AN INTRODUCTION TO CARE COORDINATION IN UTAH
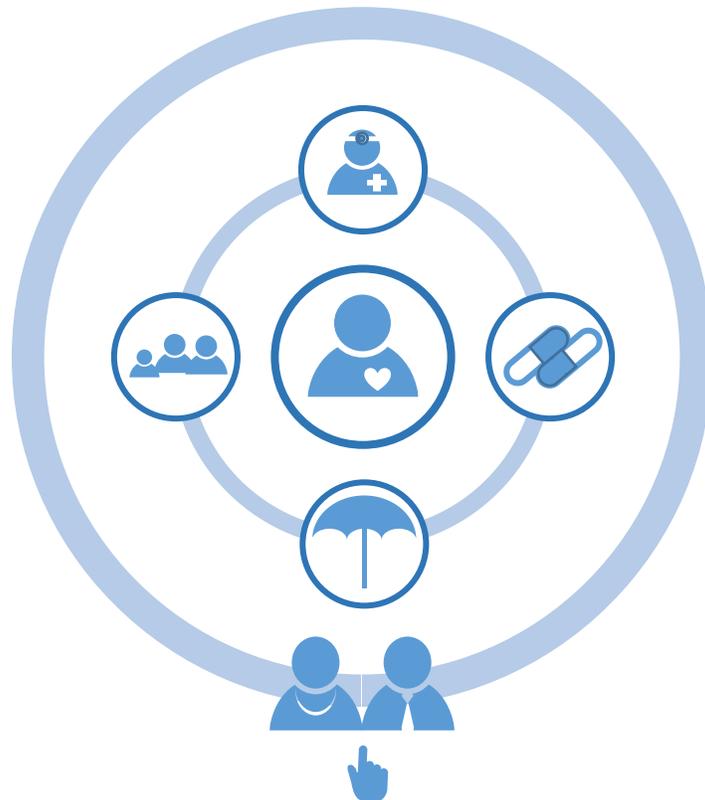
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Contents

Definition of Care Coordination

There are many ways of defining "care coordination". For the purposes of this document, we consider care coordination to be:

- A consistent effort to ensure that all key information needed to make clinical decisions is available to patients and providers.
- It is the deliberate organization and marshaling of personnel, programs, and other resources needed to carry out appropriate patient care activities between two or more participants involved in a patient's care.
- It facilitates effective delivery of health care services and access to community resources.
- Care coordination is multidimensional and essential to preventing adverse health care events.
- It intentionally engages and makes the patient the center of safe, efficient high-quality care.

Purpose

Why Care Coordination?

Care coordination is critical to quality healthcare. Keeping a patient's care team informed and the patient engaged are key to creating more positive outcomes and reducing time and resources wasted on duplicate services.

For such a critical area, however, the industry has nevertheless lacked clear overarching definitions and expectations regarding care coordination. The result is a patchwork of services that have been defined and implemented differently by each organization.

This document was created by a group of people who recognize the value of care coordination, and the need for more defined standards as the industry continues to move towards quality-based, integrated healthcare. This guide is intended to help fill this knowledge gap, and to establish the importance of communication and collaboration.

Who Should Read This Document?

This document is for health care professionals, care coordinators, and other parties who are developing care coordination or case management services.

This guide will also help you coordinate between specialties, such as between a primary care provider and a behavioral health provider.

TRUE STORY

Heather Carlson, BSN, RN;
Care Coordinator with the Utah Department of Health, Integrated Services Program

In November of 2016, I started working with a single mom who had moved a few years ago due to domestic abuse. Her 9-year old son was non-verbal and recently diagnosed with severe autism. In addition, finances were tight.

We worked together to develop a shared plan of care for her son, which included securing Applied Behavior Analysis (ABA) therapy and creating a care notebook for tracking his medical and school records.

We also needed to address the economic issues impacting his care. We applied for Supplemental Security Income (SSI) and the Home Heating Assistance (HEAT) program, and at our next appointment we will begin the application process for the Division of Services for People with Disabilities (DSPD). I also educated the family pediatrician on how to show medical necessity to Medicaid so diapers and wipes would be covered. Lastly, the mom had not filed her income taxes for years, which was a huge source of stress. I contacted Cottages of Hope, and they set up appointments for mom to meet with a Certified Public Accountant.

The results have been stunning. With the help of the ABA therapy, the mom's formerly non-verbal son is now saying 5-10 words, and can tell his mother that he loves her. The family is receiving heating assistance from the HEAT program, and was approved for diapers and wipes through Medicaid, which saves them hundreds of dollars a month. Furthermore, they qualified for a $3,000 tax return.

The mom has been so inspired by this progress, she is currently interviewing for a Licensed Clinical Social Worker position at a local charter school and has applied to the American Red Cross.

