

POLICIES FOR CARE COORDINATION ACROSS
SYSTEMS: LESSONS FROM ABCD III

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EXECUTIVE SUMMARY

Throughout the nation, health care systems and private and public health care payers are working to improve care coordination for people with multiple health needs. States are adopting new policies and leveraging existing policies to improve care coordination. In the Assuring Better Child Health and Development III (ABCD III) project, five states have developed pilot projects to improve care coordination for young children with or at risk for developmental delays; these efforts ensure that coordination occurs not only within the health care system but also between primary care providers (PCPs) and early intervention programs and other community service providers. In so doing they have leveraged policies that incentivize cross-system care coordination and established working protocols that are needed to embed care coordination within the systems involved. A particular focus has been ensuring not only that appropriate referrals are made to these community resources, but also that the referral sources communicate back to the PCP. Policies that have formed the basis of their work include policies to pay for care coordination, to systematize communication between the PCP and the referral agency, and to ensure sustained quality, including ongoing measurement and quality improvement efforts.

Payment policies in the ABCD III states include paying for multidisciplinary team conferences, tying per member per month payments to care coordination standards, and using Medicaid targeted case management dollars for a population (children with or at risk for developmental delay) that requires cross-system care coordination. States may also incentivize care coordination by structuring it in a manner that aligns with providers' "meaningful use" of electronic health records (EHR). These are standards providers must meet to qualify for substantial subsidies to help them implement EHRs.

To enhance and systematize communication between the PCP and other systems, the ABCD III pilots have adopted both paper and electronic referral and feedback systems and protocols. These are supported by interagency agreements that delineate responsibilities, provide for data sharing, and set out privacy protocols.

The ABCD III projects have implemented policies for new coordination systems using defined quality improvement and measurement methodologies, and they hope to incentivize and sustain quality in care coordination by aligning the projects with emerging medical home standards in their states. They have also leveraged federal Medicaid managed care requirements for performance improvement and medical board maintenance of certification requirements to drive improvements in cross-system care coordination. In their information technology systems, some ABCD III states have embedded the measurement of care coordination outcomes into their automated systems.

As states consider policies they can leverage to improve care coordination between PCPs and other systems, they can draw on the menu of policy levers that ABCD III states have used to build care coordination infrastructure across systems. The experience in ABCD III provides a menu of options for states and other payers of health care to consider as they seek to improve care coordination across systems.

INTRODUCTION AND BACKGROUND

Many people served by Medicaid require care coordination not only between their primary care provider (PCP) and other health care providers, but also between their PCP and educational, social, vocational, or other services. What policies can states leverage to improve care coordination between PCPs and these other systems? In the Assuring Better Child Health and Development III (ABCD III) project, five states (Arkansas, Illinois, Minnesota, Oklahoma, and Oregon), led by their Medicaid agencies, are participating in a three-year learning collaborative focusing on improving care coordination for young children at risk for developmental delays. They are leveraging existing federal and state policies and developing new policies to support care coordination between PCPs and service providers in other systems to ensure that children receive the coordinated care and services they need. This paper examines the care coordination experience of the ABCD III states. It identifies common themes and policy levers that could help improve care coordination between PCPs and other systems for people of any age. Although many of these policy levers are also useful in promoting more typical care coordination between a PCP and another health provider, this paper focuses on the policies as they relate to the cross-system care coordination being advanced in ABCD III. As state administrators consider how to promote coordination between PCPs and home health services, schools, mental health systems, or other institutional systems, they may find the policy levers developed within ABCD III useful and adaptable.

ABCD III

States participating in the ABCD III Learning Collaborative have focused on improving coordination between the PCPs of very young children (ages 0–3) with or at risk for developmental delay and other community resources, most notably the early intervention system. Now in its third year, ABCD III builds on two previous ABCD collaboratives and a screening academy that have engaged 25 states, the District of Columbia, and Puerto Rico in improving developmental screening and care for children from birth to age three. With funding and support from The Commonwealth Fund, the National Academy for State Health Policy (NASHP) is administering this third ABCD initiative that has focused on linkages and coordination between the PCP and others agencies that provide developmental services for young children and their families.¹

All states that have participated in an ABCD initiative have sought to improve screening, referral, and treatment for young children in order to identify and treat developmental delays early in life. State participants in ABCD I and II found that screening for developmental delays improved significantly as a result of their efforts, but coordinating referral and treatment was more challenging. In addition, some PCPs were hesitant to screen children because they did not know where to refer identified children for more in-depth assessment and treatment. For these reasons, states participating in ABCD III focused on developing the policies and practices necessary to create linkages between PCPs, early intervention providers, and community resources, such as early education and family support programs, in order to better coordinate care.²

THE PRIMARY CARE PROVIDER AND CROSS-SYSTEM CARE COORDINATION

Care coordination is becoming an important part of PCP practices. Across the country, state health agencies, private payers, quality improvement organizations, and others are collaborating with PCPs to transform those practices into patient-centered medical homes, characterized by patient engagement, evidence-based practice, measured outcomes, and both population-based and individualized care management. Care coordination was recently described in a publication by the Agency for Healthcare Research and Quality (AHRQ) as

a core activity of a medical home, where it was defined as the deliberate effort to organize patient care activities between two or more participants involved in the patient's care (including the patient) in order to facilitate the appropriate delivery of health care services.³ Care coordination can encompass a variety of activities. It includes facilitating communication within and across settings and between health professionals, patients, families, and community resources. It also involves creating a clear plan of care that identifies who is responsible for what aspect of the care.⁴

Caring for children requiring assessment and treatment for developmental delays often requires coordination with the early intervention system—a separate system administered by state agencies with federal funding according to a mix of federal and state policies.⁵ To qualify for early intervention services, children from birth to age three must meet state criteria for having developmental delays or for being at risk for developmental delays. The early intervention program provides an in-depth assessment of physical, social, emotional, cognitive, communication, and adaptive development. Early intervention staff then use the assessment to prepare an Individual Family Service Plan (IFSP) that sets out the specific services the child and family are eligible for and need.⁶ A broad array of health and social services are coordinated through the early intervention system. These include, for example, assistive technology, family counseling, and transportation assistance as well as more medically oriented therapies such as physical, occupational, or speech/language therapies that require coordination with the PCP. In addition, early intervention services include care coordination itself.⁷

In short, families with young children with or at risk for developmental delays have access to services through both their PCP and the early intervention system. These systems require coordination. This need has been recognized by the American Academy of Pediatrics, which has recommended that pediatric professionals screen for developmental delays, refer to early intervention services, collaborate with the family and care coordinator, and provide medical input into the IFSP.⁸

The coordination needed between the early intervention system and PCPs is not unlike the coordination needed for many other populations receiving services from other systems. For example, PCPs must coordinate with school systems, systems providing long-term services and supports, behavioral health systems, and vocational rehabilitation systems. Lessons from the ABCD III experience about improving care coordination between the PCP and other systems are useful and adaptable for other kinds of cross-system coordination.

