VCU
School of Medicine
Health Behavior and Policy

Care Coordinator Experiences

in the Virginia Medicaid Program

Results from a survey of Virginia Medicaid Care Coordinators

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ACKNOWLEDGEMENTS

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1   EXECUTIVE SUMMARY

This report presents findings from a survey of care coordinators serving members in Virginia's Medicaid program. The survey was conducted by Virginia Commonwealth University School of Medicine on behalf of Virginia's Department of Medical Assistance Services. Medicaid care coordinators are employed by the six managed care organizations (MCOs) that are part of Virginia's Medicaid program including Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0. CCC Plus covers primarily older adults and individuals with a disability or long-term care needs. The Medallion 4.0 plan covers children, non-disabled adults and pregnant individuals. The Medicaid MCOs are responsible for managing their member's medical and behavioral health needs, including the Addiction and Recovery Treatment Services (ARTS) benefit for the treatment of substance use disorders (SUD).

At the request of DMAS, the MCOs provided lists of their care coordinator employees, along with contact information (including email addresses). Between May and July of 2022, a total of 1,318 care coordinators were contacted via email to complete the online survey. A total of 329 care coordinators completed the survey, for a response rate of 24%.

Care coordinators play a vital role in linking Medicaid members with necessary services to ensure that the needs of the Medicaid members are met. This survey focused on the background, training and professional experiences of care coordinators; care coordinators' normal work activities with Medicaid members; care coordinators work with members who have a SUD and specific activities commonly performed to assist members with SUD; the type of data and information used by these coordinators to support their duties and responsibilities; major barriers faced by care coordinators, and care coordinators feelings about their job. We highlight key findings here.

Care coordinator demographics, training, and professional experiences:

- Care coordinators overwhelmingly reported identifying as women; three-fifths were registered nurses (RNs), licensed practical nurses (LPNs) or licensed mental health professionals; two-thirds had a bachelor's degree or higher in a human service-related field.
- Care coordinators have a wealth of experience; over 70% had more than five years of experience as care coordinators and almost 80% had three or more years of experience working with Medicaid members.

Medicaid caseload and primary role

- Care coordinators report a median caseload of 143 members (Interquartile Range or IQR:88-208); two-thirds of care coordinators report that their caseload has increased "a lot" or "somewhat" in the past year.
- Over 85% of care coordinators report that most of their members are in CCC Plus; care coordinators report that over three-quarters of their clients had chronic health problems,

three-fifths have mild or moderate mental health problems, and two-thirds have functional limitations.

- 44 percent of care coordinators view their primary role as conducting health screenings or needs assessments for members; two-thirds of care coordinators report that they meet with their clients on average several times a year.

Care coordinators experiences with Medicaid members with SUD:

- Among care coordinators who work with members with SUD, 36% learned about their client's SUD diagnosis through a health risk assessment screening and 31% learn through a referral from the member's MCO.
- Relative to care coordinators who had a low SUD caseload, care coordinators who worked with a higher SUD caseload were more likely to report doing a wide variety of treatment activities, including locating treatment providers, scheduling appointments, following up with members, and facilitating care transitions and peer support services.

Tools that care coordinators use for tracking Medicaid members

- Care coordinators report using Emergency Department/Hospitalization data, electronic health records, health risk assessments and claims data as the most common methods of tracking Medicaid members in their caseload.

Major barriers faced by care coordinators

- Size of case load, administrative burden and paperwork and finding resources for social services were the three challenges most cited by case workers as major barriers to successfully performing their role.

Job satisfaction among care coordinators

- Over 92% of care coordinators generally feel their work is "moderately", "a lot" or "extremely" meaningful, while over 43% report feeling burned out from work once a week or more.

2   INTRODUCTION

In Virginia, the majority of Medicaid members are enrolled in one of six managed care organizations, each of which provides a care coordinator for its members. The care coordinator's main role is to help ensure that Medicaid members can access the services that they need. Virginia's Department of Medical Assistance Services has encouraged the expansion of the role of care coordinators in multiple Medicaid programs. For example, the Addiction and Recovery Treatment Services (ARTS) incentivizes the creation of Preferred Office-Based Addiction Treatment providers (OBAT) to integrate SUD treatment services with other physical health and social needs.

In Virginia's Commonwealth Coordinated Care Plus program (CCC Plus), a managed long-term services and supports program, care coordinators serve a pivotal role in integrating and coordinating care services. CCC Plus serves some of Medicaid's most vulnerable members, including dually-eligible members with functional limitations and serious mental illness. In all programs, care coordinators are charged with assessing member needs, helping facilitate transitions in care, ensuring access to needed prescriptions and durable medical equipment, locating health and social resources, and navigating pre-authorizations and referrals.

To better understand the experiences of care coordinators, the specific types of care they provide to members, and the challenges they face in providing this care, DMAS contracted with Virginia Commonwealth University School of Medicine to conduct a web-based survey of Medicaid care coordinators. This survey of care coordinators was conducted from May to July of 2022 to help improve care for Medicaid members in ARTS. The objective of the survey was to obtain information on care coordinators' personal and professional backgrounds; client characteristics including major challenges; care coordinator activities, both generally and for members with SUD; tools used by coordinators for data gathering; and barriers faced by coordinators. The results of this survey are presented in this report.

3   METHODS

Lists of care coordinators employed by the six MCOs and their contact information were obtained from each MCO. These lists included the universe of care coordinators employed by the MCOs to serve Medicaid members, a total of 1,318. These include care coordinators primarily serving members enrolled in the CCC Plus program, members receiving SUD treatment and recovery services through the Addiction and Recovery Treatment Services (ARTS) benefit, members with serious mental illness, and others.

A REDCap database was designed to send out a web questionnaire to the 1,318 care coordinators, designed to take no longer than 10-15 minutes to complete. Care coordinators were sent the survey via email and received follow up reminders after ~30 days if they did not respond. A total of three reminders were sent.   Data collection began in late April 2022 and went through July 2022. We received 329 completed surveys for a response rate of 24%.

The REDCap database with the completed surveys was converted to a SAS file for the purpose of analysis. The report provides overall frequencies of the responses to the survey questions. Some questions allowed for "free responses" rather than a set choice of responses in order to allow for more in-depth understanding of certain responses. Verbatim answers for these free responses were recorded and analyzed. A selection of these responses is provided in Appendix A, with links to these responses included in the tables with the frequency results.

4   QUANTITATIVE RESULTS

4.1   CARE COORDINATOR DEMOGRAPHICS, TRAINING, AND PROFESSIONAL EXPERIENCES

4.1.1 : Demographic characteristics of care coordinators who responded to the survey

- The vast majority of care coordinators are female; about one-third are racial/ethnic minorities, and the majority are married.

- Almost all care coordinators have annual household incomes of $50,000 or higher.

