

Wisconsin State Plan to  
Serve More Children and Youth  
within Medical Homes  
*Including those with special health care needs*



Wisconsin Title V Children  
and Youth with Special  
Health Care Needs Program

# Acknowledgments

The Wisconsin Children and Youth with Special Health Care Needs Medical Home Systems Integration Project Team wishes to acknowledge the contribution of many parents and professionals statewide to this plan. In addition to the Medical Home Implementation Team partners listed below, contributions were also made by numerous Wisconsin Maternal Child Health Program collaborators with additional guidance from leadership from the Federal Maternal Child Health Bureau, National Academy for State Health Policy and the National Improvement Partnership Network.

## Wisconsin Medical Home Implementation Team Partners

Wisconsin Department of Health Services

Division of Health Care Access and Accountability

Division of Public Health

Family Health Section

Children and Youth with Special Health  
Care Needs Program

Maternal Child Health

Minority Health Program

Division of Long Term Care

Birth to 3 Early Intervention Program

Office of Children's Mental Health

Wisconsin Department of Children and Families

Bureau of Milwaukee Child Welfare

Home Visiting Program

Wisconsin Department of Public Instruction

Head Start Program

ABC for Health

American Academy of Pediatrics, Wisconsin Chapter

Children's Hospital of Wisconsin

Children's Community Health Plan

Children's Health Alliance of Wisconsin

Foster Care Medical Home Program

Northeast and Southeast Regional Center  
for CYSHCN Programs

Parent to Parent of Wisconsin

Wisconsin Statewide Medical Home

Initiatives Program

Chippewa County Health Department

Western Regional Center for CYSHCN Program

Great Lakes Intertribal Council

Group Health Cooperative of South  
Central Wisconsin

Gundersen Lutheran Health System  
Wisconsin First Step

Family Voices of Wisconsin

Marathon County Health Department  
Northern Regional Center for  
CYSHCN Program

Marshfield Health System

Medical College of Wisconsin

Ministry Medical Group

United Healthcare Community Plan

University of Wisconsin Health

University of Wisconsin-Madison

Waisman Center

Southern Regional Center for  
CYSHCN Program

Youth Health Transition Program

Wisconsin Council on Children and Families

Wisconsin Primary Health Care Association

# TABLE OF CONTENTS

Letter from Secretary Rhoades .....	4
Executive Summary .....	5
Background.....	6
Strategic Plan Framework.....	13
Understanding and Promotion.....	14
Performance and Quality .....	27
Financing.....	45
Appendices	
1. MHIT Members.....	53
2. MHIT Vision and Mission.....	57
3. Evaluation Measures Listed by Objective .....	58
4. Theory of Change Diagram .....	60
References .....	61



# Wisconsin Department of Health Services

---

Scott Walker, Governor  
Kitty Rhoades, Secretary

October 2015

As Secretary of the Department of Health Services, I am pleased to share a copy of the Wisconsin Medical Home State Plan with you. This plan reflects the input of families, health care providers, payers, and our state and community partners who as members of the Medical Home Implementation Team have shared their stories and ideas to help create this plan.

The Wisconsin Medical Home State Plan was developed with the intent to increase the number of children and youth with special health care needs who receive care within a Medical Home. With the urging of the Medical Home Implementation Team, the plan's purpose was expanded to include all Wisconsin children.

We know that health care provided within the context of a medical home offers comprehensive, patient-centered, team-based and accessible care, which leads to better outcomes and increased family satisfaction. The Wisconsin Medical Home State Plan identifies strategies and action steps for families, clinicians, and systems of care each with objectives, timelines, and measures.

As you read the plan, I hope that you identify action steps that you can take so that together we can make a Medical Home a reality for all of Wisconsin's children.

Sincerely,

A handwritten signature in cursive script that reads "Kitty Rhoades".

Kitty Rhoades

Secretary

# Executive Summary

The Wisconsin Department of Health Services' Children and Youth with Special Health Care Needs (CYSHCN) Program received notification of funding for a 3-year grant project titled the *Wisconsin CYSHCN Medical Home Systems Integration Project* beginning September 1, 2014. Funded by the federal Maternal and Child Health Bureau of the Health Resources and Services Administration, this project aims to increase the number of CYSHCN served within a medical home by 20% or approximately 17,735 more CYSHCN by September 2017. The most recent National Survey of CSHCN (2009-2010) estimated approximately 200,000 Wisconsin children have special health care needs, and 44% of them receive care within a medical home. Care within a medical home is typically provided by a primary care clinician and his or her care team, in partnership with parents. Health care outcomes and family satisfaction are consistently higher for children served within medical homes.

This state plan was written to outline steps to achieve more children receiving care within medical homes, along with associated measures to track their accomplishment. The Department of Health Services (including Public Health and Medicaid) and statewide health care and community resource professional leadership met four times from January to July 2015 to identify strategies to be considered for inclusion in the State Plan. In addition, guidance was offered from the National Academy on State Health Policy, National Improvement Partnership Network, and the Wisconsin Maternal Child Health Bureau needs assessment process. The plan identifies three strategic areas: Understanding and Promotion of Medical Homes; Performance and Quality; and Financing. Strategies target families, clinicians and systems in an effort to achieve the goal of serving more children within medical homes.



The most recent National Survey of CSHCN (2009-2010) estimated approximately 200,000 Wisconsin children have special health care needs, and 44% of them receive care within a medical home.

## **THE PLAN** outlines goals with different timelines. Objectives are identified as **1-3 years (short term), 1-5 years (medium term), and 1-10 years (long term).**

For the purpose of this project ending in September 2017, the following will be focus areas, as prioritized by the Medical Home Implementation Team.

### **PLAN GOALS**

- Development and promotion of common messaging for parents on the topic of medical home to advance understanding of benefits associated with this type of care.
- Development and promotion of an online shared resource featuring statewide pediatric behavioral health resources to parents, youth and professionals.
- Early identification of children with special health care needs, primarily through routine and universal use of validated developmental and mental health screening tools within well-child care provision.
- Promotion of use of referral and joint release of information document between medical homes and early intervention, along with strategies to strengthen outcomes following such referrals.
- Advancement of understanding around care coordination for Wisconsin children with special health care needs, including:
  - o Statewide care coordination mapping.
  - o Development and promotion of care coordination curriculum for families.
  - o Piloting shared plan of care document with clinicians and families of children with special health care needs.
  - o Researching other states' approaches to developing professional capacity and funding for care coordination.