BARRIERS TO CARE COORDINATION ADDRESSED IN ABCD III

Amy Fine and Rochelle Mayer identified specific barriers to coordination between pediatric providers and community resources for children at risk for or identified with developmental delays. The barriers included the PCPs' lack of familiarity and comfort with nonmedical services, cultural barriers across disciplines, lack of funding for the community-based services, lack of reimbursement for the coordination, and lack of feedback to the PCP from referral services after a referral was made.⁹

The ABCD III teams experienced and then addressed these barriers. For example, ABCD III states found that PCPs were often unfamiliar with or misinformed about early intervention programs, their eligibility criteria, and the resources available to children and families in the community. The relationships and systems necessary to communicate were not developed, and the resources needed to develop them in the PCP office were not in place.

In the ABCD III states, Medicaid, public health, and other state agencies teamed up with early intervention program staff, PCP offices, parents, universities, and community service providers to improve coordination

between the PCP and community resources, particularly early intervention services. Each state established community pilot sites where PCPs who screen children for developmental delays are systematically linked with early intervention providers and other community resources so they may easily refer children and learn the results of the referral. Their experience has helped to identify policies that state agencies can leverage to address the barriers listed above—policies that are useful for care coordination generally but that were leveraged by states agencies in ABCD III to promote the more difficult cross-system care coordination they sought to improve. These include:

- Policies to pay for care coordination,
- Policies to support systematic communication, and
- Policies to support sustained quality improvement and measurement.

The following sections review policies developed in ABCD III states in each of these three areas, focusing on those that systematically improve care coordination between primary care providers and other systems that serve young children, and noting opportunities to use these policies to address care coordination for other populations.

POLICIES TO PAY FOR CARE COORDINATION

One basic way to incentivize care coordination between the PCP and other providers and systems is to pay for it. Federal regulations require that the early intervention system provide each eligible child with a service coordinator to ensure that he or she receives needed services, including medical services.¹⁰ In Medicaid, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children requires that Medicaid agencies inform families of the services available for children and assist in arranging for treatment.¹¹ Within this context, states determine how to structure and pay for care coordination for children.

In Medicaid, state efforts to incentivize and pay for care coordination for both children and adults within PCP practices vary widely from state to state and have evolved over time. Options under the federal Medicaid program include fee-for-service payments to the PCP and other health care providers for multidisciplinary team meetings, fee-for-service case management for specific populations (known as targeted case management), administrative case management, or per member per month (PMPM) payments to PCP practices. States sometimes also pay a PMPM rate to entities such as community health teams or managed care organizations in exchange for the entity's agreement to provide a defined level of care coordination. In addition, state health programs can leverage other financial incentives for care coordination, including federal subsidies for adoption of electronic health records (EHR) that can enhance communication between the PCP practice and other providers. These levers are described below.

CPT CODES FOR MULTI-DISCIPLINARY CARE COORDINATION

For a health care provider to be paid for care coordination on a fee-for-service basis, there must be a CPT (Current Procedural Terminology) or similar code under which the provider can bill and be paid. There are codes that can be used to bill for some aspects of care coordination, but many state Medicaid programs do not pay for services billed under those codes. Such is the case with CPT codes 99366–99368 to improve multidisciplinary care coordination. Introduced in 2008, the codes define the service as participation in medical team conferences by three or more professionals from different disciplines who have cared for the patient in the previous 60 days. These codes can be used to bill for services provided by nonphysician health professionals as well as physicians.¹² With these codes, for example, a payer could reimburse a physician's assistant in the child's PCP practice, a physical therapist taking referrals from an early intervention provider, and a social worker for their participation in a team conference to discuss the elements of a multi-disciplinary plan of care for a child. Oregon's Medicaid agency includes CPT code 99366 on its Prioritized List of Health Services, the first step to allowing reimbursement for face-to-face multidisciplinary conferences by qualified non-physicians, and is considering adding CPT codes 99367 and 99368, which would open the door to billing for team conferences when the patient or family is not present. The next step will be to assign a value to the codes in the billing system. By opening these codes for payment, Oregon will incentivize more multidisciplinary care coordination.

PER MEMBER PER MONTH FEES

Many state Medicaid agencies have, since 1981, paid per member per month (PMPM) fees to PCP practices in addition to the fees the practices earn per service. Thirty states pay primary care providers an additional monthly fee (typically \$3) for primary care case management (PCCM).¹³ In a typical PCCM system, the PMPM payment is in exchange for the PCP's taking responsibility for referrals to other health specialists and meeting certain other standards set out in an agreement between the Medicaid agency

and the PCP. The performance expectations of providers under older PCCM systems, however, have often been minimal and varied widely. These providers' contracts could be strengthened to target better coordination with community resources.

MEDICAL HOMES

Recently, many Medicaid agencies and their PCP partners have taken primary care transformation a step further by developing medical home initiatives. These initiatives emphasize care coordination for their patients while offering care that is patient-centered, team-based, accessible, and continuous over time. Under a state medical home initiative, Medicaid, CHIP, or their managed care contractors offer enhanced reimbursement to primary care providers who meet specified medical home qualification standards. Many states have developed their own standards for what is expected of medical homes, but others have adopted or adapted those developed by a national organization, such as the National Committee for Quality Assurance (NCQA). Most Medicaid agencies involved with medical home initiatives are offering practices enhanced PMPM payments.¹⁴ Some states, such as Minnesota, stratify these payments, paying more on behalf of patients with more intense needs. Others, such as Vermont, offer higher PMPM payments to practices that meet more demanding medical home standards.¹⁵ These PMPM payments may be complemented by pay-for-performance bonuses, such as those under development in Minnesota. Medicaid agencies might also require the enhanced medical home payment, or a portion of it, to be dedicated to funding a care coordinator within the medical home. In some states, such as North Carolina, care coordinators and other practice support professionals are shared by multiple practices. In short, states have significant latitude in structuring these payment arrangements to incentivize the care coordination that the provider must deliver. The potential of medical home initiatives to leverage improved cross-system care coordination is discussed in greater detail later in this paper's discussion on quality.

Finally, states that develop health homes for Medicaid beneficiaries with chronic conditions under Section 2703 of the Affordable Care Act can obtain a 90 percent Federal Medical Assistance Percentage (FMAP) rate in Medicaid for eight quarters to pay for health home services, including comprehensive care management, care coordination, referral to community and social support services, and comprehensive transitional care.¹⁶ These additional matching dollars could assist with the establishment of new care coordination systems that systematically connect the PCP with other systems. Here, too, the Medicaid agency has significant discretion in establishing the care coordination standards for PCPs who will receive additional payment if they qualify as health homes.

