better health together

Domain 2:
Community-based Care Coordination

Rationale:
Care coordination is essential for ensuring that children and adults with complex health service needs are connected to the evidence-based interventions and services that will improve their outcomes. Appropriately coordinated care is especially important for high-risk populations, such as those living with chronic conditions, those impacted by the social determinants of health such as unstable housing and/or food insecurity, the aging community, and those dependent on institutionalized settings.

Planning & Activities:

- Utilize Pathways Model or other evidenced based community care coordination
- Assess current community capacity based on workforce, technology, partners and financial sustainability aligned with Domain 1 plans
- Develop HUB Implementation Plan

System wide Metrics:

- Inpatient Utilization per 1,000 Medicaid Member Months
- Outpatient Emergency Department Visits per 1000 Member Months
- Plan All-Cause Readmission Rate (30 Days)
- Percent Homeless (Narrow Definition)
- Percent Employed (Medicaid)
- Home and Community-Based Long Term Services and Supports Use
- Mental Health Treatment Penetration (Broad Version)
- Substance Use Disorder Treatment Penetration

Project-Level Metrics: To be determined based on approval of region-specific target populations and selected interventions.

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