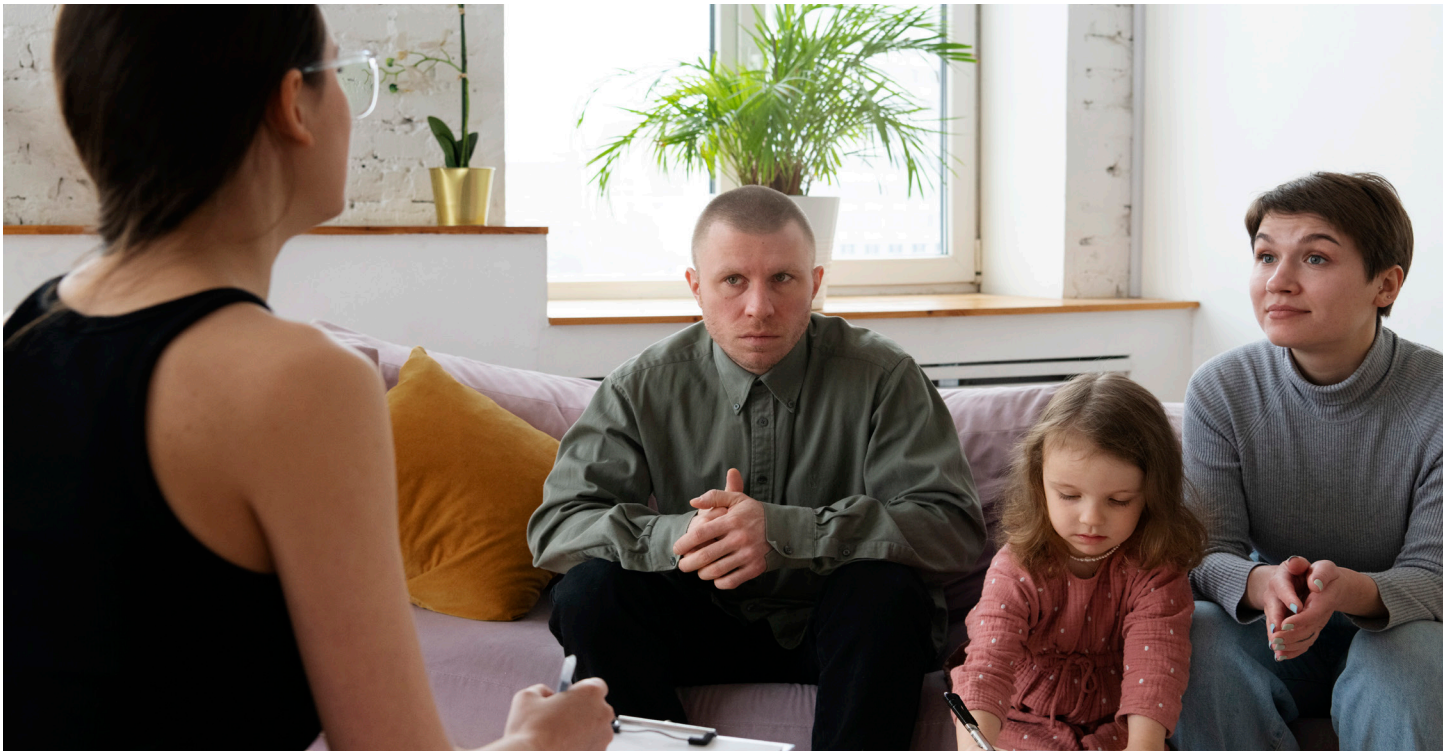
5. Case Management System

Coordinating care relies heavily on the ability to conveniently acquire and distribute crucial data such as patient and provider data, benefit coverage and authorization details, as well as resource directories that may link families to other non-medical services. A case management system can organize a child's regiment of care within one location or across several settings, in which information is accessible, inputted and shared across all parties involved in a child's care. **Case management systems focus on personalized management needs among the various providers, including clinical data on diagnoses, treatments, assessment or screening results, referrals, caregiver/patient follow-ups, progress made, as well as claims and billing.** Using care coordination tools, like a case management system, can assist care coordinators in tracking and facilitating complex cases, coordinating with clinicians, and arranging a patient's goals, which leads to improved patient outcomes and reduces costs.