	N	%
Gender		
Female	275	94.5
Male	15	5.2
Other	1	0.3
Race		
White	196	67.4
Black or African American	72	24.7
Asian	10	3.4
Other	13	4.5
Hispanic		
No	285	97.9
Yes	6	2.1
Age (median (IQR))	45 (38-52)	
Marital Status		
Never Married	47	16.2
Married	180	61.9
Separated	6	2.1
Widowed	3	1.0
Divorced	55	18.9
Household Income		
$25,000 - $49,999	9	3.1
$50,000 - $99,999	175	60.1
$100,000 - $149,999	73	25.1
$150,000 and more	34	11.7

4.1.2 Care coordinator professional experience

- Almost 60 percent of care coordinators are credentialed as nurses or mental health practitioners, and two-thirds have a bachelor's degree of higher.

- Most care coordinators (90%) have three or more years of experience as care coordinators, and about three-fourths have three or more years of experience as Medicaid care coordinators

	N	%
RN, LPN, Licensed Mental Health Practitioner		
No	117	40.2
Yes	174	59.8
BA or Higher in Human Services or related field		
No	94	32.3
Yes	197	67.7
Care coordinator experience: all time		
Less than 1 year	15	5.2
1-2 years	14	4.8
3-5 years	58	19.9
5-10 years	77	26.5
10+ years	127	43.6
Care coordinator experience: Medicaid		
Less than 1 year	32	11.0
1-2 years	33	11.3
3-5 years	149	51.2
5-10 years	57	19.6
10+ years	20	6.9

4.2 HOW CARE COORDINATORS WORK WITH MEDICAID MEMBERS

4.2.1 Medicaid caseload characteristics

- A majority of care coordinators serve members in either small cities or towns (25.9%) or rural areas (30.6%).

- The vast majority of care coordinators (84.6%) serve members in CCC Plus.

- The median caseload is 143 members. Two-thirds of care coordinators report that their caseload has increased in the past year, with one-third reporting that their caseload increased a lot. (See verbatim responses in Appendix A as to why their caseload increased a lot).

- Just under half of members that care coordinators serve (47.5%) are age 65 and over. Care coordinators serve members with a variety of physical and behavioral health problems and disabilities.

- Almost two-thirds of care coordinators reported that their caseload had increased a lot (33%) or somewhat (32.3%) over the past year. Much fewer reported that their caseload had decreased a lot (2.8%) or somewhat (13.4%).

	N	%
Primary Medicaid member region of residence[1]		
Southwest	47	14.5
Roanoke/Alleghany	63	19.4
Charlottesville/Western	77	23.8
Northern/Winchester	79	24.4
Central	99	30.6
Tidewater	72	22.2
Primary Medicaid member residential area		
Large city	55	17.0
Suburb near a large city	68	21.0
Small city or town	84	25.9
Rural area	99	30.6
Not sure	18	5.6
Primary Medicaid program		
Members enrolled in Commonwealth Coordinated Care Plus (CCC Plus)	274	84.6
Members with substance use disorders receiving services through the Addiction and Recovery Treatment Services (ARTS) benefit	8	2.5
Members with mental health problems	27	8.3

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[1] Multiple options allowed

	N	%
Members enrolled in Medallion 4.0	4	1.2
Other[2]	11	3.4
Number of members on case load		N
25th percentile		88
Median		143
75th percentile		208
Change in caseload over the past year (reasons for change included in Appendix A)	N	%
Caseload has increased somewhat	94	32.3
Caseload has increased a lot	96	33.0
Caseload has stayed the same	54	18.6
Caseload has decreased somewhat	39	13.4
Caseload has decreased a lot	8	2.8
Age distribution of Medicaid caseload		mean %[3]
Age 65 and over		47.5
Between 21 and 64		40.0
Less than age 21		11.4
Percent of Medicaid Caseload with		mean %[4]
Physical health problems, such as chronic conditions that require ongoing monitoring and treatment		77.1
Mild or moderate mental health problems, such as depression or anxiety		60.5
Severe mental health problems, such as bipolar disorder, schizophrenia, or other psychosis		40.1
Physical disabilities		62.9
Intellectual disabilities		28.5
Substance use disorders		30.7
Need for assistance with activities of daily life		66.4
Need for long-term services and supports		64.5

Other include: dsnp; ohcc no ltss; Medicaid no ltss; Mental health or community members; Patients enrolled in Commonwealth Coordinated Care Plus (CCC Plus) Patients with substance use disorders receiving services through the Addiction and Recovery Treatment Services (ARTS) benefit Patients with mental health problems; Patient enrolled in Medallion 4.0 with mental health problems; I am a supervisor of Care Coordinators who care for waivered members of the Commonwealth Coordinated Care Plus Plan. I do not have a caseload; All Lines of business. All caseloads listed; Emerging High Risk then Vulnerable Subpopulation with some Behavioral Health; Emerging High Risk then Vulnerable Subpopulation with some Behavioral Health

[2] Other include: dsnp; ohcc no ltss; Medicaid no ltss; Mental health or community members; Patients enrolled in Commonwealth Coordinated Care Plus (CCC Plus) Patients with substance use disorders receiving services through the Addiction and Recovery Treatment Services (ARTS) benefit Patients with mental health problems; Patient enrolled in Medallion 4.0 with mental health problems; I am a supervisor of Care Coordinators who care for waivered members of the Commonwealth Coordinated Care Plus Plan. I do not have a caseload; All Lines of business. All caseloads listed; Emerging High Risk then Vulnerable Subpopulation with some Behavioral Health; Emerging High Risk then Vulnerable Subpopulation with some Behavioral Health.

[3] Respondents indicated percent of Medicaid caseload with each of these characteristics; value is the mean of all responses

[4] Respondents indicated percent of Medicaid caseload with each of these characteristics; value is the mean of all responses

4.2.2 Care coordinator activities with Medicaid members

- The most frequent activities that care coordinators perform are health screenings or needs assessments (43.7%), work with members to identify specific health and service needs (25.2%), and monitor members' ongoing health problems and utilization of services (14.2%).

- Most care coordinators meet with members at least several times a year, communicate with them by email, and meet with members in their home as well as through telehealth.

	N	%
Primary role as care coordinate		
Review and/or approve requests for authorization of services by the MCO	4	1.3
Managing transitions to community-based care following discharge from a hospital stay, post-acute care, residential treatment center, or nursing facility (ask separately for each facility type).	19	6.0
Conduct health screenings or needs assessments for members	139	43.7
Work with members to identify specific health and service needs	80	25.2
Work with providers to identify specific health and social needs for members	4	1.3
Assist members with scheduling appointments with providers and arranging for transportation for them to get to their appointments.	2	0.6
Monitoring members' ongoing health problems and utilization of services	45	14.2
Other	25	7.9
Communicate with Medicaid members by email text message		
No	59	18.6
Yes	259	81.5
Percent of encounters in the last month with Medicaid members		mean %[5]
Going to the member's home and meeting with them in person		23.4
Visiting a member while there in a hospital, nursing facility, or other institutional setting		5.7
By telephone (audio only)		46.0
By video communications, such as Zoom (other typical telehealth apps)		25.5
Frequency of meetings with Medicaid members		mean %[6]
At least once a month		14.2
Several times a year		67.6
No more than once a year		15.4

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[5] Respondents indicated percent of clients with each of these characteristics; value is the mean of all responses
[6] Respondents indicated percent of clients with each of these characteristics; value is the mean of all responses

4.3 CARE COORDINATORS EXPERIENCES WITH MEDICAID MEMBERS WITH SUBSTANCE USE DISORDER

4.3.1 Identifying Medicaid members with substance use disorder (SUD)

- Most care coordinators identify members with SUD either through a referral by the MCO (31.3%) or through a health risk assessment (35.6%). Fewer care coordinators report that members request help with SUD or they are referred by healthcare providers.