### **Background**

The Wisconsin Department of Health Services' Children and Youth with Special Health Care Needs (CYSHCN) Program received notification of funding for a 3-year grant project titled the *Wisconsin CYSHCN Medical Home Systems Integration Project* beginning September 1, 2014. Funded by the federal Maternal and Child Health Bureau of the Health Resources and Services Administration, this project aims to increase the number of CYSHCN (aged 0-21 years) served within a medical home by 20% by September 2017. This represents an increase of approximately 17,735 more CYSHCN. The most recent National Survey of Children with Special Health Care Needs (CSHCN) (2009-2010) estimated that 44% of Wisconsin's approximately 200,000 CSHCN are served within a medical home. This survey examined children aged 0-18 years.

**This project aims to increase the number of CYSHCN (aged 0-21) served within a medical home by 20% by September, 2017.**

# Wisconsin Profile (2009 - 2010)<sup>1</sup>

## Estimated number of CSHCN: 201,529

PREVALENCE OF CSHCN	STATE %	NATION %
Percent of children who have special health care needs	15.5	15.1
<b>CSHCN Prevalence by Age</b>		
Age 0 – 5 years	7.1	9.3
Age 6 – 11 years	17.7	17.7
Age 12 – 17 years	21.3	18.4
<b>CSHCN Prevalence by Sex</b>		
Male	17.9	17.4
Female	12.9	12.7
<b>CSHCN Prevalence by Poverty Level</b>		
0 – 99% FPL	17.2	16.0
100 – 199% FPL	15.6	15.4
200 – 399% FPL	15.3	14.5
400% FPL or more	14.5	14.7
<b>CSHCN Prevalence by Hispanic Origin and Race</b>		
Non-Hispanic	15.8	16.2
White	15.4	16.3
Black	21.3	17.5
Other	14.4	13.6
Hispanic	12.0	11.2
Spanish Language Household	7.0	8.2
English Language Household	17.0	14.4
<b>NATIONAL INDICATORS</b>		
<b>Child Health</b>		
CSHCN whose conditions affect their activities usually, always, or a great deal	26.6	27.1

<b>Child Health</b>		
CSHCN with 11 or more days of school absences due to illness	16.5	15.5
<b>Health Insurance Coverage</b>		
CSHCN without insurance at some point in past year	5.4	9.3
CSHCN without insurance at time of survey	1.3	3.5
Currently insured CSHCN whose insurance is inadequate	31.7	34.3
<b>Access to Care</b>		
CSHCN with any unmet need for specific health care services	24.5	23.6
CSHCN with any unmet need for family support services	8.0	7.2
CSHCN needing a referral who have difficulty getting it	22.5	23.4
CSHCN without a usual source of care when sick (or who rely on the emergency room)	11.2	9.5
CSHCN without any personal doctor or nurse	3.6	6.9
<b>Family-Centered Care</b>		
CSHCN without family-centered care	32.9	35.4
<b>Impact on Family</b>		
CSHCN whose families pay \$1,000 or more out of pocket in medical expenses per year for the child	24.4	22.1
CSHCN whose conditions cause financial problems for the family	18.4	21.6
CSHCN whose families spend 11 or more hours per week providing or coordinating child's health care	11.0	13.1
CSHCN whose conditions cause family members to cut back or stop working	24.5	25.0
<b>MCHB CORE OUTCOMES</b>	<b>STATE %</b>	<b>NATION %</b>
CSHCN whose families are partners in shared decision making for child's optimal health	74.4	70.3
CSHCN who receive coordinated, ongoing, comprehensive care within a medical home	44.1	43.0
CSHCN whose families have adequate private and/or public insurance to pay for the services they need	65.1	60.6
CSHCN who are screened early and continuously for special health care needs	76.9	78.6
CSHCN who can easily access community based services	64.6	65.1
Youth* with special health care needs who receive the services necessary to make appropriate transitions to adult health care, work, and independence (*"Youth" for this survey was defined as those aged 12-17 years)	44.4	40.0



# Current State of the State

Approximately 16% of Wisconsin children have a special health care need.<sup>1</sup> Among the special health care population, many of these children are White (76%), male (60%), are 12-17 years old (46%), and live in households with incomes in between 200-399% of the federal poverty line (33%).<sup>1</sup> Furthermore, CSHCN live across the state of Wisconsin, in rural, urban, and suburban areas.<sup>2</sup>

Despite their need for additional health care services, Wisconsin CSHCN are not very likely to receive coordinated, ongoing, comprehensive care within a medical home, with only 44% of families reporting that they meet this criteria.<sup>1,3</sup> This is a decrease from the 2005/2006 level of 55%.<sup>1</sup> While the majority of CSHCN have a personal doctor or nurse (96%), a usual source of sick and well care (88%), and no problems getting referrals when needed (77%), fewer CSHCN receive family-centered care (67%) and coordinated care (59%).<sup>1</sup> Of the family-centered care components, only slightly more than half of caregivers report that doctors spend enough time with the family and give enough information specific to the child's health (58% and 59%, respectively).<sup>1</sup> This suggests a need to improve these components in order to boost the family-centered care component of the medical home outcome.

Of the components of care coordination, few caregivers report receiving direct help with care coordination (57%), being very satisfied with communication from doctors to other care providers (59%), and being very satisfied with communication among doctors (67%).<sup>1</sup> These findings suggest the need to improve all components of care coordination, especially with primary care providers and other types of practitioners that may support the child's health.



Approximately  
16% of Wisconsin  
children have a  
special health  
care need.<sup>1</sup>

A high proportion of CSHCN **(35%)** have emotional and behavioral health disorder (EBD) issues, and of the nearly **50%** of CSHCN who have more complex health care issues (defined as two or more CSHCN screener criteria), an even higher proportion **(62%)** had an EBD issue.<sup>1</sup>

Ideally, CSHCN with EBD would have equally available and accessible services and supports compared to their non-EBD counterparts. This is not the case for Wisconsin CSHCN with EBD; they are less likely than CSHCN without EBD to meet all the criteria for receipt of coordinated, ongoing, comprehensive care within a medical home (EBD = 36%, non-EBD = 49%).<sup>1</sup> CSHCN with EBD have a low receipt of family-centered care (EBD = 58%, non-EBD = 72%) and low receipt of all components of care coordination (EBD = 48%, non-EBD = 66%). Taken together, CSHCN both with and without-EBD are not likely to receive coordinated, ongoing, comprehensive care within a medical home, but CSHCN with EBD are faring far worse.<sup>1</sup>

The Wisconsin State Health Plan, *Healthiest Wisconsin 2020*, prioritizes Wisconsin EBD issues, focusing on reducing the impact of depression, anxiety and

emotional problems among CYSHCN. The need to improve the well-being of those with EBD issues is also demonstrated by Wisconsin's 2015 Title V Needs Assessment survey that was distributed to over 400 professionals, parents, and advocates. Out of Wisconsin's eight current Maternal and Child Health (MCH) priority areas, mental health was ranked as the second most important priority, endorsed by 55% of respondents, and surpassed only by promoting optimal infant and child health, development, and growth (59% endorsement). In addition, when respondents were asked to list/describe the top unmet needs in their community, nearly 50% mentioned mental/behavioral health. In that same survey, care within a medical home was only endorsed by 22% of respondents. These results demonstrate that addressing behavioral health is of significance to professionals and parents, but there is the need to raise awareness among Wisconsin families and professionals about the importance of receiving care within a medical home.