Resources to help care coordinators

Networking and Training

Establishing contact points with other care coordinators may be the most valuable resource a care coordinator can develop. The list of Utah groups and training events below is not all-inclusive, but is a good place to start.

- **AUCH Care Coordination Training Program**
  AUCH maintains a 20-topic training curriculum. The training includes online and face-to-face components. https://auch.org/training-events

- **Behavioral Health Case Managers**
  Local Mental Health Authorities are assigned to provide case management to individuals with Medicaid (adults with serious mental illness and children with severe emotional disturbances) by geographic location. In exceptional cases, case management may be available to individuals without funding. To find a case manager, select the pertinent location on the map: https://dsamh.utah.gov/contact/location-map

- **Community Health Workers**
  "Community Health Workers (CHWs) are trusted members of the community they serve, and act as liaisons between their community and health and social services. They understand the culture and language of the community where they live and work" (Community Health Workers, choosehealth.utah.gov).
  Community Health Workers often act as coordinators, and are particularly engaged with minority populations. For more information about local and national groups of Community Health Workers, as well as additional resources like scope of practice and membership directories, see: Utah: http://choosehealth.utah.gov/healthcare/community-health-workers.php and National: https://www.apha.org/APHA-Communities/Member-Sections/Community-Health-Workers

- **Division of Services for People with Disabilities (DSPD)**
  If your client has conditions related to Intellectual Disability or related condition, Acquired Brain Injury, or Physical Disability, the client may be eligible for DSPD services.
  Support Coordination is a service provided most often by privately owned agencies under contract with the Division, though at times by Division employees as well in limited situations. Support Coordinators assist individuals with disabilities and their families to develop plans to find the most appropriate services and select the most appropriate service delivery model, based on the individual person's needs and wishes.
  https://dspd.utah.gov/resources/find-a-support-coordinator/ or 1-844-275-3773

- **EDCM (Emergency Department Case Management) Committee**
  The EDCM committee meets regularly to discuss and resolve issues affecting case management in/around emergency departments. Attendees include case managers in hospitals, as well as coordinators who work with hospitals while serving their clients.
  Contact: Christine Weischedel at 801-587-2698 or Christine.weischedel@hsc.utah.edu.

- **Family-Centered Care for Children and Youth with Special Health Care Needs**
  Family-Centered Care is a theme that is woven throughout efforts focused on children and youth with special healthcare needs. It puts the family front and center in determining appropriate goals and steps to serve the needs of the child. For more information, click the link below. https://mchb.hrsa.gov/chscn/pages/family.htm#family

- **Family Resource Facilitators (FRF)**
  FRFs are trained family members who develop working partnerships with the Local Mental Health Authorities' staff to represent family voice at service delivery, administration and policy levels. At no charge to families, FRFs provide referrals to local resources and programs, advocacy for culturally appropriate services, links to information and support groups, and family wraparound facilitation.

- **Health Resources and Services Administration (HRSA)**
  HRSA is a federal government entity with a mission to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs. Visit the HRSA site to view background information and trends in the healthcare field.
  https://www.hrsa.gov/

- **Huntsman Cancer Institute, list of Oncology Patient Navigators**
  Search the Oncology Patient Coordinators page to find Care Coordinators within Huntsman Cancer Institute.
  https://healthcare.utah.edu/huntsmancancerinstitute/wellness-support/patient-navigators/

- **System of Care (SOC)**
  System of Care is a customized service approach to keep families safely together while effectively helping children with emotional and/or behavioral health needs thrive in their homes, schools and communities. Its "wraparound" approach helps families and children get the right service at the right time and appropriate level. In this model, the Family Peer Support and care manager have been separated into two positions. The Family Peer Support provides advocacy and support, while the care manager provides intensive coordination of services.
  https://systemofcare.utah.gov

- **Utah Chapter- American Case Management Association**

  Join the association for access to training and resources. Attend the Annual Utah Chapter Case Management Conference for a day of education and networking.

  http://acmaweb.org

- **Utah Children's Care Coordination Network (UCCCN)**

  UCCCN is a source of information, resources, tools, expert advice, and peer learning and support. It is geared for pediatric and family practice staff members who help coordinate the care of patients.

  https://www.medicalhomeportal.org/clinical-practice/care-coordination-in-portal-partner-states/utah-childrens-care-coordination-network

- **Utah State Office of Rehabilitation (USOR), Division of Deaf & Hard of Hearing Services** USOR provides rehabilitative services to individuals with disabilities. Case managers at the Sanderson Community Center in Salt Lake City provide services in American Sign Language to individuals who are Deaf or Hard of Hearing. These case managers assist individuals to identify and obtain needed services from federal, state or county programs, teach independence and self-advocacy, and coordinate mental health counseling if needed. Services are provided across the State at no cost.

  https://jobs.utah.gov/usor/dhh/programs/casemanagement.html

Technology as a Resource

Much of the work performed by care coordinators falls into the category of "information transfer." When it comes to communicating information between parties, there are often technological solutions that reduce or eliminate time-consuming steps. To increase your efficiency, use technology to facilitate faster communication and to take care of tasks that are repetitive or painstaking in nature.