- Time to initial appointment and convenience of treatment providers are important factors in getting members engaged with SUD treatment, while support of family, friends, and peers also often play an important role.

	N	%
How care coordinators learn about Medicaid members having a substance use disorder		
Member is referred by the MCO	87	31.3
Member is referred by healthcare provider	42	15.1
Member screens positive during a health risk assessment	99	35.6
Member requests help	50	18.0
Most important factor for member engagement with treatment		
Convenience of treatment providers to home	30	11.5
Time to initial appointment	96	36.6
Member satisfaction with quality of care	38	14.5
Support of family, friends or peers	57	21.8
Overcoming stigma of having a substance use disorder or people finding out	16	6.1
Other	25	9.5
Use EDCC reports to identify Medicaid members in the ED due to an overdose		
Yes	105	37.6
No	37	13.3
Don't know what EDCC reports are	137	49.1

Free Responses to other questions included in Appendix A:

- Specific steps taken if Medicaid member is decompensating or at increased risk of relapse
- How often care coordinator successful in getting Medicaid members with SUD into treatment
- How often care coordinator successful in getting Medicaid members with SUD to engage and stay with treatment
- Specific steps taken if a Medicaid member with SUD has a complex medical condition

4.3.2 Frequency of activities of care coordinators for members with SUD

- Care coordinators report that their most frequent activity is following up with members after an overdose, ED or inpatient visit related to SUD; 63% do so "always" or "often".

- Care coordinators report that their least frequent activity is facilitating admissions to residential treatment and MCO authorization for treatment. Only 12% reported facilitating admissions for residential treatment often or always, while 13% reported facilitating MCO authorizations often or always.

Percent of care coordinators who perform activity often or always for members with SUD

Activity	Percent
Hello locating providers	28%
Help schedule appts	19%
Monitor if members keep appt. and fill Rx	36%
Followup if member discontinued care	46%
Followup after overdose or acute hospital visit	63%
Facilitate admissions to residential treatment	12%
Facilitate care transition after residential treatment	16%
Facilitate MCO authorizations	13%
Assist with transportation for treatment	35%
Work with treatment providers	37%
Facilitate peer recovery services	15%

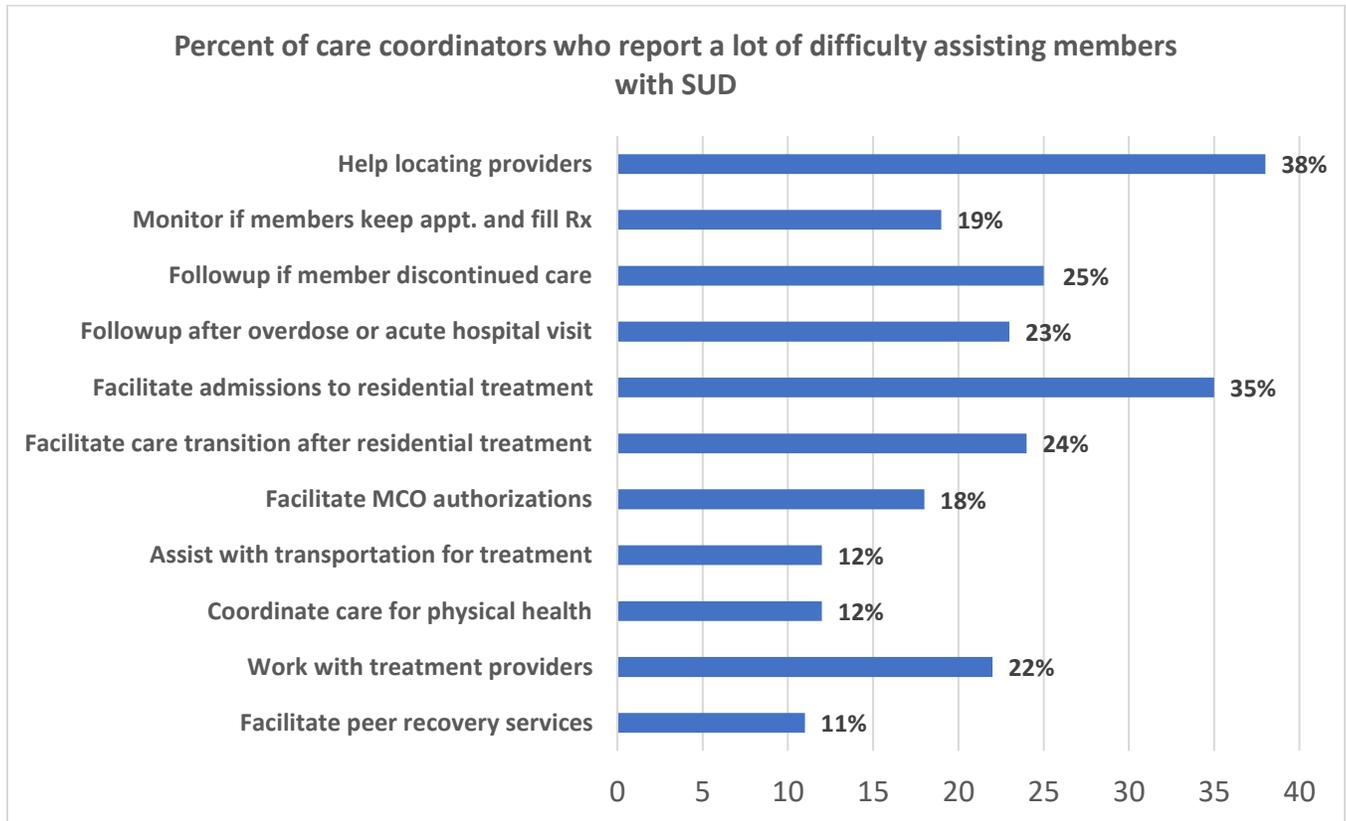### 4.3.3 Frequency of activities of care coordinators for members with SUD, by extent of SUD caseload

- Frequency of care coordinator activities is associated with SUD member caseload; care coordinators with a greater proportion of members with SUD (50% or more of total caseload) report performing SUD activities more frequently.