Research has shown that receipt of care within a medical home, and specifically care coordination, is positively related to family-reported receipt of family-centered care, decreased unnecessary office and emergency department visits, and reduced unplanned hospitalizations.<sup>4</sup> Similarly, CSHCN and their families who received care coordination reported improved satisfaction with behavioral health services and were observed to have reduced unmet needs and improved ratings of child health and family functioning.<sup>4</sup> Care within a medical home early in life for CSHCN and CSHCN with EBD could also have profound effects on the entire life course of these children. Early identification of EBD issues within a medical home could lead



to earlier intervention and potential remediation or reduction. In turn, this could reduce the child's need for future services and provide long-term benefit to communities and the state overall. This type of care is consistent with the *Standards for Systems of Care for Children and Youth with Special Health Care Needs*<sup>5</sup> as advanced by the National Association of Maternal Child Health Programs and the Lucile Packard Foundation for Children's Health.

## MHIT FORMATION

To achieve the goal of having more children served within a medical home, the project is required to develop a state plan to serve as a road map in its efforts.

A team of over 40 professionals serving CYSHCN and their families were assembled to assist with this effort. The team included family leaders, primary care clinicians, public and private payers, community resource professionals and state professionals from multiple agencies, including the Department of Health Services, Department of Children and Families, and Department of Public Instruction. Specific systems and programs participating are listed on this report's title page; individual participants are listed in appendix 1. This team was designated the Wisconsin Medical Home Implementation Team, or MHIT.

The MHIT first crafted a vision, mission, and set of common definitions (below and appendix 2). There was initial debate around whether the vision should include all children versus CYSHCN as specified within the Medical Home Systems Integration Grant (MH SIG) project goal. After consideration, the group decided the ultimate goal for the plan should include all children in the state.

The MHIT also reviewed other state plans, including those from Minnesota and Washington. The group decided to use the framework presented in the Washington State plan to organize its ideas. Several meetings were spent brainstorming ideas to include

The ultimate goal of the Wisconsin plan to have more children served within medical homes is one of care integration.

in each of the strategic areas; the ideas were later clustered into related themes. These themes were shared with the group for their consideration, and upon approval, inclusion within the plan itself.

Following idea and theme generation, MHIT members used an impact matrix to help identify priorities. The four categories within the impact matrix varied according to ease of implementation and potential long-term impact. These ratings assisted the group in determining initial priorities (i.e., strategies falling into the relatively easy implementation and high impact category), as well as longer term priorities (such as those strategies deemed likely to have significant impact but likely more difficult to achieve). The draft plan was shared with the group for feedback and refinement. Upon reaching consensus around the plan, members were asked to identify specific strategies that were relevant to their roles within their individual organizations.

## STATE PLAN (AS OF OCTOBER 2015)

Within this version of the State Plan, a variety of objectives and activities related to advancing medical home care for children in the state are captured. It is expected that these objectives and activities will be refined over time. The ideas reflected within this document came from a variety of sources including MHIT members, Wisconsin Maternal Child Health (MCH) needs assessment sessions on medical home and developmental screening, and the initial Medical Home Systems Integration Grant (MH SIG) application. Some of the ideas are relatively more achievable within the three-year time span of the MH SIG project, whereas achieving others will likely take longer. The objectives have been classified according to whether they are potentially achievable within 1-3, 1-5, or 1-10 years. The MH SIG project will focus on those ideas that are potentially achievable within three years, and the remaining longer-term objectives will serve as a guide for continued work in this area.

The ultimate goal of the Wisconsin plan to have more children served within medical homes is one of care integration. Ideally, care for all children provided within medical homes will be integrated across age, condition, providers, systems, family income and coverage. Although this type of seamless care benefits all children, CYSHCN as a population are especially vulnerable to the negative effects of care fragmentation. When CYSHCN are served in medical homes offering integrated care, the benefits to long-term health outcomes, total cost of care and overall patient and family satisfaction are significant.

## MHIT VISION AND MISSION

**Vision:** All children and youth in Wisconsin will receive care within a medical home to promote optimal health and support families.

**Mission:** In collaboration, the MHIT and other statewide partners will develop, promote, implement and evaluate a state plan to increase the number of Wisconsin children and youth served within a medical home, particularly those with special health care needs. Implementation of the plan will be sustained through members' integration of plan elements into their work and organizational priorities.

## COMMON DEFINITIONS

**Medical Home:** A comprehensive way of providing health care to children and youth, medical homes are most commonly composed of primary care clinicians (such as pediatricians, family physicians, pediatric nurse practitioners and physician assistants), care team members, and family members. In a medical home, care is coordinated based on family priorities. It is also accessible, continuous, comprehensive, compassionate and culturally effective. There is growing evidence that care provided within the medical home model supports the Institute for Healthcare Improvement's Triple Aim, including improved patient and family experience, overall improvement in population health, and for certain patient populations, reduced cost of care.

**Children and Youth with Special Health Care Needs (CYSHCN):** The federal Maternal and Child Health Bureau defines CYSHCN as "those who have a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." The CSHCN Screener® (a parent-based survey tool) was designed to reflect this definition. Children with a positive screen on this instrument are those up to age 18 with prescription medication dependence, above-average use of services, and/or functional limitations expected to last or lasting at least one year. The National Survey of Children with Special Health Care Needs (2009-2010) estimated approximately 200,000 Wisconsin children have special health care needs according to these criteria.