Medicaid's influence in improving care coordination in a PCP practice is limited if Medicaid is the only payer seeking to influence the practice. Routine care coordination requires implementing systems in a practice that affect care for all complex patients regardless of payer. Legislatures in at least four states (Maryland, Minnesota, Rhode Island, and Vermont) have required private insurers to participate along with Medicaid in paying for care coordination and other primary care improvements associated with medical homes. In other states, private insurers have voluntarily participated in multi-payer primary care initiatives in an effort to improve these services for patients.

TARGETED CASE MANAGEMENT

Another route for paying for care coordination is Medicaid's targeted case management program. Federal Medicaid dollars are available to pay FMAP for certain targeted case management activities.¹⁷ Oklahoma, for example, provides targeted case management to reimburse for case management services provided to children from birth to age three who are eligible for early intervention services. Case management consists

of those services required to assist a client to gain access to needed medical, social, educational, and other services. It includes referral, coordination, arranging for service delivery, linkage, monitoring, follow-up, and documentation.¹⁸ Oregon's Medicaid program also reimburses for targeted case management for its Early Intervention/Early Childhood Special Education Program.¹⁹

MEANINGFUL USE OF ELECTRONIC HEALTH RECORDS

The advent of electronic health records provides state health agencies seeking to use information technology to improve care coordination between PCPs and other systems an avenue to leverage another important financial incentive. Throughout the country, state Medicaid programs are implementing the Electronic Health Records Incentive Program, which provides up to \$63,750 in federal dollars over six years to eligible health care professionals who serve a significant portion of Medicaid patients and demonstrate meaningful use of EHRs.²⁰ Meaningful use includes the capacity to use EHRs to provide patients with relevant educational and resource information and the capacity to exchange key clinical information with other providers electronically.²¹

As PCPs design and adopt EHRs in their practices, their ability to obtain substantial funding will depend in part on whether they are able to show that they can electronically and securely send key clinical information—including test results—to organizations (such as early intervention providers) authorized by the patient to receive it. Educational materials will also assist PCPs in meeting EHR meaningful use standards in addition to being helpful to patients.

In ABCD III, Illinois, Oklahoma, and Minnesota are using or developing electronic systems that allow PCPs to refer children for early intervention and then receive information back. State agencies in ABCD III are also making efforts to electronically place community resources within a click of a PCP's mouse. Physicians will be incentivized to use this technology for coordination with other systems if their design helps them meet meaningful use standards.

POLICIES SUPPORTING SYSTEMATIC COMMUNICATION

For communication to become routine, effective, and efficient, it has to happen as a matter of policy. Policies are typically established in a policy manual, a rule, or a law, but can also be embedded in communication infrastructure. For example, policies are embedded in forms that require the communication of specific information and in computer applications that direct the user to a particular course of conduct. A required, systematized method of creating a complete loop of communication between the PCP and another provider with whom frequent communication is required would be useful whether the other provider is another health care provider or part of another system like early intervention. The referral and feedback systems created within ABCD III provide valuable lessons regarding some of the areas—such as privacy issues and interagency responsibilities—that must be addressed when creating a systematic communication loop across systems.

REFERRAL AND FEEDBACK SYSTEMS

All five ABCD III state projects have required the use of a referral and feedback system between the PCP practices and early intervention providers in the pilot sites. ABCD III teams have developed both paper and electronic methods for PCPs in pilot sites to refer patients to early intervention providers and then to receive information back about the results of the referral. This process can inform interagency policies that establish and sustain communications between medical homes and other health, education, or social service providers. Imagine, for example, a PCP office having easy, secure capacity to refer to and, with appropriate patient consent, *hear back from* a substance abuse program, a school-based health program, a dementia care unit, or a vocational rehabilitation program.

The five ABCD III teams have each designed standardized paper “referral and faxback” forms, together with appropriate authorizations to release information, which are being tested in their states. (A sample paper referral and faxback form from Illinois is included in Appendix A.) In Oklahoma, where pilot practices were given a choice between a paper system and a web-based system, the web-based system has been chosen in all practices and shows particular promise.²² The web-based system includes a web portal in which physicians make referrals and early intervention providers communicate information back. To implement the system, the pilots had to implement a set of policies set out below.

- PCP practices in the pilots are expected to use the Preventive Service Reminder System (PSRS), an electronic system upon which the new web-based referral and feedback system was built. The PSRS is designed to help physicians track preventive services and remind them when services are due.
- PCP practices in the pilot must adopt either the paper or the web-based referral and feedback system for children from birth to age three identified with or at risk for developmental delays.
- The state Medicaid agency and the University of Oklahoma Health Sciences Center support the adoption of the system with practice facilitators and structured quality improvement cycles.
- Early intervention service providers and other community service providers identified within the pilot must respond to a referral within 24 to 48 hours, notifying the PCP of the status.
- When the IFSP is complete, the early intervention provider sends an IFSP Summary Report Form to the PCP. In the web portal, the document can be attached to the transmission.

- The PCP is expected to review the status of the referral when notified. An application in the web portal keeps track of these reviews. In addition, the web portal allows for two-way secure communication between early intervention staff and the PCP.
- Community service providers with access to the web portal (specifically, staff that provide peer support through the Oklahoma Family Network) must undergo the same Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) privacy training as do state employees who work with the system.
- PCPs and early intervention providers must check the appropriate box in the web portal affirming that appropriate parental HIPAA and FERPA consent forms are signed.
- The use of the system and the outcomes for children will be measured and the results used in structured quality improvement cycles.

The summary IFSP form is an important innovation in ABCD III. Project leaders found that when early intervention providers sent the full multi-page IFSP to PCPs, the PCPs did not have time to review the entire document and plan of care; PCPs needed a summary. For this purpose, Illinois's early intervention providers in the pilots communicate back to the PCP twice: first, very shortly after the referral regarding early intervention eligibility, and then again with a summary after they are able to inform the PCP of the services the child will receive (See Appendix).

Illinois is also building an electronic system to be piloted. They are considering a policy requiring that early intervention staff send the results of early intervention referrals to the child's PCP, *even if the referral did not originate with the PCP*.²³ They are presently determining how to most appropriately meet federal Department of Education parental consent requirements as they consider this policy.

Illinois's pilot PCP practices also adopted a policy of telephoning parents within 36 working hours after a referral to find out if the parent intends to follow through. Although the outcome of this practice has not yet been measured, the practices report that it is an effective window of time to make contact because the parent is often in the process of making the decision.

INTERAGENCY AGREEMENTS

Creating the communication loop between PCP offices and early intervention programs requires agreements between the agency overseeing Medicaid and the agency overseeing early intervention services. In some states, early intervention services are administered by a different agency (often the Department of Education) from the agency that administers Medicaid (typically a Department of Health or of Human Services). Congress anticipated multiagency collaboration when it created the Early Intervention Program, requiring each state to create an interagency coordinating council that includes the agency that administers Medicaid.²⁴ If strong and active, this council may prove to be an important source of interagency policy coordination and agreement in a state.