	Low SUD member load (<25% of members with SUD)		Medium SUD member load (25-45% of members with SUD)		High SUD member load (≥50% of members with SUD)		Overall	
	N	%	N	%	N	%	N	%
Help locating treatment provider or facility								
Never	18	14.6	10	15.2	6	7.4	34	12.6
Rarely	59	48.0	23	34.9	10	12.4	92	34.1
Sometimes	27	22.0	11	16.7	30	37.0	68	25.2
Often	12	9.8	19	28.8	30	37.0	61	22.6
Always	7	5.7	3	4.6	5	6.2	15	5.6
Help members schedule appointments with treatment providers								
Never	19	15.5	8	12.1	6	7.4	33	12.2
Rarely	48	39.0	25	37.9	15	18.5	88	32.6
Sometimes	38	30.9	23	34.9	37	45.7	98	36.3
Often	15	12.2	8	12.1	22	27.2	45	16.7
Always	3	2.4	2	3.0	1	1.2	6	2.2
Monitor if members are keeping appointments and filling prescriptions								
Never	18	14.6	8	12.1	5	6.2	31	11.5
Rarely	31	25.2	9	13.6	11	13.6	51	18.9
Sometimes	33	26.8	25	37.9	32	39.5	90	33.3
Often	31	25.2	21	31.8	23	28.4	75	27.8
Always	10	8.1	3	4.6	10	12.4	23	8.5
Follow-up with members if they have discontinued care or treatment								
Never	15	12.2	7	10.6	4	4.9	26	9.6
Rarely	31	25.2	5	7.6	15	18.5	51	18.9
Sometimes	26	21.1	21	31.8	23	28.4	70	25.9
Often	32	26.0	28	42.4	32	39.5	92	34.1
Always	19	15.5	5	7.6	7	8.6	31	11.5
Follow-up with members if they had an overdose, after an ED visit, or acute inpatient visit related to SUD								
Never	15	12.2	4	6.1	3	3.7	22	8.2
Rarely	23	18.7	10	15.2	4	4.9	37	13.7
Sometimes	16	13.0	10	15.2	15	18.5	41	15.2
Often	29	23.6	15	22.7	28	34.6	72	26.7
Always	40	32.5	27	40.9	31	38.3	98	36.3

	Low SUD member load (<25% of members with SUD)		Medium SUD member load (25-45% of members with SUD)		High SUD member load (≥50% of members with SUD)		Overall	
	N	%	N	%	N	%	N	%
Facilitate admissions to residential treatment								
Never	42	34.2	16	24.2	20	24.7	78	28.9
Rarely	48	39.0	30	45.5	23	28.4	101	37.4
Sometimes	21	17.1	14	21.2	25	30.9	60	22.2
Often	9	7.3	3	4.6	11	13.6	23	8.5
Always	3	2.4	3	4.6	2	2.5	8	3.0
Facilitating transition to outpatient treatment after discharge from residential treatment								
Never	44	35.8	19	28.8	13	16.1	76	28.2
Rarely	49	39.8	25	37.9	21	25.9	95	35.2
Sometimes	15	12.2	15	22.7	25	30.9	55	20.4
Often	9	7.3	3	4.6	19	23.5	31	11.5
Always	6	4.9	4	6.1	3	3.7	13	4.8
Facilitate MCO authorization process for treatment services								
Never	57	46.3	32	48.5	31	38.3	120	44.4
Rarely	36	29.3	18	27.3	22	27.2	76	28.2
Sometimes	17	13.8	7	10.6	15	18.5	39	14.4
Often	8	6.5	7	10.6	11	13.6	26	9.6
Always	5	4.1	2	3.0	2	2.5	9	3.3
Assist members in getting transportation to go to a treatment provider								
Never	18	14.6	3	4.6	4	4.9	25	9.3
Rarely	28	22.8	13	19.7	8	9.9	49	18.2
Sometimes	45	36.6	23	34.9	33	40.7	101	37.4
Often	24	19.5	20	30.3	30	37.0	74	27.4
Always	8	6.5	7	10.6	6	7.4	21	7.8
Work with treatment providers to coordinate needs (ie. housing, food, employment)								
Never	22	17.9	8	12.1	6	7.4	36	13.3
Rarely	36	29.3	13	19.7	8	9.9	57	21.1
Sometimes	31	25.2	21	31.8	25	30.9	77	28.5
Often	21	17.1	18	27.3	31	38.3	70	25.9
Always	13	10.6	6	9.1	11	13.6	30	11.1
Facilitate peer recovery support services								
Never	45	36.6	20	30.3	16	19.8	81	30.0
Rarely	45	36.6	19	28.8	20	24.7	84	31.1
Sometimes	21	17.1	19	28.8	24	29.6	64	23.7
Often	9	7.3	7	10.6	17	21.0	33	12.2
Always	3	2.4	1	1.5	4	4.9	8	3.0

4.3.4 Difficulties encountered assisting members with SUD

- Care coordinators experience the greatest difficulty in locating treatment providers and facilities for SUD patients (38%) and in facilitating their admission to residential treatment (35%)

- Care coordinators experience the least difficulty in assisting members with SUD getting transportation to a treatment provider (12%), coordinating care for physical health problems (12%) and facilitating peer recovery services (11%).

Percent of care coordinators who report a lot of difficulty assisting members with SUD

Category	Percent
Help locating providers	38%
Monitor if members keep appt. and fill Rx	19%
Followup if member discontinued care	25%
Followup after overdose or acute hospital visit	23%
Facilitate admissions to residential treatment	35%
Facilitate care transition after residential treatment	24%
Facilitate MCO authorizations	18%
Assist with transportation for treatment	12%
Coordinate care for physical health	12%
Work with treatment providers	22%
Facilitate peer recovery services	11%

4.3.5 Difficulties encountered assisting members with SUD, by size of SUD caseload

- Difficulties in assisting SUD members did not vary greatly by SUD member caseload

	Low SUD member load (<25% of members with SUD)		Medium SUD member load (25-45% of members with SUD)		High SUD member load (≥50% of members with SUD)		Overall	
	N	%	N	%	N	%	N	%
Help locating treatment provider or facility								
A lot of difficulty	29	34.1	15	30.6	33	47.1	77	37.7
Some difficulty	48	56.5	26	53.1	32	45.7	106	52.0
No difficulty	8	9.4	8	16.3	5	7.1	21	10.3
N/A	37		13		8		58	
Monitor if members are keeping appointments and filling prescriptions								
A lot of difficulty	14	16.7	16	31.4	9	12.7	39	18.9
Some difficulty	45	53.6	24	47.1	45	63.4	114	55.3
No difficulty	25	29.8	11	21.6	17	23.9	53	25.7
N/A	38		11		7		56	
Follow-up with members if they have discontinued care or treatment								
A lot of difficulty	20	23.3	17	32.7	15	22.1	52	25.2
Some difficulty	45	52.3	25	48.1	42	61.8	112	54.4
No difficulty	21	24.4	10	19.2	11	16.2	42	20.4
N/A	36		10		10		56	
Follow-up with members if they had an overdose, after an ED visit, or acute inpatient visit related to SUD								
A lot of difficulty	15	17.2	15	28.3	17	24.6	47	22.5
Some difficulty	48	55.2	24	45.3	43	62.3	115	55.0
No difficulty	24	27.6	14	26.4	9	13.0	47	22.5
N/A	35		9		9		53	
Facilitate admissions to residential treatment								
A lot of difficulty	17	35.4	13	37.1	17	32.1	47	34.6
Some difficulty	25	52.1	16	45.7	27	50.9	68	50.0
No difficulty	6	12.5	6	17.1	9	17.0	21	15.4
N/A	74		27		25		126	
Facilitating transition to outpatient treatment after discharge from residential treatment								
A lot of difficulty	14	25.5	10	27.8	11	19.3	35	23.6
Some difficulty	30	54.5	18	50.0	33	57.9	81	54.7
No difficulty	11	20.0	8	22.2	13	22.8	32	21.6
N/A	67		26		21		114	

