# Health Care Coordination in New Hampshire

Abigail Morrow, BA, Speech & Language Pathology Graduate Student Trainee NH-ME LEND, Institute on Disability, University of New Hampshire



#### **Health Homes an Introduction**

Health Homes are care coordination networks that support families and individuals to get the care they need. There are two types of Health Homes, the first is a product of Affordable Care Act and focuses on broad populations with chronic conditions, including children and youths with special health care needs (CYSHCN) and the second is a product of 2019 ACE Kids Act that focuses on a subset within CYSHCN, children with medical complexities (CMC), and ultimately can provide more comprehensive support (Definitions/Eligibility Committee, 2024). Care for CMC is expensive. With the implementation of Health Homes, the cost of care for CMC would be shared more equally between the state and federal government increasing the funds to support CMC and their families. Additionally, the care coordination and supports that are embedded in Health Homes results in more accessible services ultimately preventing emergency and long-term hospital stays (Fitton, 2022).

New Hampshire Department of Health and Human Resources (NH-DHHS), by way of Bureau of Family Centered Services (BFCS), is looking into the viability for a Health Home State Plan Amendment (SPA) to support CSHCN, in particular children with medical complexities. This two-year project is currently in the assessment and feasibility of a health home model, in preparation for approval from DHHS leadership. Overall, this project incorporates a complex mix of collaboration for a health home team to communicate and be family-centered in their approach to care.

## **Trainee Activities**

- o Attended Health Home project meetings
- $\,\circ\,$  Self paced, self and mentor guided research on Health Homes
- o Attended check-in and update meetings with the mentor
- Formulated a case example to submit with the proposal to DHHS
  - $\circ~\mbox{Background}$  case information
  - $\circ~\mbox{Care}$  coordination map
  - $\circ\,$  Family experience of with and without Health Home in place
  - $\circ~$  Theoretical Health Home response to medical emergency in the context of the case

#### Melvin's Care Map



## Conclusions

Care coordination for CSHCN is complex and time consuming. Currently, without care coordination built into the healthcare system, these responsibilities fall on a caregiver. Service providers from different departments and different offices do not talk to each other. When there are changes to care plans or condition of the individual and their families, it is up to that caregiver to reach out to each provider and update them as well as advocate for changes and needs.

CMC make up approximately 6% of the population of CSHCN however they utilize 40% of Medicaid funding. With increased care coordination and receiving care in their communities, emergency visits and long-term hospital stays are reduced thus decreasing cost and increasing engagement in the community.

Health Homes are not new, other states have enacted similar care coordination programs successfully. If the NH Health Homes Care Coordination proposal is approved by DHHS, based on the information a submission of a Health Home SPA application to the Center of Medicare and Medicaid Services (CMS) will be created for official approval and implementation.



#### Dartmouth GEISEL SCHOOL OF MEDICINE

#### Melvin is a 4 year, 3 month old boy who lives in NH with his father, older brother, and mother who's pregnant with twins. Melvin is a child with complex health care and medical needs. Without care coordination services through a Health Home, Melvin's mother is left to coordinate with each office, each service, and each provider, in addition to providing care for Melvin and their family. Melvin's mother left the work force following his birth due to his care needs.

#### Health Home Process



## References

- Definitions/Eligibility Committee. (2024). 'Plan for ACA option and ACE Kids option'. In *Minutes of NH* health home conversation. New Hampshire Department of Health and Human Services: Zoom.
- Fitton, S. (2022). A perspective on cost effectiveness in pediatric comprehensive complex care service models. V/XIX Consulting.
- https://drive.google.com/file/d/1vquzmEcD5hrK3800EyvHVqMh7M28wiEh/view?usp=drive\_link





NH-ME LEND is supported by a grant (#TT3MC33246) from the Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services and administered by the Association of University Centers on Disabilities (AUCD).