Interagency agreements, and the cross-agency discussions that must take place to reach agreement, are important to helping each agency understand the other's working environment and operations. This helps to overcome barriers and take advantage of opportunities for regular communication and cooperation. The agreements are essential for establishing the responsibility of each agency, creating expectations and protocols for interagency and inter-provider communication and data sharing, and ensuring compliance with all relevant privacy laws.

Responsibilities of Agency and Provider Staff

A clear interagency agreement about whose staff are responsible for communicating what information in what amount of time will help cross-system care coordination proceed smoothly. In Minnesota, ABCD III staff have created standardized forms and protocols for use between PCPs and early intervention staff receiving referrals. As the Department of Education undertakes a restructuring of its early intervention system to place greater responsibility within school districts, the Minnesota Medicaid agency is also working to develop new protocols that set out what PCPs and school districts can expect from each other in terms of early intervention referral and follow-up communication.²⁵ Medicaid agency staff are also meeting with Minnesota Department of Education staff to discuss ways in which the statewide “Help Me Grow” website that supports referrals to early intervention can be modified to improve communication back to the source of the referral.

Data-Sharing Agreements

Agencies must have written agreements in place in order to share the confidential information needed for care coordination. The Illinois ABCD III team found that their Departments of Human Services, Public Health, and Healthcare and Family Services already had a data-sharing agreement in place that permitted the electronic exchange of information among these agencies for a defined list of data sources specified in the agreement. They are presently working on an electronic interchange for transferring information about children from PCPs to early intervention offices and back again. The issues they are addressing as they attempt to craft the agreement include necessary HIPAA, early intervention, and FERPA parental consent compliance and the appropriate uses of both individual data and data in the aggregate.²⁶

In a managed care context, Oregon has a data-sharing agreement that allows appropriate use of both individual and aggregated data by the Medicaid agency. The early intervention program has agreed to make aggregated reports periodically available to the Division of Medical Assistance Programs (DMAP) to help assess whether Oregon is reaching its goals for closing the communication loop between the PCP and early intervention providers. The reports also help identify where the communication loop breaks down so that systems can be improved. In addition, DMAP is able to identify within its Medicaid claims data those children who are receiving early intervention services. Under service agreements with their managed care plans, DMAP can share the names of these children with the managed care plans responsible for their care, allowing the plan to follow up with the patient’s family and primary care physician and encourage coordinated care.

Privacy Policy Across Agencies: Making Compliance with Multiple Privacy Laws Simple for Providers and Patients

Interagency agreements should include protocols for complying with laws that protect privacy. Physicians who follow up on the results of a referral to a community agency are often stymied when the community agency is unable to provide any information because there is no signed release from the parent in place. Care coordination across systems requires a routine method of obtaining the parent’s or patient’s permission to transfer information in accordance with relevant privacy laws. The earlier in the agency process the release is obtained the better. ABCD III states have discovered that if the early intervention agency waits until the time they are setting up a plan of care to obtain a release from a parent allowing disclosure of information to the PCP, the process will miss situations where the child is found ineligible for services. Yet this is information that the PCP needs to know in order to connect the family with other appropriate services. The release must be obtained when the family comes in the early intervention door so that information about eligibility can be communicated back to the PCP.

Compliance with privacy laws can be complicated across systems, but must be made easy and seamless for providers and patients. In ABCD III, communication back and forth between the PCP and the early intervention provider must comply with privacy laws that pertain to health, education, and early intervention. HIPAA protects individual health information, FERPA protects individual educational information, and Part C of the Individuals with Disabilities Education Act (IDEA) is specific to early intervention.²⁷ ABCD III states have required assistance from legal counsel to ensure that their specific systems comply, but their goal has been to make this communication simple and routine for providers. The basic principle behind all the laws is the same: whether information is transferred via a web portal, a fax, or a telephone, the individual or his or her parent or guardian must consent in writing to the disclosure.

Early Intervention Colorado, an alumna of the ABCD program, has developed a single, relatively simple Referral and Release form for referrals to early intervention.²⁸ The form provides two places for the parent or guardian to consent: one for consent to transfer information from the referring source (such as a PCP office) together with any appropriate test results and another for consent to transfer the results of the early intervention eligibility determination and the type and frequency of early intervention services, back to the referring source. As a result, when a physician or other provider makes the referral to early intervention using this form, the consent for two-way communication has been completed.

POLICIES SUPPORTING AND SUSTAINING QUALITY AND MEASUREMENT OF
CROSS-SYSTEM COORDINATION

ABCD III states have been pursuing improved quality of care coordination across systems by implementing their pilot projects using structured, measured quality improvement projects, and by seeking to sustain quality by aligning their care coordination policies with medical home standards developing within their states.

POLICIES TO INCENTIVIZE QUALITY IMPROVEMENT PROTOCOLS AND MEASUREMENT

Structured quality improvement programs can provide the parties implementing a new system for coordinating care across systems a clear roadmap for planning, testing, and implementing the change in the context of their daily workflow.

By requiring the use of structured quality improvement processes to test cross-system communication protocols, the stakeholders involved can better define their objectives, test the protocols they are implementing, adjust based on what worked and what did not, and then implement the change more broadly.

In ABCD III, four states piloted the effort to improve care coordination for children with or at risk for developmental delays by facilitating a process based upon the Plan-Do-Study-Act (PDSA) method for quality improvement. This effort involved bringing together pilot community teams that included PCP practices, early intervention providers, parent representatives, and others engaged in early childhood development. Under this model, the teams defined their objectives and expected outcomes and planned how to implement the change and measure the result. They then carried out their plan, including paper and/or electronic referral and feedback systems. Most are in the process of collecting the data and studying the results; they are also planning to spread statewide the practices that, in fact, work.²⁹

In Illinois, for example, the PCPs and the early intervention providers each used the PDSA process to measure their own care coordination performance and to improve it: the PCPs used the approach to improve their referral rates and the early intervention providers used it to standardize the use of the faxback form to improve feedback to PCPs. Thus, the project assessed the performance of each provider only on practice improvements that were within his or her control, with each provider's quality improvement project contributing to the whole.