- **2-1-1**

  The 2-1-1 line is maintained by United Way, and offers a quick way for callers to find health and human services resources. Just dial 2-1-1 on any telephone, or visit their website for additional options.

  http://211utah.org/

- **Clinical Health Information Exchange**

  The Clinical Health Information Exchange (CHIE) is Utah's state-designated center for electronically exchanging clinical health information. Among other functions, the CHIE allows users to look up a patient's medical records, send Direct secure emails and attachments to providers, and receive instant alerts if one of their patients is seen at a hospital or emergency room.

If your care coordination duties involve consolidating a patient's health record from multiple doctors, corresponding with providers concerning protected health information (PHI), or some form of intervention if the patient has an emergency, check with the CHIE to see if their services can assist you.

https://uhin.org/company/about/

- **Electronic Health Record (EHR)**

  If your organization already has an EHR product, there may be ways to utilize it more fully to support your duties. For example, most EHRs have Direct secure email built in to the system. This can be useful if you need to correspond with providers concerning a patient's protected health information (PHI).

  Some EHR systems may also provide helpful templates for a variety of situations. Check with your EHR to see if they can help streamline your process to gather, input, and communicate information.

- **Health Resource Hotline: 1-888-222-2542**

  This hotline, maintained by the Utah Department of Health, has access to and knowledge of numerous health resources and can connect you to helpful outreach programs and education services.

Manuals

- **Division of Substance Abuse and Mental Health Case Management Training Guides**

  Separate guides are available for adults and youth

  https://dsamh.utah.gov/case-management

- **Lucile Packard Foundation**

  "Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs"

  http://www.lpfch.org/publication/aCHIEving-shared-plan-care-children-and-youth-special-health-care-needs

- **Medicaid Provider Manuals**

  Some sections, like Rehabilitative Mental Health and Targeted Case Management, include information on Care Coordination.

  https://medicaid.utah.gov/utah-medicaid-official-publications?p=Medicaid%20Provider%20Manuals/

Other Resources

- **Agency for Healthcare Research and Quality**

  Care coordination information page by AHRQ

  https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

- **Aging Services**

  Resources for senior populations can be found at www.seniorsbluebook.com

- **Community Health Workers**

  http://choosehealth.utah.gov/healthcare/community-health-workers.php

- **Early Hearing Detection and Intervention**

  http://www.health.utah.gov/cshcn/programs/ehdi.html or 801-584-8215

- **HealthInsight Beacon/Comagine Care Coordination Program**

  https://comagine.org/services

- **Integrated Services Program**

  http://health.utah.gov/cshcn/programs/integratesrvs.html or 801-273-2988

- **Mental Health Referrals**

  Depending on the patient's insurance, they may be eligible to use the services of their Local Mental Health Authority. https://dsamh.utah.gov/contact/location-map

- **Rural Health Information Hub**

  Rural Care Coordination Toolkit by RHIhub: https://www.ruralhealthinfo.org/toolkits/care-coordination

- **SAMHSA Care Coordination pages**

  https://www.samhsa.gov/section-223/care-coordination

  https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/case-management

- **Take Care Utah**

  This network of nonprofit organizations helps people find health insurance. All services are free of charge. https://takecareutah.org/

- **Utah Department of Health**

  http://health.utah.gov or 1-888-222-2542

Best Practices

Care coordination has historically lacked a consistent set of expectations, although some parts of the industry have requirements for specific programs or insurers. The trade-off for this flexibility is a certain amount of confusion. For this reason, we have included some best practices in this guide.

The best practices below have been gathered from literature, committees, and interviews with actual care coordinators.

The Patient is Always the Center of Care Coordination

Using a "person-centered" or "family centered" approach is key in showing respect to the individual and family with whom you are working. Care coordination decisions cannot be made without the input and buy-in from the patient and family. As such, they must be included at the beginning to share their concerns, needs, values, and ability to complete goals and objectives. As the center of care coordination activities, they will be their own best advocate as they help to plan and orchestrate realistic outcomes for themselves and their families.

For more information, see the "Patient-Centered Care for the Aging" and "Family-Centered Care for Children and Youth with Special Health Care Needs" sections in the Resources area.

Communicating the Scope of Practice

"What are the expectations?" In an industry with so little consistency, it is critical to communicate promptly and clearly with other involved parties. Set clear expectations by telling the whole care team (patient, family, & providers) what you can and cannot do as part of your work. This is your scope of practice. Then, ask them for their scopes so you know what to expect from them.