# Strategic Plan Framework

Strategic Areas	INDIVIDUALS OR ORGANIZATIONS INVOLVED		
	Family, Youth, Child	Primary Care Clinicians	Systems
<b>1. Understanding and Promotion</b> People understand and promote the concept of medical home.	Objectives 1.F.1-1.F.4	Objectives 1.C.1-1.C.3	Objectives 1.S.1-1.S.4
<b>2. Performance and Quality</b> Best-practice medical home care provision for children (including those with special health care needs) is achieved through continuous quality improvement and care coordination.	Objectives 2.F.1-2.F.5	Objectives 2.C.1-2.C.5	Objectives 2.S.1-2.S.6
<b>3. Financing</b> Financing for medical home approach to care for children and youth is adequate and sustainable.	Objective 3.F.1	Objectives 3.C.1-3.C.2	Objectives 3.S.1-3.S.3

F = Family, C = Clinician, S = System

The following tables describe the proposed objectives for each of the three color-coded strategic areas (Understanding and Promotion=teal, Performance and Quality=purple, Financing=orange), working across the three sets of individuals and organizations involved, starting from the more individual orientation to the broader systems level. Goals, objectives, action steps and evaluation measures are listed for each of these strategic areas, based on input from the MHIT and members of the MH SIG management team and evaluation team. Objectives are identified as 1-3 years (short term), 1-5 years (medium term), and 1-10 years (long term). Appendix 3 contains a summary of evaluation methods, specific measures and the corresponding objectives.



# Understanding and Promotion

## **WHY THIS IS IMPORTANT:**

Families, clinicians and other professionals must understand the main tenets of care provision within a medical home in order to recognize its value and for the concept to spread.

### **GOAL 1:**

People understand and promote the concept of medical homes.

Strategies:

- Develop and promote unified set of tools to communicate the common message.
- Develop and promote use of Wisconsin's shared resource through enhancement and integration of current Wisconsin First Step resources, especially in the area of behavioral health.

# FAMILY, YOUTH, CHILD

## OBJECTIVE

### 1.F.1

#### 1-3 YEAR OBJECTIVE

By August 31, 2016, family and youth representatives along with other state partners develop a unified set of tools describing a Medical Home.

#### ACTION STEPS

Youth and family organizations will be involved, along with other members and partner organizations, in the MHIT, representing their perspectives in tool development.

Youth with special health care needs and family members will participate in development and review of the unified set of tools.

#### EVALUATION

Measures: Records of youth and family organization participation in: MHIT meetings, contributions to creating the set of tools, review and/or endorsement of the set of tools.



# OBJECTIVE 1.F.2

## 1-3 YEAR OBJECTIVE

By August 31, 2017, tools are being promoted and used across systems and groups.

## ACTION STEPS

Youth and family organizations are involved in making plans within their organizations, and advising other groups, for promotion of the tools.

Youth and family organizations are promoting and using tools, along with youth and families themselves.

## EVALUATION

Measures: Records of methods (plans) and activities for promotion and use of the tools by youth and family organizations, including inclusion in family/youth training curricula; linkages of tools on Family Voices (FV) and other family/youth organization website survey tools; records of promotional materials distribution and promotion plan implementation.

**GOAL 1:**  
People understand and promote the concept of medical homes.

# OBJECTIVE

## 1.F.3

### 1-3 YEAR OBJECTIVE

By August 31, 2017, through use of the common tools and other resources, families are knowledgeable about strategies to build child's medical home, as well as to promote partnership with their child's primary care clinician.

### ACTION STEPS

Families receive tools and materials detailing names and contact information for the members of their child's medical home.

Families participate in the Wisconsin Statewide Medical Home Initiative's (WiSMHI) *Partnering with Your Child's Physician* training.

Families access readily available materials related to medical home available on the internet through sites such as AAP's *Healthy Children.org* and *WiSMHI.org's* parent resources.

### EVALUATION

Measures: Wisconsin Regional Centers for CYSHCN providing "information and referral" to families document in Secure Public Health Electronic Record Environment (SPHERE) the use of tools and families' knowledge of medical home team members; pre- and post-test results from WiSMHI and other trainings demonstrate increase in family knowledge of medical home components; website usage surveys for FV and other family/youth organizations show that individuals are accessing tools.



# OBJECTIVE

## 1.F.4

### 1-3 YEAR OBJECTIVE

By August 31, 2017, families of children with behavioral health challenges are knowledgeable about Wisconsin's shared resource, First Step.

### ACTION STEPS

Family leadership organizations, including those focusing on behavioral health, participate in the shared resource work group (to include representatives from Mental Health American of Wisconsin, NAMI of Wisconsin and Wisconsin Family Ties).

Family leadership organizations (including those listed above, along with Family Voices of Wisconsin, Parent to Parent, Regional Centers for CYSHCN, CYSHCN Collaborators Network) share and promote the resource among their stakeholders and members upon its completion.

### EVALUATION

Measures: Records of family organization participation in shared resource work group; family organizations in Wisconsin have linkages to the shared resource on their website and demonstrate active promotion of resources related to behavioral health; family awareness of First Step resource measured via embedding questions in training evaluations for Medical Home curricula and other family leadership training activities.

# PRIMARY CARE CLINICIANS

## OBJECTIVE

### 1.C.1

#### 1-3 YEAR OBJECTIVE

By August 31, 2016, primary care clinicians are included in the development of a unified set of tools describing Medical Home.

#### ACTION STEPS

Through primary care clinicians' and health care system administrators' involvement in the MHIT, their perspectives are represented in tool development.

Primary care clinicians and their practice partners will participate in development and review of the unified set of tools.

#### EVALUATION

Measures: Records of primary care clinicians' and health care system administrators' participation in: MHIT meetings, contributions to creating the set of tools, review and endorsement of the set of tools.

# OBJECTIVE 1.C.2

## 1-3 YEAR OBJECTIVE

By August 31, 2017, tools are being promoted and used across systems and groups.

### ACTION STEPS

Clinicians and health care organizations are promoting and using tools.

- Care4Kids Centers of Excellence clinicians as one target audience.
- QI grants available to clinic sites in 2017 include piloting and evaluating the use of tools.

### EVALUATION

Measures: Data from pilot study of medical practices participating in Medical Home QI projects in 2017, data from PDSA cycles demonstrate effectiveness of promotion strategies and use of tools.



# OBJECTIVE

## 1.C.3

### 1-3 YEAR OBJECTIVE

By August 31, 2017, clinicians caring for children with behavioral health challenges are knowledgeable about Wisconsin's shared resource, First Step.

### ACTION STEPS

Upon its completion, statewide primary care clinician organizations share and promote the resource among their stakeholders and members.

Upon its completion, WiSMHI includes information on the shared resource in its physician outreach on behavioral health integration into pediatric primary care.