	Low SUD member load (<25% of members with SUD)		Medium SUD member load (25-45% of members with SUD)		High SUD member load (≥50% of members with SUD)		Overall	
	N	%	N	%	N	%	N	%
Facilitating MCO authorization process for treatment services								
A lot of difficulty	8	16.0	6	22.2	7	17.5	21	17.9
Some difficulty	24	48.0	12	44.4	18	45.0	54	46.2
No difficulty	18	36.0	9	33.3	15	37.5	42	35.9
N/A	72		35		38		145	
Assist members in getting transportation to go to a treatment provider								
A lot of difficulty	11	12.4	5	9.4	9	12.5	25	11.7
Some difficulty	38	42.7	24	45.3	31	43.1	93	43.5
No difficulty	40	44.9	24	45.3	32	44.4	96	44.9
N/A	33		9		6		48	
Work with treatment providers to coordinate care for physical health problems								
A lot of difficulty	7	8.8	6	13.0	11	15.7	24	12.2
Some difficulty	37	46.3	22	47.8	37	52.9	96	49.0
No difficulty	36	45.0	18	39.1	22	31.4	76	38.8
N/A	42		16		8		66	
Work with treatment providers to coordinate needs (ie. housing, food, employment)								
A lot of difficulty	14	16.5	10	21.7	19	27.9	43	21.6
Some difficulty	41	48.2	19	41.3	31	45.6	91	45.7
No difficulty	30	35.3	17	37.0	18	26.5	65	32.7
N/A	37		16		10		63	
Facilitate peer recovery support services								
A lot of difficulty	6	11.3	4	11.4	6	10.0	16	10.8
Some difficulty	31	58.5	11	31.4	23	38.3	65	43.9
No difficulty	16	30.2	20	57.1	31	51.7	67	45.3
N/A	69		27		18		114	

4.4 TOOLS THAT CARE COORDINATORS USE TO ASSIST MEDICAID MEMBERS

4.4.1 Helpfulness of tools used to track Medicaid members in case load

- Care coordinators most commonly use ED and hospitalization data and health risk assessments to track Medicaid members

- Care coordinators rarely use ED care coordination and Medicaid discontinuation data

- Care coordinators find ED and hospitalization data, health risk assessments and electronic health records to be the most helpful tools

| | Helpfulness of tool | | | | | | | |
| | Do not use | | Very helpful | | Somewhat helpful | | Not helpful | |
	N	%	N	%	N	%	N	%
Plan of Care/ICP	26	8.3	108	34.5	103	32.9	76	24.3
MTR data	57	18	140	44.3	97	30.7	22	7
ED Care Coordination	165	53.2	84	27.1	43	13.9	18	5.8
Electronic health records	49	15.6	184	58.4	59	18.7	23	7.3
Claims data	30	9.4	166	52.2	99	31.1	23	7.2
Health Risk Assessment	20	6.3	185	58.4	81	25.6	31	9.8
Medicaid discontinuation data	176	56.4	69	22.1	49	15.7	18	5.8
ED/Hospitalization data	13	4.1	210	65.6	74	23.1	23	7.2
High risk score	101	32.1	91	28.9	75	23.8	48	15.2
Own tracking system	121	39.8	136	44.7	26	8.6	21	6.9
Other[7]	130	93.5	5	3.6	2	1.4	2	1.4

Free Response included in Appendix A:

- [Greatest information gaps or data needs that are essential for care coordinators to be able to track how Medicaid members are doing](#)

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[7] i keep up with members going to ED and all those referred to other depts; other report like SDOH, waiver report; these members do not want help; Prior assessments on known members; Prior assessments on known members; Collective Medical; I keep my own Spread sheet to help me stay organized

4.5 MAJOR BARRIERS FACED BY CARE COORDINATORS

4.5.1 Perceived barriers to performing care coordinator role

- Care coordinators say that the size of their caseload, the extent of administrative paperwork, and finding resources for social services are the greatest obstacles in assisting Medicaid members.

- While over three quarters of care coordinators report that non-COVID regulatory changes from DMAS are somewhat of a problem or a major problem, less than half of care coordinators say the same about COVID-related regulatory changes

	Major problem		Somewhat of a problem		Not a problem	
	N	%	N	%	N	%
COVID regulation changes	71	22.8	104	33.4	136	43.7
Accuracy of data on file and ability to reach members	123	38.2	132	41.0	67	20.8
Information transfers after member changes health plan	123	38.3	124	38.6	74	23.1
non-COVID frequently changing regulations from DMAS	114	35.5	127	39.6	80	24.9
COVID regulation changes	45	14.1	113	35.4	161	50.5
Administrative burden and paperwork	160	50.0	102	31.9	58	18.1
Size of caseload	186	57.9	67	20.9	68	21.2
Lack of integrated data systems for member social services	123	38.3	117	36.4	81	25.2
Finding resources for social services	147	45.8	116	36.1	58	18.1
Finding in-network specialists for physical health problems	132	40.9	112	34.7	79	24.5
Finding in-network providers for mental health treatment	135	42.1	117	36.4	69	21.5
Finding in-network providers for SUD treatment	121	37.8	111	34.7	88	27.5
Finding in-network providers for LTSS	116	36.3	108	33.8	96	30.0
Delays in appointments/admission to treatment facilities	118	37.3	128	40.5	70	22.2
Delays in authorization from MCO for services	54	16.8	119	37.1	148	46.1
Other	17	13.3	4	3.1	107	83.6

4.6 CARE COORDINATORS FEELINGS ABOUT THEIR JOBS

4.6.1 Satisfaction with being a care coordinator

- Over 85% of care coordinators find their work at least moderately meaningful and feel worthwhile at work

- Over 40% of care coordinators feel burned out from work on at least a weekly basis

	N	%
I feel worthwhile at work		
Not at all	15	4.7
Very little	31	9.7
Moderately	107	33.5
A lot	102	32.0
Extremely	64	20.1
My work is meaningful		
Not at all	2	0.6
Very little	22	6.9
Moderately	72	22.6
A lot	116	36.4
Extremely	107	33.5
I feel in control when dealing with difficult problems or people at work		
Not at all	16	5.0
Very little	39	12.2
Moderately	132	41.4
A lot	92	28.8
Extremely	40	12.5
I feel burned out from my work		
Never	26	8.2
A few times a year or less	86	27.0
Once a month or less	70	21.9
Once a week	48	15.1
A few times a week	48	15.1
Every day	41	12.9