Help Me Grow Orange County developed the System for Tracking Access to Referrals (STAR)—a comprehensive online client database—to gather information about the children and families served, referrals, care coordination provided, communication with primary health care providers, and whether children were connected to services as a result of the referrals. Other Help Me Grow programs in other states participating in the National Network of Help Me Grow can use STAR for a fee that includes an annual membership as well as a one-time set-up and customization cost.[45]

Wellness Together's case management system tracks services provided across social and mental health services, with a real-time data dashboard, and shares non-clinical information with other team members such as the school counselor.

Several programs, CBOs and health plans use various community network navigation platforms or community resource and referral programs—such as "findhelp" (formerly known as "Aunt Bertha"), One Degree, UniteUS—with varying levels of functionality and utility in identifying available local social supports and making referrals and appointments. These systems may have case management functionality among the services. Having an available directory and referral functionality that works across a community and with various local providers and child-specific settings is an important component for effective care coordination. However, this report does not fully examine the different models.



6. Sustainable Financing Mechanisms

Sustainable funding is a major barrier to increasing access to adequate care coordination for children and families. As with the delivery of screenings and well-child visits, the functions of care coordination itself, particularly staffing needs, should be reimbursed or sustainably funded. Case management systems and infrastructure could be financed with one-time funding such as the DHCS-proposed Equity and Practice Transformation grants.[46] With regard to ongoing Medi-Cal reimbursement, as previously mentioned, Medi-Cal managed care plans currently are required to provide all levels of care coordination or case management to children, depending on need, in accordance with EPSDT with no additional payment beyond the capitation payment. In early drafts of Medi-Cal's Population Health Management Program, managed care plans would have flexibility on how to provide basic care coordination, either via in-house staff or contracted with outside care coordination providers.[47] In other words, health plans may or may not be contracting and financing with local programs already supplying care coordination to children and families. Moreover, care coordination in Medi-Cal is not currently measured and therefore not easily monitored. In fact, care coordination is not a category of service for purposes of managed care plan rate setting.

Care coordination could be delivered in non-medical settings, including in the home, school, regional center or community. Because each of these providers and organizations has varying degrees of financial infrastructures and payment models, seeking reimbursement through the medical model is challenging, requiring innovative approaches to bridge these varying financial structures and provide sustainable financing.

Specific programs have utilized various methods of financing to support their operations. HealthySteps sites reported receiving funding from different sources with private grants being the most common source. Other sources included health systems, pediatric department funds, Graduate Medical Education (GME) or residency training funds, and tobacco tax and/or settlement funds (through First 5).[48] Many HealthySteps sites are reimbursed by Medi-Cal and private insurance for their medical services.

Across the country, Help Me Grow programs use a combination of funding and in-kind support to sustain their services, including United Ways/211, state agencies, private foundation donations, corporate partners and federal grant-making agencies.[49] In California, most of Help Me Grow financing comes from local First 5 commissions through Prop 10 funding. Due to declining First 5 Prop 10 funding, some local HMGs and First 5s have partnered with counties to leverage local investments to generate federal and state funding, such as Medi-Cal Administrative Activities (MAA billing), Mental Health Services Act Funding and Medi-Cal EPSDT benefit claims.[50] Another avenue is offering HMG as a resource for foster parents as part of the foster care program to help secure funding from child protective services agencies.

Some Healthy Step sites and Help Me Grow programs have explored reimbursement for their care coordination and child-health-related services from managed care plans. Partnerships between Medi-Cal managed care plans and local HMG programs are emerging but are not well established yet. Each depends on individual relations and partnerships with local Medi-Cal managed care plans because currently Medi-Cal does not yet require plans to contract with local organizations or programs for child-centered care coordination.