### EVALUATION

Measures: Linkages of tools on statewide primary care clinicians organizations' (e.g., AAP) websites; records of promotional materials distribution at organizational inservices (conducted by WiSMHI); specific physician outreach activities/events promoting behavioral health resources are documented; pre- and post-test results from WiSMHI and other trainings demonstrate increase in clinician knowledge of First Step.

# SYSTEMS

## OBJECTIVE

### 1.S.1

#### 1-3 YEAR OBJECTIVE

By August 31, 2016, a unified set of tools will be developed describing Medical Home.

#### ACTION STEPS

Review current definitions and materials on the topic of medical home.

Come to consensus on definition to be included (ensuring language is accessible).

Possible elements to include:

- Business case for medical home care provision.
- Roles/responsibilities for each partner.
- Stories highlighting successful medical homes.

#### EVALUATION

Measures: Documentation, in the State Plan or MH SIG work plan, of a timeline and responsibilities for completion of the set of tools by August 31, 2016, progress in meeting the timeline is monitored by the MH SIG management team; set of tools is developed by August 31, 2016.

# OBJECTIVE 1.S.2

## 1-3 YEAR OBJECTIVE

By August 31, 2016, develop a promotion and utilization plan for unified set of tools.



### ACTION STEPS

Regional Centers for CYSHCN and Collaborators Network aid in the development of a promotion plan for the tools by including these outreach plans in their 2016 contract work plans.

Use social media to increase access to tools.

### EVALUATION

Measures: Documentation of development of a promotion and use plan for the set of tools by August 31, 2016; progress in implementing the plan is monitored by the MH SIG management team; promotional strategies and plan include social media and other mechanisms.



# OBJECTIVE

## 1.S.3

### 1-3 YEAR OBJECTIVE

By August 31, 2017, tools are being promoted and used across systems and groups.

### ACTION STEPS

Develop and include contract language for CYSHCN state contracts in 2017 to promote and use shared resource tools in education/training, on websites, through print materials, make shared resource available within different health care systems.

### EVALUATION

Measures: Promotion of tools among Regional Centers for CYSHCN and Collaborators Network included in contract language for 2017; number of websites of contracted entities including links to shared resources; analysis of Regional Center work plans and reported outcomes includes measurement of number of partnerships and utilization of tools.

# OBJECTIVE 1.S.4

## 1-3 YEAR OBJECTIVE

By August 31, 2016, shared resource is created and available for use.

### ACTION STEPS

Pediatric behavioral health resources within Wisconsin First Step are expanded and easily accessible to parents, professionals and clinicians caring for children with behavioral health concerns, as well as youth themselves.

Comprehensive and consistent information on services and resources are available to different populations depending upon need and other characteristics.

### EVALUATION

Measures: Online survey of families and professionals using the shared resource assessing ease of use, ability to locate relevant resources, whether the shared resource was a key factor/was instrumental/resulted in their ability to obtain a needed specialist, support, or service, and value of accessing supports and services within the shared resource (aligns with National Academy for State Health Policy (NASHP) Shared Resource Strategy Team Measure).



# Performance and Quality

## **WHY THIS IS IMPORTANT:**

High quality care provision within a medical home meets certain measurable standards. Achieving these standards requires intentional and sustained effort.

### **GOAL 2:**

Best-practice medical home care provision for children (including those with special health care needs) is achieved through continuous quality improvement and care coordination.

#### Strategies

- Families become activated and engaged at all levels of care (individual, practice and policy levels), with goal of partnership and shared leadership.
- Early identification of the population of children with special health care needs or those requiring additional support.
- Implement within- and between-system care coordination.
- Develop and sustain practice and system infrastructures which support continuous quality improvement, to include behavioral health integration into primary care.
- Implement use of Wisconsin's shared resource (expansion and enhancement of current Wisconsin First Step resources in area of behavioral health).

# FAMILY, YOUTH, CHILD

## OBJECTIVE 2.F.1

### 1-3 YEAR OBJECTIVE

By August 31, 2017, work to assure that families are informed and knowledgeable about relevant resources, including the shared resource.

### ACTION STEPS

Regional Centers for CYSHCN and Collaborators Network provide Information and Referral services to families of CYSHCN across the state. Families are aware of developmental milestones as reinforced by *Learn the Signs. Act Early* materials.

Families of CYSHCN are aware of the parent-to-parent mentorship opportunities available through organizations such as Parent to Parent of Wisconsin.

### EVALUATION

Measures: Regional Centers for CYSHCN providing “information and referral” to families document in SPHERE the use of tools and families’ knowledge of these specific resources; Pre- and post-test results from Family Voices of Wisconsin and other trainings demonstrate increase in family knowledge of specific resources for behavioral health.

# OBJECTIVE 2.F.2

## 1-3 YEAR OBJECTIVE

By August 31, 2017, families have information that allows them to find a medical home.

### ACTION STEPS

Regional Centers for CYSHCN and Collaborators Network provide Information and Referral services to families of CYSHCN across the state, including connection to medical homes.

Families participate in WiSMHI's *Partnering with Your Child's Physician* training.

### EVALUATION

Measures: Regional Centers for CYSHCN providing "information and referral" to families document in SPHERE the information given to families, WiSMHI training records of families, demographic and geographical distribution of audience reached, also pre- and post-tests to measure knowledge and values.

# OBJECTIVE 2.F.3

## 1-3 YEAR OBJECTIVE

By August 31, 2017, families increase their knowledge of elements of care coordination.

## GOAL 2:

Best-practice medical home care provision for children (including those with special health care needs) is achieved through continuous quality improvement and care coordination.

### ACTION STEPS

Care coordination training is developed and implemented by Family Voices of Wisconsin.

Families participate in care coordination training offered through Family Voices of Wisconsin.

Families participate in pilot projects with medical homes using a shared plan of care document.

### EVALUATION

Measures: Monitor development and implementation of family care coordination curriculum; records of families, demographic and geographical distribution of audience reached by the Care Coordination curriculum, also pre- and post-tests to measure change in knowledge and values. Utilize a family survey tool (FCCA or FECC) to assess rates of satisfaction and knowledge among families regarding elements of care coordination. Monitor families' participation in the shared plan of care pilots (aligns with NASHP Cross System Care Coordination Strategy Team Measure).

# OBJECTIVE 2.F.4

## 1-3 YEAR OBJECTIVE

By August 31, 2017, families of children with behavioral health challenges receive training and are able to access available resources, including Wisconsin's shared resource.



## ACTION STEPS

Behavioral health resources training curriculum is developed by Family Voices of Wisconsin.

Families participate in behavioral health resources training program offered through Family Voices of Wisconsin, to include promotion of the shared resource.