APPENDIX A: SELECTED VERBATIM RESPONSES

Table 2: Reasons for change in caseload

Our team, and most teams, was carrying caseloads over ratio for the majority of the past couple of years; Virginia Premier was able to finally hire new care coordinators over the past few months, which helped tremendously. Our caseloads are now either at, or below, ratio. However, even with 155 members, it is still quite stressful and overwhelming, because Care Coordinators are now doing tasks that the Social Workers used to do (assisting with locating housing for example). We have been delegated significantly more job duties over the past year, and I think I can speak for most Coordinators when I say that we easily get burned out trying to stay caught up. It can be difficult at times to give excellent quality care, while at the same time keeping up with assessment requirements. I personally really enjoy talking with my members and allowing them the time they need; however, with the constant pressure of completing a certain number of assessments per week, this can often be hard to do. I just don't want my members to ever feel 'rushed' during conversations, nor, assessments. They deserve quality care and time....and in order to provide both, it is easy to fall behind on the countless other tasks.
Lack of staffing due to stress and low compensation for care coordinators that are not nurses, high caseloads, too many tasks put on the care coordinator and not being able to take care of members as we would like. Hard to manage EDCD waiver and SMI individuals with this high of a case load. My case load has been between 230-270.
Staff keep leaving, RNs are given ridiculously low caseloads even though the amount of tech waivers are near zero so caseloads should be equal, DMAS refuses to let DSNP members who are UTC or Refuse HRAs to be moved to telephonic case managers so they remain on our caseload, the current UTC process is impossible to meet with this caseload meaning members who could be transitioned off my caseload as UTC cannot be because I cannot get a drive by in within the 14 day timeframe as my caseload covers a large jurisdictional area. Members are noted as having MH issues and needing face to face CC when they have common diagnoses such as Depression/Anxiety and it is managed by their PCP, which should not be considered as MH needing face to face CC but is with the MMHS screenings
I now handle dual members which in some cases doubles the work and caseload
Partially due to needing more staff, and partially due to influx of members from Medicaid expansion. I work in SMI and have also seen an increase correlating with the pandemic as well.
No Medicaid disenrollment during the pandemic. More people struggling financially and qualifying for Medicaid. More individuals struggling with mental illness require assignment to my Behavioral Health team.
Not enough staff, unorganized caseloads, members being put in the incorrect populations
We had Care Coordinators resigning all the time. I'm in the Roanoke/Allegany region and I was covering 15 members near D/C and 11 more in the Southwest regions plus my own 75. We did this for over 9 months. It was so stressful. We were told to do the F2F over video chat instead of in person. If the member had no way to video chat we were supposed to report the member refuse to complete the assessment. We have been working 40 hours of overtime each month for about 9 months. My case load finally went back to 75 this month but we are all so far behind its crazy.
The number of individuals who now qualify for Medicaid has increased. Many of the medical and behavioral health needs has increased, though the services provided in the community, especially in my area of Roanoke, has not increased. Many go without the needed services for months, which then lead to increase in hospitalizations and/or ER visits.
We are short staffed and they just keep assigning certain care coordinators members. Some of our NCM's only have 135 members to my 211. There is another CC with 260+. It's truly unfair and does not help our members. I

feel that I cannot adequately do my job at this large of a caseload. I have expressed this, but only get excuses, no assistance. My mental health is being affected as well.
I believe it is due to the low amount of case worker at the moment causing my case load to increase significantly. The burnout rate of case workers is extremely high and has caused people to quit and the case load of current case workers to increase.

Table 4: Other activities performed by care coordinators for Medicaid members

ALL OF THE ABOVE: twice year assessments for eligibility/needs, working with providers to identify and ensure needs are meet, work with and follow up with members monthly/quarterly to assess if needs are met or any new needs have occurred.
As an IDDD coordinator I interpret coordination of benefits (Medicare, Tricare, ID/DD Waiver Vs Medicaid) to assist with medication, medical equipment, provide assistance with locating provider with appropriate insurance, navigation crossover rules (Medicaid copayment to Medicare CMS rules), assisting with authorizations and appeals, and explaining to providers the course for grievances.
Nursing facility members. Visiting the facilities, seeing the members, asking what their needs may be. Making sure they are having the best care for where they are. Some members cannot tell you what the needs are for them you have to observe and spend time helping them on an individual basis.
Conduct health screenings or needs assessments for patients Work with patients to identify specific health and service needs Work with providers to identify specific health and social needs for patients Assist patients with scheduling appointments with providers and arranging for transportation for them to get to their appointments. Monitoring patients' ongoing health problems and utilization of services

What specific steps do you take (if any) when you learn that a Medicaid member is decompensating or at an increased risk of relapse?

Notify providers, sometimes contact ED
I would reach out to member's support and providers to arrange treatment for member. I will refer member to treatment facilities and/ or meetings
In my territory, there are limited providers and those we have continue to utilize Telehealth which the majority of my members hate. They need F2F contact and are dying for attention. I encourage a home visit to conduct assessment and develop a care plan and address coping skills and environmental changes.
Seek to initiate contact with provider/member Look to increase Level of Care
Discuss with my manager for services and resources available
1. I facilitate a good rapport with member and their families as much as possible (or as much as they will allow) 2. I rely on family members at times to provide indicators of increased risk of relapse. 3. I monitor EDCC reports to check for high ED utilization 4. I call the providers as needed to ensure patient is attending apts as scheduled. 5. I schedule a F2F meeting with member or try to at least speak with them via telephone to get them reengaged with their providers and in compliance with necessary treatment.
I would connect the patient to crisis or get an ECO if needed.
If member on current caseload, then UM will identify, or ED case management identifies the risk then outreach is attempted
Immediate phone contact to member, 3 calls, send a letter, 3 more calls, a drive by, then a second letter.
I offer substance use treatment options I have a list of outpatient (CSB and Human Services) and inpatient facilities, the National substance use Hotline, Peer Supports and i will confer with my team of SMI CM's on possible resources for my member. I will offer mental health skill building if the member has been IP and I provide a list of providers. Also, I will present this member in rounds in order to get ideas or different approaches to help the member before the member has a relapse.
I request reassignment to the appropriate team.

How often do you believe you are successful in getting Medicaid members with SUD into treatment?

I have to rely on ARTS staff as I do not have time to dedicate to SUD patients due to high level of need of my other members. There is too much emphasis on doing assessments as we have a quota to reach each month and its become very stressful. There is limited bed availability and SA providers often do not work well with us as far as care coordination.
If the member is intrinsically motivated to engage in relevant SUD treatment services and provides informed consent for me to assist them with linkage to SUD services, getting the member into SUD treatment is typically successful, however this is rarely the case and the vast majority of the members identified as likely in need of SUD treatment whom we attempt to engage in care coordination assistance with are unable to be contacted, do not return our calls, are unwilling or unable to engage in some or all of the recommended SUD treatments and services available to them, or decline offers of assistance with linkage to SUD providers. It should also be noted though that the primary barriers that most of the members we serve who have significant BH, SUD, or co-occurring BH/SUD treatment needs face revolve around unstable and unmet SDOH needs, specifically housing insecurity/homelessness/financial insecurity/food insecurity/traumatic exposure, etc. I've been working with Virginia Medicaid patients and populations with BH/SUD needs for almost 20 years and am well-versed in all of the primary challenges impeding this population's ability to heal, transcend, and legitimately self-actualize. The only way this will ever be possible must begin with adequate access to affordable housing, food, and all other basic needs minimums humans require in order to survive. Evaluating SUD treatment linkage assistance success rates is therefore functionally meaningless as a metric unless we begin adequately addressing these primary underlying SDOH needs first.
Not very often, I would say 15% of the time. I have received a lot of push back from members regarding their SUD depending on their stage of addiction. Most members have stated housing being one of the biggest barriers and the lack of housing resources has made assisting difficult.
Rarely....we have very limited BH/ARTs assistance within our MCO. (ex: member who inquired about ETOH treatment/IP. BH/ARTS team provided a directory of facilities for the MEMBER to contact to inquire about admission. Member was actively utilizing ETOH and did not have the ability to reach out to facilities. If my caseload wasn't so overwhelming, I would have happily assisted.)
Not very. Facility bed placement is difficult to find, and members are often reluctant if they have already attempted treatment at a facility unsuccessfully.
45-50% of the time. The biggest problem is if members do not receive treatment immediately when ready to accept it, you can lose them and not be able to reach them for a while because they have relapsed and are not ready for treatment at that time.
The SUD treatment in my area is poor. The standard of care is to keep them in the Methadone or Suboxone program. Many of my members complain that they are substituting heroin etc...with methadone or suboxone. I don't feel successful at all, this is very depressing when you are boots on the ground and seeing such human suffering.
Most of the time when member is open to treatment it is hard to get connected with provider (especially when member is requesting IP treatment) before they back to precontemplation and decline treatment.
Maybe 20 % of the time. I have a homeless population that often leaves AMA from treatment centers and relapses