Who's on First?

Patients who have the highest need for care coordination may have multiple conditions and multiple providers. It's important to remember the impact of those other providers and treatments when you're working with the patient.

How do you know other care coordinators might be involved? The first and best way is to ask the patient and their Primary Care Provider (PCP). In addition, the following scenarios are examples where existing care coordination is likely.

- The patient has Medicaid/ACO coverage.
- The patient had an inpatient stay for a behavioral health reason.
- The patient was recently discharged from a hospital, facility, or incarceration.

Consider the following:

1. Your client could be in multiple programs, and working with multiple care coordinators. Rather than asking the patient to keep track of information from multiple care coordinators, **support a single point of contact for the patient.**

    a. This point person should be whomever can best serve the patient.

      b.   Work with this single point of contact to determine the best way to share pertinent patient information. Consider electronic information exchanges and other resources, such as a Clinical Health Information Exchange (for more information, see **Resources**).

      c.   Keep in mind that the primary point person might change with the patient's circumstances. For example, a PCP may be the best point of contact for a patient with critical physical conditions, at least until those conditions become less severe.

      d.   Some organizations are required to complete care coordination for certain patient populations, and they are usually audited on their compliance. In these cases, the coordinators might not be able to completely hand over coordination to a different primary contact. So, what can you do?

            i.   Can you supplement their efforts and stay within your scope of practice? Consider program-specific forms, applications, medication management, etc. Are there any pieces not covered yet that will be needed by the patient?

            ii.   If you're doing anything in parallel with the other coordinator, keep in contact so you're not duplicating efforts.

2. **Recommend an assessment at the beginning of your relationship with the patient[1].**

      a.   Use an assessment to identify any other active programs, treatment teams, and their points of contact. Also, check whether the patient is restricted or locked in to a single provider.

      b.   Has anyone else done an assessment? It can be helpful to know which teams have done assessments, and which elements were included.

      c.   Compare assessments and any other available information to identify gaps in care or duplicate care. Work with the patient, the other providers, and any electronic information sources to address these gaps or duplicate care.

3. **Ask anyone else working with the patient if they are discussing and setting goals**. Goals that conflict or overload the patient can be more harmful than helpful, so make sure everyone is on the same page.

4. **Consider creating a paper or electronic document with the highest priority information** (in terms of care coordination) for that patient. This could include care coordination contact information, active medications, allergies, and other similar information.

5. **Transitions of care are critical times for patients.** Communication during these stages are extremely important, and repetition can be very helpful. There is no such thing as "over-communication" during a transition of care.

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[1] In some parts of the industry, assessments (and other coordination work) are routine and/or required. For example, in the case of a mental health and/or substance use disorder, prior to providing services a coordinator must complete an assessment that identifies case management as a client need.

Use Your Resources

There may be resources available to you that would make care coordination easier. Technology, for example, is continually expanding to offer more and more support for information sharing.

First, research the available technology resources. We have a list in the **Resources** chapter as a starting point, but your search doesn't have to stop there. Then, sign up or get access to the resources that you need.

The other side of information sharing is contributing your information for other treating providers to access. Find out whether your organization is connected to any networks that will allow information sharing.

Do you consistently work with someone to coordinate for one or more shared patient(s)? See if you can establish a contract/privacy agreement with the provider to make the exchange of information simpler.

Note: Some Behavioral Health information carries additional restrictions on sharing. However, even in those cases, there is useful information that *can* be shared. Read more about **HIPAA** and **42 CFR Part 2** below.

Relevant Regulations, Standards, & Policies

Note: the information in this section is for informational purposes only, and is not intended to act as legal advice. When in doubt, consult a lawyer.

42 CFR Part 2

The Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services, aims to advance the nation's understanding and treatment of Substance Use Disorders (SUD) and mental health issues, and to decrease their negative impact on people and society. As part of this goal, SAMHSA oversaw the creation of regulation 42 CFR Part 2, which is intended to provide additional protection for patients receiving SUD treatment.

Recognizing that knowledge of SUD treatment is sensitive and potentially damaging, 42 CFR Part 2 aims to give these patients additional control over the sharing of their medical records. For example, before disclosing the SUD records to another provider (even one in a treatment relationship with the patient), the patient must sign a consent form indicating that a specific provider or entity may receive their records. Even when this form has been signed, no re-disclosure is allowed; the patient must sign additional disclosures if that information needs to be sent elsewhere. (Note that some information may be shared in emergency situations.)

While SUD information is subject to 42 CFR Part 2, other mental health records not related to SUD might only need to follow HIPAA.

For more, go to https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs, or https://www.healthit.gov/sites/default/files/exchange_treatment.pdf.