Leveraging Medicaid Managed Care Policies for Quality Improvement

Federal Medicaid regulations and the state managed care contracts that implement them provide significant leverage to require that managed care organizations (MCOs) implement structured quality improvement initiatives to improve care coordination between PCPs and other systems. The regulations require that MCOs contracting with states have an ongoing quality assessment and performance improvement program. Performance improvement projects must include objective quality indicators, system interventions to improve quality, evaluation of the effectiveness of the intervention, and planning and initiation of activities for increasing or sustaining improvement; these criteria fit the PDSA model as well as other models for quality improvement.³⁰ The validity and effectiveness of each performance improvement project must be assessed by an independent external quality review organization (EQRO) or "EQRO-like" organization, which may also be used to provide technical assistance to MCOs in their implementation.³¹ The performance improvement project activities performed by the EQRO are eligible for an enhanced 75 percent federal Medicaid administrative match.³²

Oregon took advantage of this federal managed care quality improvement requirement to incentivize MCOs to improve care coordination for children with or at risk for developmental delays. They included in their contract with each of 15 MCOs a provision requiring that the MCO engage in at least two performance improvement projects, one of which must be either ABCD III or another mental or physical health collaborative project. Eight of the fifteen MCOs chose to conduct ABCD III performance improvement projects; they are now engaging parents, providers, and early intervention agencies at the community level to implement quality improvement projects to improve care coordination for children with or at risk for developmental delays.

Leveraging Maintenance of Certification Part 4 Requirements for Physician Practices

Standards for physicians to maintain certification as pediatricians, family practitioners, or other specialists can motivate their participation in quality improvement programs to improve care coordination. To maintain certification by the American Board of Pediatrics, the American Board of Family Practitioners, or other specialty medical boards, physicians must fulfill four components of a Maintenance of Certification (MOC) process.³³ Component (Part) 4 for each of the boards is to participate in practice improvement. The American Board of Pediatrics, for example, stipulates that only board-approved quality improvement projects qualify for MOC Part 4 credit.

In Illinois, qualifying PCP participation in the ABCD III pilot for MOC Part 4 credit has proved to be an important motivator. The American Board of Pediatrics approved Illinois pediatricians' participation, and Illinois is considering seeking similar credit toward Maintenance of Certification for the American Board of Family Medicine. This credit turned out to be a far more motivating factor for physician practices than the ABCD III teams first imagined.

AUTOMATED MEASUREMENT OF CARE COORDINATION BETWEEN PCPs AND OTHER SYSTEMS

The ABCD III state teams designed their pilots at the outset to include measurement of whether the PCP made a referral and whether the PCP found out about the results of the referral. As these were pilot projects, significant manual chart review was necessary in the beginning to establish baseline and outcome data. Nevertheless, states have used electronic systems where possible to support outcome measurement. For example,

- Arkansas's Medicaid program added a referral modifier code to allow providers who screen children under the EPSDT program to indicate whether children screened were referred for additional services.
- In Oklahoma, the electronic referral and feedback system was set up to register when the PCP office clicks to find out the results of the referral, so that project staff can easily count the number of cases for which the PCP actually found out the results.
- In Illinois, data on feedback to the PCP from the early intervention system will be transferred from early intervention to an electronic data warehouse accessible to the Medicaid system for quality analysis.
- In Oregon, Early Intervention and Medicaid are working together to identify children in the Medicaid claims system who are served by Early Intervention. Identifying these children will assist in evaluation as well as give managed care plans the information needed to coordinate care.

These and other design features in data systems make measurement of outcomes easier.

ALIGNING WITH MEDICAL HOME POLICIES

Medicaid agencies in most states, including those in all five ABCD III states, are establishing medical home policies and working with their PCPs to transition toward meeting specified medical homes standards.³⁴ State agencies that seek to encourage or require coordination between the medical home and another system can either adjust their medical home standards to clearly address this goal or ensure that the methods for coordination they are establishing will help physicians meet medical home criteria already in place.

States have great flexibility in establishing medical home care coordination standards. States can use or adapt medical home standards developed by NCQA or the Joint Commission, or they can establish their own standards. The NCQA and Joint Commission standards on care coordination tend to address more typical care coordination between health providers, but they can also incentivize and sustain care coordination across systems. The 2011 NCQA patient-centered medical home (PCMH) standards address both referral to community resources (PCMH Standard 4) and tracking and coordinating care (PCMH Standard 5).³⁵ In a state that requires PCP practices to meet care coordination standards in order to be recognized as medical homes, PCPs will have greater incentive to adopt a particular protocol to coordinate with other systems if doing so helps them be recognized as medical homes.

Examples: Minnesota and Oregon

In Minnesota, the ABCD III team has aligned its work with state medical home standards that require significant care coordination. Minnesota's health reform legislation required the establishment of health care homes, defined as medical homes targeting service to people with chronic or complex conditions.³⁶ Under the program, health care homes are paid PMPM payments using a tiered scale based on the number of major conditions the patient has. Rules from Minnesota's Medicaid agency require that the care team identify and work with needed community-based resources, and, after the first year, that the care plan incorporate relevant parts of care plans from external providers, resulting in a comprehensive care plan.³⁷

The Minnesota ABCD III team built upon the health care home standards when they established protocols for PCPs to communicate with the early intervention system and other community providers. The team developed an electronic system for tracking referrals and defined the role of care coordinators to align with health care home standards. These efforts created a significant incentive for practices seeking to qualify for additional payment as health care homes to adopt the use of the ABCD III electronic system and the coordination protocols that go with it. Most practices perceived their participation in ABCD III as a step toward health care home certification.³⁸ One practice has already adapted the electronic referral and tracking system for use with patients being treated for depression in the mental health system.

The Oregon Health Authority has also built cross-system care coordination standards into their primary care home standards. There, the standards adopted in the state's ABCD III project were used to influence the state's primary care home standards as they were developed. Practices that adopt the screening and care coordination protocols of ABCD III will obtain points toward achieving medical home certification. The standards require care coordination with community resources including tracking referrals and tracking whether the referral results have been communicated back to the medical home clinician.³⁹

Professionals involved with the Oregon effort recommend establishing some pediatric standards separately from adult standards.⁴⁰ They note that under current medical home standards practices often target care coordination by defining populations based on diagnosis or medical condition. This definition tends to leave out children with developmental or other multiple needs who require significant coordination with other providers. Separate pediatric standards may also be indicated because onsite and local refer-

ral resources that should be available to families may be unique for children. Further, subpopulations of children with special health care needs often require a different set of relationships with community and school-based providers than is typical for adults. To ensure that pediatric care coordination needs are met, separate pediatric standards for medical homes that serve a significant pediatric population could help improve care coordination for children.

Whether for children or adults, aligning PCP cross-system care coordination protocols with medical home standards will take advantage of the regular quality reviews that are necessary to maintain medical home status.

SUMMARY OF POLICY OPTIONS

As states consider policies they can leverage to improve care coordination between PCPs and other systems, they can draw on the menu of policy levers that ABCD III states have used to build care coordination infrastructure across systems.