How often do you believe you are successful in getting Medicaid members with SUD to engage and stay with treatment?

It is not a very high success rate. I do not have time to follow up as needed and provide the care that these members need, this MCO dissolved the specific ARTS care coordination team that focused solely on members only with SUD needs
Very poor, many members struggling with SUDS, have children and can't go to outpatient treatment, 5 hours a day, 5 days per week. This population depends on Medicaid transport which is completely unreliable and word has spread quickly in my area. Many of my members complain that they receive judgement from the providers and are treated as sub human beings. The 'one size fits' all approach is not working with most
no attempts, a lot of members say they are open to treatment but will refuse services when offered
I have been very successful, if the resources are available and I encircle my members with a very strong support system from all realms of care, Medical, BH or SA.
I would say successful outcomes are difficult to assess, because SUD patients are difficult to remain in contact with. They are often do not answer the phone, do not keep their phone turned on, and have difficulty maintaining stability in a residence. We also refer member to different people within the organization for special follow up.
10% of the time. Usually if a member is unsuccessful I am not informed until they have already left their treatment program.
It is difficult to get members to continue to engage, as they often feel that they are successful upon completion of IP treatment and refuse to complete OP services to help maintain sobriety.
Maybe 5% but that is because they have decided that they have had enough of living with SUD and want to get better or they find housing or they get sick. Generally it is another life event that leads to a member staying engaged in SUD treatment. As a case manager for SMI i am there to provide resources and assistance but rarely do I personally have the ability to help a member stay in treatment. There are NOT enough treatment options for members and rarely is it even possible to get a member in treatment without them being hospitalized. There are not many outpatient options for members in Tidewater and often times there are waits and the members get the run around. Often members only get services when they go to the ED. Unfortunately, that is how the system is set up.
I feel that if a member actually goes to treatment or IOP programs, or behavioral health programs typically they have a good chance of staying active with the program because they have took that step and they feel supported.

Table 5: Most important factor for successful engagement- other

In my experience ,if the member is living in the community/not inpatient, they need a clinician to reach out very frequently, daily or every other day, for reminders/reassurance, redirection. There is not staff/funding/services available in our area to provide that level of support, unfortunately.
Self-motivation and the willingness to engage in treatment, The member can have all of the other things mentioned in place but nothing helps unless the member is a willing participant in their own treatment and goals.
All of the above are important factors, though the accessibility of treatment providers that accept Medicaid is the biggest barrier next to not having any beds available.
Patient desire to accept assistance and treatment
Patient with SUD wanting to seek treatment and it not being court or coercion from natural supports. It is also very important they go directly from hospital/detox to a residential treatment facility and have support following discharge.
If hierarchy of needs are met. In my area members are usually focused on meeting daily needs like food and housing before they can worry about treating their substance use issue.
There are multiple factors, but the top two would be how quickly they can get in, and how long the program lasts. Another is also whether or not they also offer high risk detox as well

What specific steps do you take when you learn that a Medicaid member with substance use disorder also has a complex medical condition? (ie. chronic physical or mental health problem - that requires ongoing attention and follow-up)

If the member is cooperative and will participate in care coordination, I assist member to schedule appointments and contact providers as needed. Education also plays a large role. Sometimes it is a chronic illness that will help member to get clean
We get notified of member admissions to EDCD program by the member's assigned CC or via the daily census. The CC will get notified of member and then refer to out EDCD LTSS program. Then I would pick up the member when admitted to the hospital or SNF
If pain is related to the chronic condition that must be addressed first. Using physical activity and medication management to engage them in their own health management at first. Frequent calls if receptive to contact.
Complete the face to face assessment to gather all information needed, set up ICT to collaborate with providers, staff the case with the team in rounds. Develop care plan with member and determine how frequently contact is needed.
Make sure that member reveals SUD to treating and prescribing physicians. Provide education about the danger of mixing prescription and recreational/street drugs. Part of our assessment asks the patient if we have their permission to share this kind of information with their primary care physician. If they say no- make that an ongoing goal to keep discussing and addressing barriers.
Address physical / mental health problems. A lot of members in pain self medicate with substances. Attempting to manage pain with pain specialist/peer supports etc. is beneficial.
Establishing a rapport with the member, completing an HRA assessment, developing service plan goals, and follow up.
Review clinical information when available (I rarely have access to discharge clinicals these days) to see if there is a treatment plan and/or follow-up appointments. Review the follow-up appointments with the member if I can get in contact with them for the post ER follow up call. Ensure member is aware of discharge appointments. Assess the member's understanding of their complex medical condition. Provide contact information for specialists if needed. Provide education re; the effects of alcohol or substance use on medication adherence, efficacy and possibility for adverse interactions. Review to see if member needs a referral to an internal program for chronic health conditions where a specialized care coordinator can discuss the specific impacts the alcohol or substance use have relative to the chronic or complex condition. New chronic conditions may require a triggering assessment and revision to the Plan of care and an ICT meeting
Review my concerns about worsening medical conditions if ongoing drug use. Review their level of support in the home and community and try and link to healthy supports. Provide hotlines for after hours.
There are a few facilities in this area who offer comprehensive care for SUD patients - they have providers on-site who can treat the whole person. This has been a valuable asset for this category of patients. I can also request a complex-care RN within the MCO to also follow the member's case to ensure all medical concerns are being addressed. Unfortunately, most of the time, I find when a patient has ongoing substance use disorder difficulty they remain less focused on the physical health needs and often engage in activities that continue to have a negative health effect.

Table 6: What specific steps do you take when you learn that a Medicaid member has been in the ED due to an overdose or other SUD-related problem?