## EVALUATION

Measures: Monitor development and implementation of family curriculum for behavioral health challenges; records of number of families, demographic and geographical distribution of audience reached by the behavioral health curriculum, also pre- and post-tests to measure change in knowledge and values.



# OBJECTIVE 2.F.5

## 1-3 YEAR OBJECTIVE

By August 31, 2017, families of CYSHCN serve in a leadership and advisory capacity in community and health care systems serving high volumes of children.

## ACTION STEPS

In 2015 and 2016, conduct a mapping exercise among family leadership organizations throughout the state to determine family capacity-building opportunities at individual, community, and system levels.

Communicate results of mapping exercise to relevant partners, along with encouragement to connect families with relevant opportunities.

Families participate in opportunities that build capacity to serve in leadership positions within their communities and health care organizations.

## EVALUATION

Measures: Monitor development and implementation of mapping exercise; record number of family leaders trained to participate in advisory capacities for community and health care, including demographic and geographical distribution.

# PRIMARY CARE CLINICIANS

## OBJECTIVE 2.C.1

### 1-5 YEAR OBJECTIVE

By 2020, additional infrastructure is in place to support quality improvement strategies related to medical home at a practice level.

### ACTION STEPS

Specific quality improvement initiatives are implemented to promote care coordination efforts, along with behavioral health integration into pediatric primary care, including awareness and use of one of the following:

- Shared plan of care.
- Care Coordination Measurement Tool.
- Promotion of Family Voices of Wisconsin's Care Coordination curriculum with families.
- Promotion and assessment of common messaging tools to advance understanding of medical home among parents.
- Track use and outcomes associated with joint release of information and referral from medical homes to early intervention document.
- Wisconsin's shared resource.
- Child Psychiatry Consultation Program.
- Triple P-Positive Parenting Program training for primary care clinicians.
- WiSMHI physician outreach on developmental screening, mental health screening and mental health community resources.

### EVALUATION

Measures: Pilot QI projects demonstrate successful strategies for developing infrastructure to support medical home implementation related to the above activities, including integration of behavioral health resources (aligns with NASHP Cross System Care Coordination, Integration and Shared Resource Strategy Teams Measures).

# OBJECTIVE

## 2.C.2

### 1-3 YEAR OBJECTIVE

By August 31, 2017, early identification of children with special health care needs through universal use of validated developmental and mental health screening tools (consistent with AAP's Bright Futures recommendations) is incorporated into pediatric practices in Wisconsin.

### ACTION STEPS

Policies are established within clinics to ensure all children receive developmental screening and mental health screening in accordance with AAP's Bright Futures recommendations.

Partner with Care4Kids Program to support at least three of their highest volume clinic sites to increase the number of children enrolled in foster care receiving developmental or mental health screening as part of their comprehensive health assessment.

WiSMHI provides practice support around quality initiatives of developmental screening, pediatric mental health screening, and pediatric mental health community resources.

### EVALUATION

Measures: Data from QI project to increase developmental and mental health screening in Care4Kids practices; measures of other practices implementing screening practices through WiSMHI trainings.

# OBJECTIVE 2.C.3

## 1-3 YEAR OBJECTIVE

By August 31, 2017, clinicians implement use of relevant clinical and community resources for CYSHCN, including Wisconsin's shared resource.

## ACTION STEPS

Clinicians and care team members implement use of relevant clinical and community resources, including Regional Centers for CYSHCN.

WiSMHI offers practice support around quality initiatives of developmental screening, mental health screening, and mental health community resources.

## EVALUATION

Measures: Clinician assessment data examining use of relevant community resources prior to and following completion of WiSMHI practice education. Online survey of families and professionals using the shared resource assessing ease of use, ability to locate relevant resources, whether the shared resource was a key factor/was instrumental/resulted in their ability to obtain a needed specialist, support, or service, and value of accessing supports and services within the shared resource (aligns with NASHP Shared Resource Strategy Team Measure).

# OBJECTIVE 2.C.4

## 1-10 YEAR OBJECTIVE

By 2026, clinicians have improved ability to efficiently exchange information with relevant partners in order to facilitate care coordination.

### ACTION STEPS

Clinicians are using referral and release documents to facilitate communication between sectors, and collecting data on referral outcomes.

Clinicians are participating in Medical Home QI grants piloting use of referral and release documents.

Clinicians are piloting shared plans of care in collaboration with families of CYSHCN.

### EVALUATION

Measures: Track utilization of referral and release documents currently in use between primary care and early intervention for those practices participating in Medical Home QI initiatives (aligns with NASHP Integration Strategy Team Measure), Regional Centers for CYSHCN and others using SPHERE record outcomes following referrals. Assess utilization among clinicians of the shared plan of care, along with perceptions on how quality of care was affected by use of the document (aligns with NASHP Cross System Care Coordination Strategy Team Measure).

# OBJECTIVE 2.C.5

## 1-5 YEAR OBJECTIVE

By 2020, the role of care coordinator relative to the broader care team is established.



### ACTION STEPS

Clinicians are involved in the work group reviewing other states' approaches to defining the role of care coordinators.

Clinicians are involved in establishing training programs to create a cohort of individuals to serve as care coordinators.

Once the role of care coordination is defined and individuals trained, clinicians are able to access care coordinators as members of the medical home team.

### EVALUATION

Measures: In pilot projects, track who is doing care coordination, time and skills required; reimbursement and utilization data from billing for care coordination activities from pilot and other funded projects (e.g., CMS), adoption and implementation of care coordinator roles.

# SYSTEMS

## OBJECTIVE 2.S.1

### 1-10 YEAR OBJECTIVE

By 2026, health care systems have established early identification processes in place to conduct universal and routine screening of children's development and mental health according to AAP's Bright Futures' Periodicity Schedule.

### ACTION STEPS

CYSHCN collaborators and partner programs promote the State Plan for the *Learn the Signs. Act Early* campaign.

Policies will be promoted and established by partners within health care systems to ensure all children receive developmental screening and mental health screening in accordance with AAP's Bright Futures recommendations.

CYSHCN collaborators work with statewide initiatives to promote development and utilization of a common data reporting system to align reporting of developmental screening results across and between systems.

Health care systems will integrate pediatric-specific measures as part of the standard of care related to universal screening, including having data systems to measure improvement and impact.

### EVALUATION

Measures: "Act Early" state plan includes goals and activities related to early identification through universal screening according to AAP's Bright Futures periodicity schedule.