POLICIES TO PAY FOR CARE COORDINATION

- Pay for CPT codes for multidisciplinary team conferences (99366-99368).
- Structure per member per month fees such as PCCM, PCMH, and health home payments under section 2703 of the Affordable Care Act to incentivize care coordination between PCPs and other systems.
- Target Medicaid targeted case management payments where coordination between PCPs and other systems is needed.
- Align electronic systems designed to communicate to and from the PCP and other systems with EHR meaningful use criteria.

POLICIES FOR SYSTEMATIC COMMUNICATION

- Use referral and feedback forms, electronic communications, and clear protocols.
- Negotiate interagency agreements with agency and provider responsibilities delineated and with data-sharing and privacy protocols.

POLICIES FOR QUALITY IMPROVEMENT AND MEASUREMENT

- Use structured quality improvement protocols, such as Plan-Do-Study-Act.
- Leverage Medicaid managed care requirements for performance improvement projects.
- Leverage physician Maintenance of Certification Part 4 requirements to incentivize participation in performance improvement efforts.
- Automate, wherever possible, measurement of outcomes.
- Align protocols for cross-system care coordination with medical home recognition criteria.

These policies can support cross-system care coordination for a variety of populations, in addition to the very young children targeted by ABCD III. For example, those serving geriatric populations may be able to improve care coordination between home health service providers and the PCP. Similarly, those serving people with severe and persistent mental illness may find systematic coordination is needed between the PCP and mental health systems or supported housing arrangements. Policies developed in ABCD III could also easily be adapted to improving care coordination between the PCP and school systems for children with special needs.

In identifying where to begin a quality improvement project to improve cross-system coordination, factors to consider could include:

- For which populations is there the greatest need for the PCP to be able to coordinate with other systems?

- Who would be the partners in the project and what could they devote to the effort? Will they be your needed champions of the quality improvement process?
- What infrastructure and systems are already in place that could be built upon? (Could a computer application be tweaked?)
- What else is happening with medical homes, accountable care organizations, managed care, or care coordination in the state that could be leveraged to add in a component incentivizing coordination between PCPs and other systems? (Could you add a paragraph to a managed care contract?)
- What resources are available and how would such efforts be sustained? (Could you build on an existing health home initiative?)
- If you develop protocols for PCP coordination with other systems that are targeted for a particular population or need, will the infrastructure you build carry over to other populations?

Considering these and other factors in designing quality improvement programs to improve care coordination systems at the outset will enable states agencies and the teams with whom they work to develop projects that achieve significant gains in coordinating care and services for the people they serve.

CONCLUSION

ABCD III is but one example of collaboration among state agencies and providers to improve care coordination between PCPs and other systems. The strategies and examples developed within ABCD III offer lessons adaptable to other populations as well, including school children, geriatric populations, people with physical disabilities, or those requiring mental health or substance abuse treatment. There are many challenges to coordinating care among health care providers and greater challenges to improving care coordination between a PCP practice and another system. Yet these efforts offer the opportunity to serve people with multiple health and social needs in a more integrated manner that will be less susceptible to duplication and error. The policies developed and leveraged by the ABCD III states offer state health agencies, PCPs, community service providers, and other stakeholders a place to start as they map coordinated care protocols between PCPs and other systems.

APPENDIX

APPENDIX: ILLINOIS REFERRAL FORM AND REFERRAL FAX BACK FORM

The next few pages contain the most recent version (dated 10/04/2011) of the forms developed by the Illinois ABCD III team. These forms are the Standardized Illinois Early Intervention Referral Form and the Illinois Early Intervention Program Referral Fax Back Form.

Standardized Illinois Early Intervention Referral Form

Please complete Sections 1 through 6 of this form to refer a child to Early Intervention (EI) for eligibility determination.

Section 1. Child Contact Information
Child Name: _____ AKA _____ Date of Birth: ____/____/____ Child Age: ____ Gender: M F Race: _____ Street Address: _____ City: _____ State: _____ Zip: _____ County: _____ Type of Insurance Coverage: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance Parent/Guardian Name: _____ Relationship to Child: _____ Primary Language: _____ Home Phone: ____/____-____ Other Phone: ____/____-____ Alternate or Emergency Contact Person: _____ Phone: ____/____-____
Section 2. Reason(s) for Referral
Reason(s) for referral to EI (Please check all that apply): Identified condition or medical diagnosis (e.g., spina bifida, Down syndrome): _____ Suspected developmental delay based on objective developmental screening using (please note screening tool used) _____ (Please check area[s] of concern): ___ Motor/Physical ___ Cognitive ___ Social/Emotional ___ Speech ___ Language/Communication ___ Behavior ___ Vision/Hearing ___ Adaptive/Self-help Skills ___ Other, specify _____ Comments: _____ At Risk (Please describe risk factors): _____ Other (Please describe): _____ <input type="checkbox"/> Family is aware of reason for referral
Section 3. Referral Source Contact Information
<input type="checkbox"/> Check here if Primary Care Provider (PCP) is source of referral and skip Section 3 and complete Section 4 Referral Date: ____/____/____ Name of Agency Making Referral: _____ Address: _____

Standardized Illinois Early Intervention Referral Form

City: _____ State: _____ Zip Code: _____ Office Phone: ____/____-____ Office Fax: ____/____-____ E-mail: _____ _____ Contact Person at Referral Site: _____ _____

Section 4. Primary Care Provider Contact Information

Referral Date: ____/____/____ Name of Child's Primary Care Provider: _____ Street Address: _____ City: _____ State: _____ Zip Code: _____ Office Phone: ____/____-____ Office Fax: ____/____-____ E-mail: _____ Contact Person at Primary Care Provider Office: _____ CFC Office, please send the following checked items: <input type="checkbox"/> Date the family was contacted and outcome of the contact <input type="checkbox"/> Eligibility for services and a list of services the child is eligible for <input type="checkbox"/> A summary of the Individualized Service Plan (IFSP) <input type="checkbox"/> Other referrals provided by EI to the child/family
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Section 5. Early Intervention CFC Office Referral Location

Using the attached list of CFC Offices, insert the CFC number where the child is being referred:
 CFC #: _____

Section 6. Authorization to Release Information

1. Referral to Early Intervention. The purpose of this disclosure is to refer _____ (print child's name) to the Illinois Early Intervention program. I, _____ (print name of parent or guardian), give my permission for my child's primary health care provider, _____ (print provider's name), to share pertinent information about my child, _____ (print child's name), regarding suspected developmental delay or related medical conditions with the Early Intervention program. I understand that I may withdraw this consent by written request to my child's primary health care provider, except to the extent it has already been acted upon.

2. Release Early Intervention Eligibility Determination Information to Referral Source. The purpose of this disclosure is to provide Early Intervention eligibility determination information, i.e., whether my child is eligible to receive Early Intervention services and what services they are, and other referrals provided by Early Intervention for _____ (print child's name) to:

- my child's primary health care provider listed in Section 4 (parent/guardian initial:____)
- the referral agency listed in Section 3 (parent/guardian initial:____).