DOPL

The Division of Occupational and Professional Licensing (DOPL), administers and enforces laws relating to licensing and regulation of certain occupations and professions. DOPL also administers the Utah Controlled Substance Database (CSD), which is a resource for prescribing medical practitioners and pharmacists. It helps these practitioners and pharmacists identify potential cases of drug over-utilization, misuse, and over-prescribing of controlled substances. In some instances, physician and pharmacy staff can apply to receive access to the CSD on behalf of a licensed practitioner or pharmacist.

For more, go to http://dopl.utah.gov/programs/csdb/index.html and http://dopl.utah.gov/about.html.

FERPA

The Family Educational Rights and Privacy Act (FERPA) is a Federal law designed to protect student education records. Health records maintained by the school are often solely under the jurisdiction of FERPA rather than HIPAA. (Note that a school may need to abide by HIPAA as well if they provide medical care AND they electronically transmit medical information.)

Since FERPA's consent and disclosure model is based on the needs of schools that communicate with parents about their minor children, there are some differences in the requirements and responsibilities for a school vs. a HIPAA-covered entity.

To learn more, go to https://ed.gov/policy/gen/guid/fpco/ferpa/index.html.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) sets national standards for the privacy and security of electronic health information. The purpose of HIPAA is to protect electronic patient health information.

Health information that could allow the recipient to identify the patient's identity and/or medical status and medical history is considered Protected Health Information (PHI). In general, HIPAA restricts the sharing of PHI except when the purpose of the exchange is for **T**reatment, **P**ayment, or **O**perations (TPO). TPO allows access of medical information by providers, insurers, and other parties with a legitimate need, so that they can discharge their responsibilities to the patient. This can include sending claims or requests for reimbursement to insurers, paying claims, conducting quality reviews, and other actions ultimately designed to serve the patient.

However, there are other parts to this regulation and a few exceptions that require additional steps before information can be exchanged. One such exception applies to certain behavioral health information, such as substance use disorder information. Additional consent is required from the patient to communicate that information. For more details, see the **42 CFR Part 2** section.

To learn more, go to https://www.hhs.gov/hipaa/for-professionals/index.html.

HITECH

The Health Information Technology for Economic and Clinical Health (HITECH) Act was created in 2009 to address gaps in HIPAA around the use of technology in healthcare settings. HITECH clarified the definition of a privacy violation and outlined specific penalties for each level of severity. Under HITECH, the potential consequences of violations increased, and allowances for waiving penalties have decreased.

With the advent of HITECH, not only are healthcare practices being held to a higher standard of privacy and security, but so are their business associates. If a healthcare practice hires a contractor or business associate, HITECH outlines necessary precautions and the consequences to both the business associate and the practice if the business associate causes a violation.

To learn more, go to https://www.hhs.gov/hipaa/for-professionals/special-topics/HITECH-act-enforcement-interim-final-rule/.

Mental Health Case Management Services

Case management is a mandated service for adults, youth and children as specified in Utah Code 17-43-301(4)(b)(vii). The Division of Substance Abuse and Mental Health (DSAMH) certifies adult and child mental health case managers and monitors the quality of case management services that are provided. Case managers who bill Medicaid are required to adhere to certain minimum standards of knowledge, conduct, and ethics. Training is typically required, although if providers enter the program with the requisite licensure they can bypass the formal training.

DSAMH maintains training documents and guidelines for case managers. More detailed information is available on dsamh.utah.gov and https://dsamh.utah.gov/case-management, as well as the Medicaid Provider Manual for Targeted Case Management.

Common Myths & Misunderstandings

Scope of Practice

Defining the scope of practice

As discussed in the [Best Practices](#) section, it is critical to have realistic expectations regarding what you and others should and should not do. We term these restrictions "scope of practice." If you know the scope of practice for a hospital emergency room versus a primary care provider, or for an independent care coordinator versus a behavioral health provider, you can avoid many miscommunications and misunderstandings.

As you begin coordinating care, ask everyone involved in the patient's care about their scope of practice. Remember that the care team may include physicians, other coordinators, the patient, and potentially family members who are active in the patient's care.

Myth: "Scope of practice" is tied to credentials

In most parts of the medical industry, a person's scope of practice is determined by their licenses and credentials. In the care coordination industry, there is no standardized expectation regarding tasks, duties, or minimum credentials needed to be a care coordinator. Some insurances have determined their own standard of minimum credentials, which are applicable if a care coordinator wants to be paid by that insurance. However, those minimum requirements can vary.

Care coordinators may have differing amounts of flexibility in their scope of practice depending on the requirements of their employers, job descriptions, and any insurances being billed. Some organizations even have individuals in the same job description performing different types of tasks. This variation is a primary reason it is so important to clarify each party's scope of practice.