Ohio's Medicaid program began a pilot program to create a new payment pathway that recognizes the value HealthySteps Specialists can provide to families during brief interventions and counseling. Allowing reimbursement for certain preventive medicine counseling codes, overall billing reimbursement is sufficient to cover the costs associated with HealthySteps Specialists' salaries.[51]

Without managed care plan performance measures and a rate setting category of service for care coordination, it is difficult to ensure accountability. As such, many families must assume the difficult responsibility of coordinating care for their child and/or, when possible, seek outside help from systems and programs like those mentioned throughout this report. Currently, there is no monitoring or measurement of the care coordination provided by MCPs nor is their specific funding devoted to supporting care coordination for children.

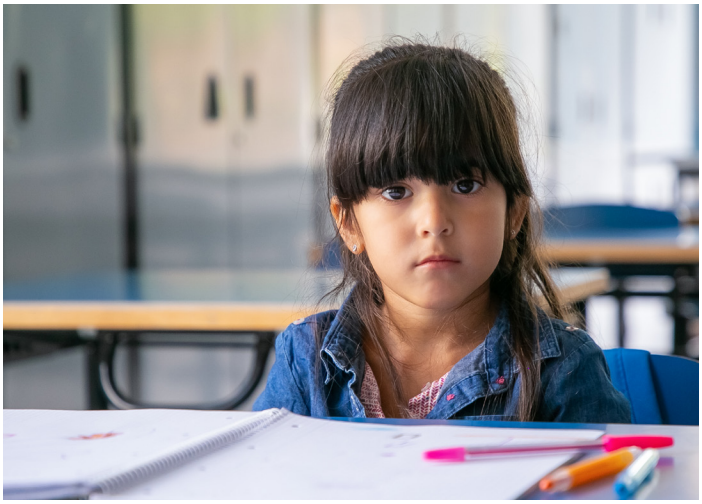
Moving Forward: Recommendations

While care coordination has been and can be provided directly from managed care plans, care coordination—including basic care coordination—is best when relational and embedded in the community being served. Managed care plans could better serve children by contracting with and funding local organizations and programs to provide care coordination that demonstrates capacity and experience with meeting the core functions and fundamentals of care coordination infrastructure. There would likely be multiple entities to partner with depending on the model or setting in which the child is served, such as part of a pediatric medical home, a school clinic, or a culturally centered community organization. Part of care coordination is not only supporting the staff that serve as the care coordinator but also the infrastructure and local support partners that interact with that coordinator (such as CBOs or school mental health staff).

Many pediatric practices and settings will need assistance in incorporating care coordination into their workflow (and funding for the additional staff) or partnering with other organizations to provide care coordination functions. As Medi-Cal designs its Population Health Management program and service, the following policy recommendations will help California build toward the care coordination envisioned in EPSDT for all Medi-Cal children:

EPSDT medical necessity must override any Population Health Management care management eligibility qualifications

First and foremost, the PHM stratification of "risk" and eligibility criteria to determine the level of care management should not undermine a child's access to appropriate care management based on EPSDT medical necessity. While it is unclear whether children are able to access this required benefit now, the new PHM program should not create eligibility criteria that would override a level of care coordination EPSDT warrants for a child. DHCS and managed care plans' algorithms and eligibility criteria should not allow PHM qualifications to interfere with what EPSDT determines as medically necessary for a child. If a child needs complex care management based on EPSDT medical necessity, the child should receive it, regardless of whether they meet PHM qualifications for such services.



Provide outreach, training and infrastructure support for care coordination activities

Based on our ETE project interviews and focus groups, families and pediatric practices are often not aware that any form of care coordination is available to families through their managed care plans nor that there are varying degrees of care coordination children could qualify for. EPSDT already requires Medi-Cal Managed Care Plans and health plans to educate families on their rights, which is not occurring effectively.