I give my permission for the Early Intervention program to share reports and results related to the previously referenced information with my child's primary health care provider listed above. (parent/guardian initial:____). I understand that I may withdraw this consent by written request to Early Intervention, except to the extent it already has been acted upon.

I certify that this Authorization to Release Information has been given freely and voluntarily. Information collected hereunder may

Standardized Illinois Early Intervention Referral Form

not be re-disclosed unless the person who consented to this disclosure specifically consents to such re-disclosure and or the re-disclosure is allowed by law. I understand I have a right to inspect and copy the information to be disclosed.

Parent/Legal Guardian Signature* _____ Date: ____/____/____

*Consent is effective for a period of 12 months from the date of your signature on this release.

Section 7. For CFC Office Use Only

Date Referral Received: ____/____/____ Name of person receiving referral: _____

**Illinois Early Intervention Program
Referral Fax Back Form**

PART 1 of 2

Complete Part I upon contacting the family, or when a family cannot be contacted in a timely manner. Send Part I completed to the primary care provider listed in the Standardized Illinois Early Intervention Referral Form to inform them about the referral outcome.

Date: ____/____/____

Child's Name: _____ **DOB:** ____/____/____

Parent/Guardian Name: _____

Date Referral Received: ____/____/____

This child was referred to our Child and Family Connections office. The following is the status of that referral:

The family was contacted on (date): ____/____/____

A Service Coordinator has been assigned to the family:

Name: _____

CFC # / Location: ____ / _____

Phone Number: ____ - ____ - _____ Fax Number: ____ - ____ - _____

E-Mail: _____

Repeated attempts have been made to contact this family - we were unable to establish contact.

Date final contact attempt made: ____/____/____

Please let us know if the family is still interested in having an evaluation for their child.

The family has been contacted and requests that you contact them directly for results.

Date request made by family: ____/____/____

The family has declined services at this time.

Date service declined: ____/____/____

Additional comments:

PART 2 of 2

To be completed after eligibility is determined and the Individualized Family Service Plan (IFSP) is completed to inform the primary care provider about Early Intervention eligibility, other referrals provided, and Early Intervention services recommended, if eligible.

NOTE: Information can be released to the provider identified in Section 6, Authorization to Release Information, in the Standardized Illinois Early Intervention Referral Form. The parent(s) or legal guardian must sign a separate consent form in order to send the information shown below to an entity other than the referral source listed in Section 6 of the Standardized Illinois Early Intervention Referral Form.

Date: ____/____/____

Child's Name: _____ DOB: ____/____/____

Parent/Guardian Name: _____

1. The family has been contacted and the following has occurred:
 - The child has been evaluated and found to be **not eligible** for services at this time (Skip to #4).
 - The child has been evaluated and found to be **eligible** for services based on the following:
 - 30% or greater developmental delay
 - Qualifying Diagnosis of: _____
 - Other: _____

2. The child and family have been recommended to receive the following Early Intervention services:
 - Developmental Therapy
 - Occupational Therapy
 - Physical Therapy
 - Speech Therapy
 - Social Work/Counseling
 - Other: _____
 - Notes: _____

3. An IFSP was/will be developed for the child and family. The IFSP Summary Report will be released to the provider identified in Section 6, Authorization to Release Information, in the Standardized Illinois Early Intervention Referral Form (a full copy of the plan may be obtained through the contact listed in Part I).

4. The child and family received referrals to the following non-EI services: _____

5. The evaluation/assessment and service planning process have not been completed because: _____

Additional comments:

ENDNOTES

1 For more information about ABCD please visit: <http://nashp.org/abcd-history>.

2 Coordinating necessary health care and social service providers as they assist a patient is often referred to as case management or care coordination. In ABCD, the process has been referred to as creating better linkages among providers. See, for example, Kay Johnson and Jill Rosenthal, *Improving Care Coordination, Case Management, and Linkages to Service for Young Children: Opportunities for States* (Portland, ME: National Academy for State Health Policy, 2009). Here it is referred to as care coordination, the term most commonly used in the growing medical home movement.

3 David Meyers, et al., *The Roles of Patient-Centered Medical Homes and Accountable Care Organizations in Coordinating Patient Care*, AHRQ Publication No. 11-M005-EF (Rockville, MD: Agency for Healthcare Research and Quality, 2010) (Quoting Kathryn M. McDonald, et al., "Volume 7-Care Coordination," in K.G. Shojania, et al., editors, *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies*. Technical Review 9, AHRQ Publication No 04(07)-0051-7 (Rockville, MD: Agency for Healthcare Research and Quality, 2007).

4 David Meyers, et al., *The Roles of Patient-Centered Medical Homes*.

5 Early intervention services are authorized under the *Individuals with Disabilities Education Act*, Part C, § 631, as amended; 20 U.S.C. § 1431 et seq. Funding is administered by the United State Department of Education. See <http://www2.ed.gov/programs/osepeip/index.html>. Services are administered by a state agency, usually a state Department of Education or Health or Human Services. The state agency typically contracts with nonprofit providers to assess the child, develop a service plan, and coordinate care.

6 Learning Disabilities Association, Guidelines for the Individualized Family Service Plan (IFSP) Under Part C of the IDEA, <http://www.ldanatl.org/aboutld/professionals/guidelines.asp>.

7 See, for example, Vermont Department of Children and Families, IDEA Part C – Early Intervention Services for Infants and Toddlers, http://dcf.vermont.gov/cdd/cis/IDEA_Part_C_early_intervention.

8 American Academy of Pediatrics, "Role of the Medical Home in Family-Centered Early Intervention Services," *Pediatrics* 120, no. 5 (Nov. 2007): 1156.

9 Amy Fine and Rochelle Mayer, *Beyond Referral: Pediatric Care Linkages to Improve Developmental Health* (New York, NY: The Commonwealth Fund, 2006). <http://www.commonwealthfund.org/Publications/Fund-Reports/2006/Dec/Beyond-Referral--Pediatric-Care-Linkages-to-Improve-Developmental-Health.aspx>.

10 The United States Department of Education recently revised the rule requiring service coordination in the early intervention system. 76 Fed. Reg. 60140, 60248 (Final rule)(September 28, 2011), to be codified at 34 CFR § 303.34.

11 42 CFR §§ 441.56, 441.62.

12 American Medical Association, "Coding Communication: Case Management Services," *CPT Assistant* 18, no. 9 (Sept. 2008): 3-4. Retrieved November 16, 2011 from <https://catalog.ama-assn.org/MEDIA/Product-Catalog/m1710012/CPTAssistantSeptember2008.pdf>.