Refer to ARTS, facilitate a provider for follow up or outpatient treatment facility. Assist in gathering resources like food and housing.
I obtain the discharge summary from the facility to see what was done medically for the member to stabilize the member. I also follow up with the behavioral health provider that the member was referred to. I check to see if the provider is in-network and if the provider can provide the correct services that the member is in need of. I will contact the provider to offer a history and to assist with safe discharge planning.
I read the notes from transition coordinator and read any hospital records and I also sometimes call the facility. I always call member after discharge and attempt to do a triggering assessment.
Contact the medical staff.
Attempt to reach facility to discuss dc planning needs, attempt to reach member within 30 days following dc to discuss discharge appointments (would like to be able to reach out to member within one week but due to case load, its typically near the end of the 30 day period), reach out to case manager at CSB to inquire about member follow up if unable to reach member. No BH assistance within MCO other than providing case managers with directories of in network specialist (which our MCO Case managers already have access to therefore we very rarely reach out to our BH case management team any longer. If we attempt to refer a member to our ARTs/BH care coordinators, we typically receive a message from our BH staff within the MCO stating that the ARTS/BH team will not accept the referral to work with the member due to the member NOT currently being enrolled in ARTS/BH services---which is the entire reason we were attempting to refer the member to the ARTs/BH team: for assistance connecting the member to BH/ARTS services).
Place call the member for follow up and offer assistance with locating services. Sometimes, I speak with providers at the ED to learn more about the nature of the problem
Talk to patient, assess motivation and desire for assistance. Provide education and information about substance abuse, specific dangers of their particular patterns of abuse, etc. Continue to track discussion and education despite initial resistance. If patient wants assistance, refer to health plan ARTS program and/or community services such as where to find 10-step programs.
Recommend psychiatric care services and help them find the services
Take case to high-risk rounds with Medical Director; contact and collaborate with outpatient and inpatient providers

What are the greatest information gaps or data needs that you believe are essential for care coordinators to have for keeping track of how Medicaid members are doing?

Valid member contact information is at the top of this list and far above most other needs. Discharge summaries. If would be great if Collective Medical tracked psychiatric and ARTS admissions.
From my perspective, we do not get enough Clinical Information (ex: MD progress notes from the hospital or SNF, Progress notes from HH, etc) The information is supposed to be in the Collective Medical/Pre-Manage system, but there never is anything from the hospitals to review. Also not having all the clinical information and authorization info in one place doesn't help efficiency.
We really need a SINGLE system or database that can show us, on every member: 1) number of hospitalizations (with details) or ER visits 2) medications as of last pharmacy fill 3) diagnoses 4) services in place 5) list of providers member has seen in the last 12 months This would GREATLY reduce administrative burden and double work.
When a patient has expired, there is no communication to the CC, which can cause trauma to the members family when calling to schedule an appointment or following up with a member
Data is documented; however care coordinators don't receive education regarding what all UM and claims definitions mean, or how to read and interpret what is documented; that would allow CC's to assist providers and members with updated information and the status of submitted requests.
lack of phone # in the system for calling hospital, doctors, mental health provider, and the member # of UTC population. Etc
Follow up reports from BH providers. Monthly or ongoing communication with BH providers with outside agencies would be very benefical
Biggest gaps are that so few members only have Medicaid as their insurance so they have 1-2 other primary insurances that we are unable to track the care and services billed through other insurances. routine touchpoints with members are helpful to document their input on their tx.
The main focus to do HRA/ICP is outdated and consumes the majority of CC's focus and time (90% of our day to day work flow) and takes away CC's from actually being available to members when they call in for urgent needs. CC's time would be better utilized focusing on outreaches associated with noncompliance and HEDIS measures and being more available for the members when they have needs to be addressed and assisted with.
We need access to Medicare records for our Dual Enrolled members. We miss a lot of information without having access to that side of the coin.
There needs to be a more logical and easy way to track hospitalizations/transfers. It is ridiculous how hard and time consuming it is to find out information on hospitalizations or discharge dates. I have often not found out until the member calls me, and the current systems are not updated.
Members discharged from NF to Hospital or home with no notification

Table 9: Barriers to performing care coordinator role- other

Transportation is a huge issue. Transportation providers are not held accountable when they fail to pick up a member. When a provider cancels a trip, they never let the members know. Only when members call back to say their provider hasn't come do they find out that there is no one available to take them. By then, it is too late and they miss appointments
Finding in-network providers for dental treatment
Caseloads are not manageable. It is unrealistic to have so many cases and be effective and provide quality services.
lack of providers willing to support members with intellectual and developmental disabilities
When a member is placed on a plan with an MCO such as the CCC+ waiver the UAI should be provided. All of these UAIs have to be uploaded via the DMAS portal - so they have them all yet we waste time having to track them down, especially when attempting to initiate services for new members.
Mixed caseloads: The division I work within at our MCO manages CCC plus, DSNP, and DSNP only--my caseload has so many different types of members with different types of benefits and waivers that it is impossible to remember all of the different documentation needs and benefits.

APPENDIX B: ANALYSIS OF ACTIVITIES REPORTED AS "NEVER" BEING DONE BY CARE COORDINATORS

Care coordinators were asked about the frequency of completing various activities for members with SUD. The results below show the **percentage of respondents who reported never performing the following activities**, among care coordinators who indicated that ARTS was their primary program or that they had at least one percent of members with SUD (Table 6):

- Help locating treatment provider or facility- n=34- 12.6%
- Help members schedule appointments- n=33- 12.2%
- Monitor if members are keeping appointments- n=31- 11.5%
- Follow up with members if they have discontinued care or treatment- n=26- 9.6%
- Follow up with members if they had an overdose, after an ED visit or acute inmember visit related to SUD- n=22- 8.2%
- Facilitate admission to residential treatment, n=78- 28.9%
- Facilitating transitions to outmember treatment after discharge from residential treatment, n=76- 28.2%
- Facilitate MCO authorization process for treatment services, n=120- 44.4%
- Assist members in getting transportation to go to a treatment provider, n=25- 9.3%
- Work with treatment providers to coordinate needs, n=36- 13.3%
- Facilitate peer recovery support services, n=81- 30%

Facilitating MCO authorization for treatment services, facilitating peer recover support services, facilitating admission to residential treatment and facilitating transitions to outmember treatment after discharge from residential treatment were the four activities that care coordinators reported never completing (28.2% to 40% reported "never" doing each of these activities). Table 1 shows the number of activities per care coordinator that care coordinators report "never" completing.

Table 1: Number of activities that care coordinators report never completing per coordinator

Number of "never" activities"	Frequency	Percent
0	118	41.7
1	55	19.4
2	31	11.0
3	16	5.7
4	19	6.7
5	9	3.2
6	9	3.2
7	5	1.8
8	3	1.1
9	3	1.1
10	6	2.1
11	9	3.2

58 percent of care coordinators report never completing at least 1 of the 11 queried activities. 28 percent of care coordinators reported never completing 3 or more activities. In comparing care coordinators who indicated they never completed 3 or more activities versus care coordinators who reported never completing 0, 1 or 2 activities, there were differences between these groups based on gender, race/ethnicity, marital status, income, professional

background, years of experience, size of caseload, change in caseload in the past year, or health plan. Additionally, no differences in any of these characteristics were seen comparing care coordinators who reported completing all activities versus those who reported not completing 3 or more activities.