# OBJECTIVE

## 2.S.2

### 1-3 YEAR OBJECTIVE

By August 31, 2017, systems promote efficient exchange of information between medical homes and early intervention to facilitate care coordination.

### ACTION STEPS

DHS CYSHCN Program and Birth to 3 Program develop an agreement to support referral and follow up between the child's medical home and early intervention.

Regional Centers for CYSHCN work with health care systems to promote the use of referral and release documents between medical homes and early intervention, DHS medical home release.

### EVALUATION

Measures: Agreement is in place between DHS's CYSHCN Program and Birth to 3 (aligns with NASHP Integration Strategy Team Measure); Using SPHERE and other systems to be developed, track promotion by Regional Centers and utilization of current referral and release documents between primary care and service partners such as early intervention.



# OBJECTIVE

## 2.S.3

### 1-3 YEAR OBJECTIVE

By August 31, 2017, health care systems and relevant partners utilize a mapping exercise to obtain information regarding current components of care coordination for CYSHCN being conducted.



### ACTION STEPS

CYSHCN program through the MHIT will complete a strength and gap analysis (mapping exercise) of current care coordination activities being implemented in different systems and organizations across the state.

CYSHCN program will disseminate the results to collaborating partners including MHIT members and to representatives of different health care systems.

### EVALUATION

Measures: Work group is established to identify relevant partners and conduct strength/gap analysis; activities are monitored according to a timeline integrated with the MH SIG work plan; report/information is disseminated to relevant partners and health care systems administrators.

# OBJECTIVE 2.S.4

## 1-10 YEAR OBJECTIVE

By 2026, the role of care coordination within and between health care systems is defined.

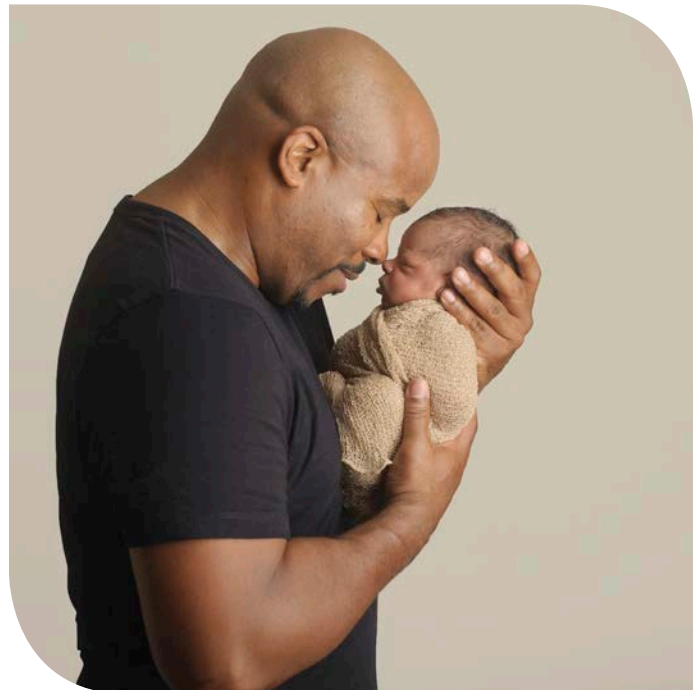
### ACTION STEPS

Involve administrators and payers in the work group reviewing examples from other states defining the role of care coordinators, establishing training programs to create a cohort of individuals to serve in this sector, and creating reimbursement structures to ensure sustainable financing for role.

Once care coordination role is defined and individuals trained, systems will incorporate care coordinators as members of the medical home team.

### EVALUATION

Measures: Work group is established to review examples from other states (either in Wisconsin or as part of cross-state learning collaborative); including funding models, qualifications of care coordinators, methods of integration between systems. Monitor policy development/change within the QI initiatives for Medical Home, and/or cross-system implementation of care coordination; billing for care coordination activities.



# OBJECTIVE 2.S.5

## 1-3 YEAR OBJECTIVE

By August 31, 2017, Title V and others contribute to an infrastructure that supports continuous quality improvement at a practice level.

### ACTION STEPS

CYSHCN program will partner with Care4Kids Program to support a quality improvement initiative within at least three of their highest volume clinic sites to increase the number of children enrolled in foster care receiving developmental or mental health screening as part of their comprehensive health assessment.

CYSHCN program will support grants to practices to participate in quality improvement activities related to pediatric medical home care provision and all grantees will include family leaders on quality improvement teams.

- Specific quality initiatives include care coordination efforts, along with behavioral health integration into pediatric primary care, including:
  - o Use of a shared plan of care will be piloted and evaluated by all initiatives.
  - o Care Coordination Measurement Tool.
  - o Promotion of Family Voices of Wisconsin's Care Coordination curriculum with families.
  - o Promotion and assessment of common messaging tools to advance understanding of medical home among parents.
  - o Track use and outcomes associated with joint release of information and referral from medical homes to early intervention document.
  - o Wisconsin's shared resource will be utilized, including additional resources for behavioral health.
  - o Child Psychiatry Consultation Program.
  - o Triple P-Positive Parenting Program training for primary care clinicians.
  - o WiSMHI physician outreach on developmental screening, mental health screening and mental health community resources.
- All quality improvement initiatives will include participation in shared learning experiences such as webinars, phone calls and an annual meeting to share successes and challenges in implementing their QI projects.

### EVALUATION

Measures: Data from practice-based QI projects related to PDSA cycles is analyzed and summarized; a plan is in place for successful strategies related to specific quality improvement initiatives to be disseminated. Monitor participation in the shared learning experiences by grantees.

# OBJECTIVE

## 2.S.6

### 1-5 YEAR OBJECTIVE

By 2020, State health policy includes the early identification of children with special health care needs through universal use of validated developmental screening tools.

### ACTION STEPS

CYSHCN partners will work to include the Bright Futures periodicity schedule for developmental screening in Wisconsin EPSDT guidance.

Develop support for and pursue policy change to include developmental screening as a core measure of child health.

MH SIG leadership will assure that the *Learn the Signs. Act Early* state plan aligns with medical home state plan policy recommendations.

CYSHCN program partners will work to integrate pediatric-specific measures of developmental screening in standards of care.

### EVALUATION

Measures: Monitor policy change proposals and outcomes; monitor for updated EPSDT Memo with new guidance; contract language reflects new core measures.



# 3

## Financing

## **WHY THIS IS IMPORTANT:**

Reimbursement must support clinicians and care team members in offering essential aspects of care within a medical home in order for this model to be incentivized and sustainable.

### **GOAL 3:**

Financing for medical home approach to care for children and youth is adequate and sustainable.