13 Kaiser State Health Facts, *Enrollment by Medicaid Managed Care Plan Type as of June 30, 2009*, Retrieved September 1, 2011 from <http://www.statehealthfacts.org/comparable.jsp?ind=218&cat=4>.

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- 14 Mary Takach, "Reinventing Medicaid: State Innovations To Qualify And Pay For Patient-Centered Medical Homes Show Promising Results," *Health Affairs* 30, no. 7 (2011): 1325-1334. doi: 10.1377/hlthaff.2011.0170.
- 15 National Academy for State Health Policy, *Aligning Reimbursement and Purchasing*, retrieved September 1, 2011 from <http://nashp.org/med-home-strategies/reimbursement-purchasing>.
- 16 Center for Medicare and Medicaid Services, State Medicaid Director Letter No. 10-024, November 16, 2010, <http://www.cms.gov/smdl/downloads/SMD10024.pdf>.
- 17 Thus, targeted case management services do not have to be provided comparably to all persons regardless of condition and do not have to be provided throughout the state. For the federal regulation on targeted case management, see 42 C.F.R. § 440.169(b), <http://www.law.cornell.edu/cfr/text/42/440/169>.
- 18 Oklahoma Administrative Code, § 317.30-5-621 (2)(A)(ii), <https://www.sos.ok.gov/oar/online/viewCode.aspx>.
- 19 Oregon Health Authority, Division of Medical Assistance Programs, *Targeted Case Management Services Program Rulebook* § 410-138-0020(5)(c), <http://www.dhs.state.or.us/policy/healthplan/guides/tcmngmt/main.html>.
- 20 Centers for Medicare and Medicaid Services, EHR Incentive Programs, http://www.cms.gov/EHRIncentivePrograms/01_Overview.asp#TOP. The Medicaid EHR Incentive program is administered voluntarily by states that are launching their programs at various times. The status of state programs and links to their web pages are posted at the link to "Medicaid State Information," http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp#TopOfPage.
- 21 Centers for Medicare and Medicaid Services, *Eligible Professional Meaningful Use Core Measures, Measure 14 of 15*, (Stage 1, last updated June 8, 2011) http://www.cms.gov/EHRIncentivePrograms/Downloads/14_Electronic_Exchange_of_Clinical_Information.pdf and *Eligible Professional Meaningful Use Menu Set Measures, Measure 6 of 10*, (Stage 1, issued: November 7, 2010) http://www.cms.gov/EHRIncentivePrograms/Downloads/6_Patient-Specific_Education_Resources.pdf.
- 22 For a thorough description of Oklahoma's web-based referral and feedback system, read Larry Hinkle and Carrie Hanlon, *Oklahoma's Web Portal: Fostering Care Coordination Between Primary Care and Community Service Providers* (Portland, ME: National Academy for State Health Policy, 2012), <http://www.nashp.org/publication/oklahomas-web-portal-fostering-care-coordination-between-primary-care-and-community>.
- 23 Larry Hinkle and Jill Rosenthal, *Building Electronic Information-Sharing Systems to Support Care Coordination in Illinois* (Portland, ME: National Academy for State Health Policy, 2011), <http://www.nashp.org/publication/building-electronic-information-sharing-systems-support-care-coordination-illinois>.
- 24 The requirements for the coordinating council are set out at 20 U.S.C. § 1441.
- 25 Minnesota's Communities Collaborating for Healthy Development ABCD III Project Report (7/1/11-9/30/11 and Annual Report combined).
- 26 More detail about the data transfer protocol is available in Hinkle and Rosenthal, *Care Coordination in Illinois*.
- 27 Regulations regarding privacy under both FERPA and Part C of the IDEA were recently promulgated. 76 Fed. Reg. 75604 (December 2, 2011)(FERPA) and 76 Fed. Reg. 60140 (September 28, 2011)(Early Intervention program).
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28 The Referral and Release Form used by Early Intervention Colorado is presently undergoing updating in relation to recent early intervention privacy rules. The form and other useful forms are available at this website: <http://www.eicolorado.org/index.cfm?fuseaction=Documents.content&linkid=291>.

29 For more information on PDSA cycles, see the Institute for Healthcare Improvement, How to Improve, <http://www.ihl.org/knowledge/Pages/HowtoImprove/default.aspx>.

30 42 C.F.R. § 438.240, <http://www.law.cornell.edu/cfr/text/42/438/240>.

31 42 C.F.R. § 438.358, <http://www.law.cornell.edu/cfr/text/42/438/358>.

32 42 CFR § 433.15(b)(10), <http://www.law.cornell.edu/cfr/text/42/433/15>

33 See American Board of Pediatrics, “Maintenance of Certification (MOC) Four-Part Structure,” <https://www.abp.org/ABPWebStatic/?anticache=0.9367928353267143#murl%3D%2FABPWebStatic%2Fmoc.html%26surl%3D%2Fabpwebsite%2Fmoc%2Faboutmoc%2Fmaintenanceofcertification%28moc%29fourpartstructure.htm>; American Board of Family Medicine, “ABFM Maintenance of Certification for Family Physicians,” <https://www.theabfm.org/moc/index.aspx>; American Board of Medical Specialties, “MOC Competencies and Criteria,” http://www.abms.org/maintenance_of_certification/MOC_competencies.aspx.

34 For a state-by-state review of medical home initiatives, see National Academy for State Health Policy, Medical Home States, <http://nashp.org/med-home-map>. For a discussion of care coordination efforts among eight states that are building medical homes, see Neva Kaye, Jason Buxbaum, and Mary Takach, *Building Medical Homes: Lessons from Eight States with Emerging Programs* (Portland, ME: National Academy for State Health Policy and The Commonwealth Fund, 2011), 15.

35 National Committee for Quality Assurance, *Standards and Guidelines for NCQA’s Patient-Centered Medical Home (PCMH) 2011*. Standards may be downloaded from <http://www.ncqa.org/tabid/629/Default.aspx>.

36 Minnesota Session Law 2008, Chapter 358-S.F. No 3780.

37 Minnesota Administrative Rules, Chapter 4764, Subparts 6 and 7, <http://www.health.state.mn.us/healthreform/homes/standards/adoptedrule.html>.

38 Susan Castellano, “Communities Coordinating for Healthy Development: Minnesota’s ABCD III Initiative,” Presentation at the National Academy for State Health Policy Annual Conference, October 5, 2011.

39 Office for Oregon Health Policy and Research, *Oregon Patient-Centered Primary Care Home Model, Implementation Reference Guide*, Standard 5.E, October 2011 (Draft, subject to Oregon Administrative Rule process). The link to the guide is available here: <http://health.oregon.gov/OHA/OHPR/HEALTHREFORM/PCPCH/index.shtml>.

40 Email comments from R.J. Gillespie, MD, MHPE, Medical Director, Oregon Pediatric Improvement Partnership, Oregon Health and Science University, December 20, 2011.