- **Medi-Cal should train, partner and contract with CBOs to provide outreach to families about the availability of care coordination**, assistance with making appointments for referrals, interpretation services, transportation, and guidance in determining in which circumstances higher levels of care management are available.
- **CBO Navigator grants could be supplemented** to include this outreach and training.
- **Pediatric practices and programs should be provided training on how to access care coordination and care management for the families they serve**, including the availability of new benefits like dyadic care and CHWs.
- **Medi-Cal and health plans should provide technical assistance and invest in practice infrastructure** for transforming workflow and claiming Medi-Cal reimbursement for staffing those care coordination

activities if clinics, providers, or CBOs directly provide care coordination or subcontract with programs like those noted in this report.

Contract with community-based organizations and/or community health workers to provide care coordination functions

Managed care plans should be directed to build upon and partner with existing local care coordination programs available to their child enrollees, rather than duplicating efforts.

- **Medi-Cal should provide incentive payments when plans contract with CBOs for CHWs** rather than hiring them in house, similar to states like Michigan.[52]
- **The proposed Equity and Practice Transformation grants should support developing approaches to sustainable financing** within local practices and programs.

Provide childhood development training and infrastructure-building assistance for community health workers

DHCS and managed care plans should support CHWs and their affiliated CBOs or pediatric practices in developing means of seeking reimbursement for CHWs' care coordination and relational health care functions.

- **The proposed Equity and Practice Transformation grants could be increased and expanded to include CHW infrastructure support**, or a similar but separate grant program could be created for CHWs.
- **The governor's budget proposal to train a CHW workforce should explicitly incorporate training on child health, childhood development and relational health.**

Require explicit accountability for managed care plans' care coordination responsibilities

Adding a new PHM requirement alone will not effectuate the availability of care coordination, as evidenced by the decades-old EPSDT requirement and its unknown performance to date.

- **Medi-Cal should clarify appropriate care coordination,** namely community- and family-based pediatric models of care or CBOs with CHWs, and not health plan call centers.
- **Care coordination requirements should be measured and reported** by developing performance metrics to which health plans are held accountable, such as closed feedback loops from referrals[53] and patient satisfaction surveys.
- **Care coordination should be added as a category of service in managed care plan rate setting methodology,** as required by federal Medicaid managed care regulations.[54]

Fund and support Accountable Communities for Health

In addition to building care coordination infrastructure to serve the individual, the PHM program requires a macro-level approach to population health interventions. Local Accountable Communities of Health (ACH) can serve that function: ACHs are community collaboratives that identify community needs and resources and develop and invest in community-based interventions and community care coordination systems to meet those needs. It is the goal of ACHs not to focus on a single intervention or program, but rather to ensure that all of the community's programs work together in harmony to achieve the greatest possible benefit.

- **Medi-Cal and its managed care plans should invest in the establishment of local ACHs** and partner with them in the shared implementation of population health interventions.

Conclusion

As stated in DHCS' Medi-Cal Children's Strategy, Medi-Cal is "an essential tool for pursuing DHCS' strong commitment to addressing entrenched health inequities and the resulting disparities that diminish children's health outcomes and life prospects." The upcoming implementation of Medi-Cal's PHM program coupled with DHCS' Medi-Cal Children's Strategy offer promise for actualizing meaningful and sustainable care coordination for all Medi-Cal children. There is an understandable wariness that this new PHM requirement will become another check-box exercise, a requirement in name only. Because the Enhanced Care Management (ECM) benefit is designed as a specified array of services, the benefit and its accountability will be more tangible. Basic care coordination is less defined and not yet measured and thus is not clear whether it exists. **Until an infrastructure of basic care coordination is deliberately built, funded and monitored, child health advocacy leans into qualifying as many children as possible into an ECM model to ensure that even basic care coordination is accessible for Medi-Cal children.**

With more than half of California's children enrolled in Medi-Cal, ensuring Medi-Cal is delivering the right care at the right time in the right setting is an overdue state commitment to invest in the well-being of our children's future.

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