

## Learning Experience of a Medicaid Care Co-ordination Plan in Navigating the Dynamics of Social Determinant

Thomas W Chapman\*

The HSC Foundation, USA

\*Corresponding author: Thomas W Chapman, Chief Executive Officer and President, The HSC Foundation, USA, Tel: +1 202-454-1220; E-mail: [tchapman@cscn.org](mailto:tchapman@cscn.org)

Received date: April 04, 2016; Accepted date: September 29, 2016; Published date: October 06, 2016

Copyright: © 2016 Chapman TW. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

### Summary

Coordinating the multiple needs of severely chronically ill children and youth with special health care needs (CYSHN) is a daunting and constantly changing challenge. It is especially overwhelming in low income communities in families ill prepared to manage these responsibilities. Over the past several years a variety of researchers have concluded that the concentration and complexity of children and youth with special needs (CYSHN) in urban communities and the disparities in rates and conditions between low income Blacks, Hispanic, children versus white children were significant [1]. Researchers have also established that 15 to 20 percent of families living below the Federal poverty level in most urban communities are 1/3 more likely to have a special need child or youth in their family. Education plays a determining role as well. Families with 12 or less years of education have more special needs issues dominant within their ranks and single parents are more likely than a two parent family to have special needs challenges. Medical conditions who rely on Medicaid is growing at 5%, outpacing pediatric population growth overall [2].

CYSHN can cost \$40,000 to \$50,000 more per year than their TANF (Medicaid) counterparts in most major cities. Social conditions and poverty clearly play a role in producing complexity and instability for these children and their families. The macro level of social determinants such as poverty, substandard housing, poor nutrition and education, undesirable environmental conditions, lack of transportation play a role in destabilizing families and challenging access to care for CYSHN population's need. However, effectively dealing with the micro level of social determinants requires knowing how to navigate around these unpredictable and episodic obstacles, manage the multitude of bureaucratic barriers, and properly secure and use community resources to facilitate improved health outcomes. Achieving this for most special needs low income families is practically impossible without a well-organized system. These families require an organized plan and strata to ensure the insurance coverage they have can be put to effective use and providers serving them need assurance they will engage and interact appropriately to maximize outcomes. The plan can assist in resolving problems that are occasional or routine, e.g. home displacement and frequent address changes, food insecurity crisis, finding special needs daycare to remain employed or qualified for welfare, suddenly losing utility services, withdrawal from health services based on embarrassing communicable diseases, having poor eating and dental habits that exacerbate chronic illnesses.

### Why care coordination, social support and community outreach works vital to SJ special needs populations?

Special needs populations require much more than an effective medical system, enrollment in insurance coverage is simply the first

step in a long journey towards meaningful healthcare access. Over decades the predominate needs of chronically ill children and youth with special needs has shifted from medical surgical needs to psychosocial needs. This requires Medicaid (managed care) coordination organizations to acquire significant knowledge of community-wide government social, educational transportation, welfare, and mental health programs. They must also develop expertise in integrating and synchronizing these services into an individual plan for each member that is regularly updated. These services are often organized in separate government departments with distinct standards, policies and procedures for benefits qualifications.

The care coordination organizations must also assist in stabilizing families to cope with the challenges of getting routine access to necessary resources which enables them to consistently access medical care. All of this is a major challenge for any Medicaid care coordination plan serving CYSHN and for States contracting with plans and assessing their quality of performance. To succeed at these tasks States should additionally require highly organized outreach strategies, homecare, systems, and wide deployment of experienced outreach workers who are from the community and have intimate knowledge of its working. The role of the outreach worker is to monitor the family's needs, offer information, training and support to manage their special needs children and intervene on a regular or emergency basis to prevent and avoid problems. They are the critical pipeline that connects the Medicaid care coordination plan, its provider network, government resources and the CYSHN population.

Consequently, States must contract for more than medical insurance coverage. What is required is a "Medicaid Care Coordination Model" for severely chronically ill children and youth with special needs in urban settings. The model must be strategically designed, systematic and comprehensive.

Health Services for Children with Special Needs, Inc. (HSCSN) is a specialty Medicaid health plan that has provided care coordination for individuals with disabilities and chronic illnesses in Washington, D.C. since 1994. HSCSN's evolution has occurred in tandem with the unique. Structure of The HSC health care system, which offers an integrated approach to stabilize families and encourage independence by combining the resources of a care coordination plan, pediatric specialty sub-acute hospital, home health agency, national youth transitions center and charitable foundation.

Since its inception, HSCSN has collected and managed what has become one of the longest, continuous health utilization datasets in the country for youth with disabilities in managed care. In collaboration with the Eunice Kennedy Shriver National Institute of Child Health and Human Development, this dataset will be assessed for replication of the HSCSN model. The HSC System has also supported and

collaborated with 4<sup>th</sup> pediatric researchers from prestigious universities and the American Academy of Pediatrics on various projects.

### **The HSCSN care coordination plan has various components model components**

- 1) A broad scope of medicaid managed care that incorporates preventive, primary, acute, chronic and long-term care services.
- 2) Family-centered care with a real commitment to care management.
- 3) Continuity of care facilitated by 24-hour access to care coordination.
- 4) Intensive and comprehensive outreach services, including respite care, transportation and medically necessary home modifications.
- 5) Integration of health, mental health and social supports.

### **An experienced delivery model**

Highly organized (by dominant diagnosis) care coordinating Teams. Individual plan for each member updated quarterly.

### **Family-centered care management**

**Community-based partnerships and outreach:** 1) Multiple partners in a segment of the community in the private and public sector. 2) HSCSN maintains a high-contact outreach program that closely collaborates with more than 100 community partners, government agencies and the local school system to increase awareness of HSCSN benefits, especially as they relate to housing, nutrition, school engagement and transition resources.

Obviously there are various ways to organize services for CYSHN and to support their families. Our observations and experiences suggest the scope of these services goes far and beyond direct medical care, organized properly they should be comprehensive, and engage many other community entities and be available 24/7 to achieve the best possible outcomes.

### **References**

1. Koop CE (2010) Pursuing Excellence in Early Hearing Detection and Intervention Programs. *Pediatrics* 126: S1-S2.
2. Weil AR (2015) Medicaid's Growing Role In Care Delivery. *Health Aff* 34: 1079.