Behavioral Health Providers

In Utah, Local Mental Health Authorities are responsible to provide or contract for case management for individuals with Medicaid who reside in their local areas. Qualified providers of case management include licensed behavioral health professionals, or a non-licensed individual working under their supervision who are also certified by the Division for Substance Abuse and Mental Health.

TRUE STORY

Maria,* mother to a teenage son, spoke limited English. When her son was arrested for drug possession and began exhibiting symptoms of mental health issues, she was frantic with worry and had difficulty communicating his need for medical care. The court proceedings left Maria confused and frustrated, as she was not included in decisions or information about her son's condition.

Finally, Maria was assigned a bilingual, bicultural family support specialist and System of Care manager. With the care manager's support and translation, Maria got a voice in the process, and she got a detailed explanation of her son's condition (diagnosed as schizophrenia). The rest of the family was included and became a support system for her son, to keep him compliant with his treatment plan and therapy.

With this support system, Maria's son began to recover and experience success with his medications and therapy. Continuing support from the System of Care program until her son is 21 will give Maria's family time to strengthen the family support structure and give her son a better chance at long-term success.

*Name has been changed.

In addition to substance abuse and mental health disorders, individuals experiencing homelessness are also eligible for case management services. In this context, "homeless individual" includes literally homeless persons, those at risk of homelessness, and those formerly homeless persons who are housed through homeless programs.

Payers & Payment

Payers have been increasing their involvement in care coordination, both in terms of paying for care coordination services and in providing some of their own case management. If an entity pays for the provision of health care, that entity is covered under the HIPAA Privacy Law and can be a recipient of relevant Private Health Information (PHI). Thus, payers can fully participate in care coordination collaboration when the payer organization offers Case Management services.

- **Accountable Care Organizations (ACOs)/Medicaid Health Plans**
  ACOs in Utah are technically known as "Medicaid Health Plans," but are commonly referred to as Accountable Care Organizations (ACOs) as their function is essentially the same.
  ACOs/Medicaid Health Plans are third-party payers who work with The Department of Health to manage the business and financial aspects of many Medicaid services. ACOs have Case Management departments, and can collaborate with health care providers to coordinate patient care.
  In Utah, Behavioral Health Services are "Carved Out," and instead of being managed by the ACOs these services are identified as Prepaid Mental Health Plans (PMHPs) and administered by Local Mental Health Authorities and Local Substance Abuse Authorities (LMHA/LSAAs) in each county. In other words, each LMHA/LSAA acts as the payer/provider for Medicaid Behavioral Health Services in their own county. They may coordinate closely with ACOs for programs like The Restriction Program (a.k.a. The Selected Provider Program), and the ACOs may provide some case management as part of that coordination, but the PMHP is the payer/provider for Medicaid Behavioral Health Services, not the ACO. To locate your LMHA/LSAA in your area, please follow this link: https://dsamh.utah.gov/contact/location-map.

  There is one exception to the above rule. In Salt Lake County, the PMHP (Salt Lake County Behavioral Health) has contracted with Optum (a Managed Care Organization, or MCO) to provide services to the Salt Lake County population. The PMHP gives Optum most of the funds provided to them by Medicaid, allowing Optum to act as the payer and subcontract with providers to supply Behavioral Health services to Salt Lake County. The PMHP uses the remainder of their money for administrative costs, some special programs, and to support unfunded populations.
  The ACOs/Medicaid Health Plans/Managed Care ACOs in Utah are:

  - Health Choice Utah: 1-877-358-8797 (Press 5 for Case Management)
  - Healthy U: 1-888-271-5870
  - Molina Healthcare: 1-888-483-0760
  - SelectHealth Community Care: 1-800-538-5038

Rural and Frontier Considerations

The United States Census Bureau defines a rural area as having a population of less than 50,000 people, while acknowledging that there are "urban clusters" of between 2,500 and 50,000 people within rural areas. Using the Census Bureau's definition, as of 2010, nearly 20 percent of the U.S.'s population has lived in a rural area.

The United States Census Bureau's 2010 data indicates that 9% of Utah's population lives in a rural area of the state. While this may not seem like a significant percentage, this population is scattered over more than 80,000 square miles, which equates to more than 98% of Utah's geography. By contrast, Utah's urban population is concentrated within approximately 914 square miles. This geographic spread creates unique challenges to coordinate care in rural and frontier areas where resources may be scarce or nonexistent.

Consider the following suggestions[2] to best utilize existing infrastructure and make the most of care coordination in rural areas:

> **Care coordination is especially critical for rural communities. On average, rural communities report poorer health outcomes than their urban counterparts, with a higher prevalence of chronic disease, mental illness, and obesity. Rural communities tend to have higher poverty rates and lower health insurance rates.**
>
> *- Robert Wood Johnson Foundation, "Realizing Rural Care Coordination: Considerations and Actions for State Policy-Makers"*

- Work with the State Office of Rural Health. This office is Utah's federally designated agency through the Utah Department of Health and is charged with helping rural communities build health care delivery and capacity. https://ruralhealth.health.utah.gov/
- Rely on the strength of existing partnerships within local communities. Although the available resources may not be as plentiful, the relationships already established between agencies may be stronger, as is their ability to work together and problem solve at a local level.
- Encourage families and patients to form and/or participate in local efforts to:
  a. Prioritize community physical, behavioral health, educational, and social service needs.
  b. Work to strengthen existing community partnerships.
  c. Seek long-term solutions to problems.
- Work with and include community agencies representing diversity to understand how the patient's cultural and linguistic context and belief systems must be incorporated into your care coordination efforts. Consider coordinating with local Community Health Workers.

Bringing the Patient to the Resource

- Promote telehealth when possible and appropriate. While cellular and broadband technologies may not yet reach each rural resident's front door, it may be available at local medical facilities, health departments, Federally Qualified Health Centers/Community Health Centers, and other public organizations. Care coordinators may be able to coordinate telehealth visits between patients and families and remote organizations – such as specialty care – through these local facilities.

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[2] from the Robert Wood Johnson Foundation

- Patients may live hours away from even the closest resources, and in some cases travel may be necessary.
    a. Get to know and understand public and private transportation agencies in the area.
    b. Help patients and individuals understand what types of medically necessary transportation options may be available through private and public insurance options (e.g. Medicaid travel reimbursement).

Glossary

Accountable Care Organization (ACO) - An organization that contracts with groups of doctors, hospitals, and other health care providers in a Network to give coordinated high-quality care to their patients. According to Centers for Medicare and Medicaid Services (CMS), the goal of coordinated care is to ensure that patients get the right care – at the right level of care – at the right time, while reducing cost by avoiding unnecessary duplication of services.

ACOs and Medicaid In Utah: (technically, "Medicaid Health Plans")

- Health Choice Utah: 1-877-358-8797 (Press 5 for Case Management)
- Healthy U: 1-888-271-5870
- Molina Healthcare: 1-888-483-0760
- SelectHealth Community Care: 1-800-538-5038

AUCH – The Association for Utah Community Health (AUCH) is the Primary Care Association in Utah AUCH cultivating access to primary health care for all residents https://www.auch.org/

Capitation - Capitation is a fixed amount of money per patient per unit of time, paid in advance to the physician for the delivery of health care services. The actual amount of money paid is determined by the ranges of services that are provided, the number of patients involved, and the period of time during which the services are provided. Capitation rates are developed using local costs and average utilization of services and therefore can vary from one region of the country to another.

Care Coordination - A consistent effort to ensure that all key information needed to make clinical decisions is available to patients and providers. It is the deliberate organization and marshaling of personnel, programs, and other resources needed to carry out appropriate patient care activities between two or more participants involved in a patient's care. It facilitates effective delivery of health care services and access to community resources. Care coordination is multidimensional and essential to preventing adverse health care events. It intentionally engages and makes the patient the center of safe, efficient high-quality care.

Care Navigator or Patient Navigator - These terms appear on web sites of health care organizations. A navigator is "someone who helps assist patients overcome barriers to care." The National Cancer Institute also emphasizes a patient-centric model: "a navigator is someone who understands the patient's fears and hopes, and who removes barriers to effective care by coordinating services, increasing a cancer patient's chances for survival and quality of life."

Case Management - Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs. This is accomplished through communication and available resources to promote quality, cost-effective outcomes. (Case Management Society of America www.cmsa.org.)

Centers for Disease Control and Prevention (CDC) is a federal agency that conducts and supports health promotion, prevention, and preparedness activities in the United States, with the goal of improving overall public health. Funding for chronic diseases comes from the CDC to the State and Local Health Departments.

Chronic Care Model - Initially named by Wagner and colleagues as a "Model for Effective Chronic Illness Care," the basic premise of this model is that "effective chronic illness care requires an appropriately organized delivery system linked with complementary community resources available outside the organization." This system is sustained by productive interactions between multidisciplinary primary care teams and engaged patients.

A multidisciplinary primary care practice team has responsibility for organizing and coordinating care through many activities: performing comprehensive patient assessments; helping patients set goals and solve problems for improved self-management; applying clinical and behavioral interventions that prevent complications and optimize disease control and patient well-being; and ensuring continuous follow-up.

To achieve effective patient management, the Chronic Care Model promotes comprehensive system change encompassing six broad areas:

1. Health care organization
2. Linkages to community resources
3. Self-management support
4. Delivery system redesign
5. Decision support
6. Information systems

https://www.ncbi.nlm.nih.gov/books/NBK44012/#A25396

Collaboration - interactions based on shared power and authority, and mutual respect for the unique abilities of each participant. Ideal collaborative relationships among health professionals result in cooperative problem-solving and decision-making, where participants achieve better patient care by working together than would have been possible individually.
https://www.ncbi.nlm.nih.gov/books/NBK44012/#A25396

Continuity of Care - the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care, to facilitate the appropriate delivery of health care services.

Disease Management - The Disease Management Association of America defines this term as:

> A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management supports the physician or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health. - Disease Management Association of America

Full-service disease management programs include the following six components:

1. Processes to identify specific population
2. Evidence-based practice guidelines

3. Practice models based on collaboration between physicians and other supporting service providers
4. Self-management education for patients
5. Measurement of process and outcomes
6. Routine reporting to provide a feedback loop among participants

In addition, disease management and case management programs have been included together under the umbrella of "coordinated care models" in reports for the Medicare Coordinated Care Demonstration Projects. https://www.ncbi.nlm.nih.gov/books/NBK44012/#A25396

Essential Care Coordination Tasks - focus on the clinician-patient interaction (e.g., assess the patient), and the associated coordination activities (e.g., identify need for coordination), while the common features typically involve systems, resources or even policy changes to enable these tasks (e.g., personal health record to supply necessary information to multiple providers).

Evidence-Based Practices - The most common definition of Evidence-Based Practice (EBP) is from Dr. David Sackett. EBP is "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient."

Medicaid (Utah) - eligibility falls under two tracks: Traditional and Non-Traditional.

- Traditional Medicaid: members eligible for Traditional Medicaid includes, children, pregnant women, aged, blind or disabled adults, women eligible under the Cancer Program. Some services are available only to children and to pregnant women under Traditional Medicaid. If a parent is a minor child and is the head-of-household on Family Medicaid, the minor parent will be covered by Traditional Medicaid.
- Non-Traditional Medicaid: eligible for Non-Traditional Medicaid includes adults on family Medicaid programs (adults with dependent children), adult care-taker relatives on family Medicaid. Services are based on the program type a person is eligible to receive.

Programs for Enrolled Medicaid Members include: Children's Health and Evaluation Care (CHEC), Restriction Program, Tobacco Cessation Program, Living Well with Chronic Conditions Program, and Oral Health Initiative Program. https://medicaid.utah.gov/programs-enrolled-medicaid-members

Utilization Management - According to URAC, an accreditor of health care organizations, utilization management is "the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes called 'utilization.'"

Quality Improvement Organization - QIO program is one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries, and is an integral part of the U.S. Department of Health and Human (HHS) Services' National Quality Strategy for providing better care and better health at lower cost. By law, the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. Utah's QIO is HealthInsight, a group of health quality experts, clinicians, and consumers organized to improve the quality of care delivered to people with Medicare. www.healthinsight.org

Quality Measures - tools that measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structures and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. For examples of Quality Measures, see Centers for Medicare & Medicaid Services - CMS.gov at https://www.cms.gov/qualitymeasures/03_electronicspecifications.asp

System of Care - The Utah System of Care is a program administered by the Department of Human Services, as well as an approach to service delivery integrated throughout the Department. Community-based services and supports are provided for children and youth with or at risk for mental health or other challenges, and their families, using a "wraparound" approach. Wraparound is an empirically supported, family-driven, strengths-based planning approach that provides individualized care using an array of formal services and natural supports. https://systemofcare.utah.gov

Teamwork - In the context of care coordination, successful teamwork with multidisciplinary teams emphasizes that teams act in the best interests of the patient and situation rather than strictly by traditional organizational roles. https://www.ncbi.nlm.nih.gov/books/NBK44012/#A25396

Telehealth and Information Systems - Information technologies that connect patients to services electronically, and often on mobile devices.

Transition of Care - The Joint Commission has defined a transition of care as "the movement of a patient from one health care provider or setting to another. Developing ways to assure safe transitions of care requires collaboration among providers all along the care continuum." https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/guidance/understanding-capitation

Contributor's Page

Health System's Partnership

Organization	Representatives
Department of Human Services	Ruth Wilson
Health Choice of UT	Tracie Hoffman
Human Services Substance Abuse & Mental Health	Pam Bennett Jeremy Christensen
Molina	Lynette Hansen
SelectHealth	Kim Barrus
UHIN	Sara Vandermolen
University of Utah, Department of Biomedical Informatics	Jennifer Garvin Jonathan Cardwell
University of Utah Health Plans	Christine Weischedel Maureen Richardson
Utah Department of Health	Eric Christensen Kelly Robinson Brittany Guerra
Wasatch Mental Health	Doran Williams

All contributors volunteered their time and effort towards this document.

Questions? Email education@uhin.org