#### Strategies

- Adequate reimbursement for care coordination within and across systems.
- Financial incentives (from both public and private payers) are outcomes based and structured to support care delivery within a primary care setting.
- Financing supports behavioral health integration into pediatric primary care.
- CYSHCN population is actively considered in health-system reform activities.

# FAMILY, YOUTH, CHILD

## OBJECTIVE 3.F.1

### 1-3 YEAR OBJECTIVE

By August 31, 2017, families of CYSHCN are active participants in health system reform advisory groups.

### ACTION STEPS

Families participate in leadership training opportunities that build capacity to serve in leadership positions within their communities and organizations focusing on health care system reform.

Include information on the importance of completing patient satisfaction questionnaires as an element of determining health care outcomes within WiSMHI's Partnering with Your Child's Physician training, along with Family Voices of Wisconsin's trainings on care coordination and behavioral health resources.

Families participate in patient satisfaction surveys which assess health care outcomes.

Individual family members and family groups educate policy makers on financing implications of health care reform and medical home practices.

### EVALUATION

Measures: Pre/post training evaluations from family participants measure changes in knowledge, awareness and skills. Development of CYSHCN-funded statewide family leadership, care coordination, behavioral health and other curricula include participation in patient satisfaction surveys and policy education as topics.

# PRIMARY CARE CLINICIANS

## OBJECTIVE 3.C.1

### 1-3 YEAR OBJECTIVE

By August 31, 2017, the impact of improved care coordination is shared by those clinics participating in supported quality improvement projects.

### ACTION STEPS

CYSHCN program uses the *Medical Home Care Coordination Measurement Tool* to track outcomes achieved and adverse outcomes prevented (such as ED visits and hospitalizations).

Data are generated by QI pilots (and CMS grant caring for children with medical complexity) and used to inform needs assessment for future care coordination activities.

Results are shared through educational events with other practices in Wisconsin.

### EVALUATION

Measures: Data from QI pilot projects; compare results of *Medical Home Care Coordination Measurement Tool* in Wisconsin practices with those from other states and nationally.





# OBJECTIVE

## 3.C.2

### 1-5 YEAR OBJECTIVE

By 2020, financing supports additional aspects of behavioral health provision in pediatric primary care.

### ACTION STEPS

CYSHCN programs support other programs' activities in the state to train a cadre of practices from different systems to address aspects of behavioral health provision in pediatric primary care.

Clinicians trained in Triple P-Positive Parenting Program are able to deliver sessions within primary care settings and are reimbursed adequately for time spent building parent capacity.

### EVALUATION

Measures: Using data from collaborating partners, identify primary care practices that are trained in and/or using Triple P programs and parent experience with the program.

# SYSTEMS

## OBJECTIVE 3.S.1

### 1-10 YEAR OBJECTIVE

By 2026, care coordination services are reimbursed at an adequate and sustainable level.

### ACTION STEPS

MHIT mapping exercise of care coordination activities will include current types of services and whether/how they are being reimbursed.

Successful lessons learned related to financing care coordination from the CMS grant for children with medical complexity and state plan amendment for children enrolled in foster care are sustained and spread to other CYSHCN populations.

Data generated by *Medical Home Care Coordination Measurement Tool* QI pilots is used to inform needs assessment for care coordinator as a distinct member of medical home team.

CYSHCN partners will explore possible paraprofessional licensure for care coordinators to serve within medical home teams, allowing other care team members to operate at top of licenses.

### EVALUATION

Measures: In pilot projects, track who is doing care coordination, time and skills required; reimbursement and utilization data from billing for care coordination activities from pilot and other funded projects (e.g., CMS), data will be utilized from the mapping exercise on care coordination.

**GOAL 3:**  
Financing for medical home approach to care for children and youth is adequate and sustainable.

# OBJECTIVE

## 3.S.2

### 1-10 YEAR OBJECTIVE

By 2026, financial incentives for medical home care delivery are tied to additional quality outcomes.

### ACTION STEPS

CYSHCN partners will identify places where financial incentives/policies can be improved, adapted or adopted to support medical home practices as essential components of quality care. Data from quality improvement projects will be used to influence policy change.

Policies are developed and adopted within a health care/ payer system that support reimbursement for time spent in coordination between primary and specialty clinicians to support co-management of CYSHCN , including EPSDT outcomes, along with other pediatric-specific health care quality measures (such as use of developmental and mental health screening tools).

CYSHCN partners will promote the inclusion of developmental screening in Wisconsin as a core measure of child health tied to a financial incentive for quality improvement.

CYSHCN partners will promote consideration of alternate payment models (such as pay for performance and bundled payment models) over traditional fee for service payment models.

CYSHCN partners will promote payers and health plans tracking CYSHCN as a distinct population; compensation tied to appropriate use of care coordination, clinician co-management, and patient self-management skills.

### EVALUATION

Measures: Practice-level and patient satisfaction data will be collected from the quality improvement projects implementing different payment models for children, and practices implementing outcomes based care in Wisconsin. Monitor the number of practices and health care systems in Wisconsin making policy changes related to financial incentives for quality care.

# OBJECTIVE

## 3.S.3

### 1-5 YEAR OBJECTIVE

By 2020, financing supports additional aspects of behavioral health provision in pediatric primary care.

### ACTION STEPS

CYSHCN partners will work with other state agencies to leverage additional funding for the Child Psychiatry Consultation Program.

CYSHCN partners will work with providers and trainers and health care systems to explore additional ways that delivery of Triple P-Positive Parenting Program sessions within primary care can be reimbursed, starting with reviewing examples such as the financing currently offered to clinicians in Washington state.

### EVALUATION

Measures: Data from implementation of CPCP; track CPCP progress of statewide spread and utilization; document successful reimbursement models in Wisconsin.



# Appendices

## Appendix 1: MHIT Members

NAME	ORGANIZATION	POSITION OR DIVISION
<b>Family Leadership</b>		
Brigit Frank	Family Voices of Wisconsin	Family Voices Community Education Coordinator
Barbara Katz*	Family Voices of Wisconsin	Co-Director
Robin Mathea	Children's Hospital of Wisconsin	Parent to Parent Coordinator
<b>Primary Care Clinicians and Membership Organizations</b>		
Crystal Bales, RN	Children's Hospital of Wisconsin	RN-CHW Fox Valley and Pediatric DNP Student
Sharon Barkley, MD	Marshfield Clinic	Physician Lead
Becky Birchmeier, RN, MS	Marshfield Clinic	Pediatrics Clinical Nurse Specialist
Pam Crouse, MS, RN	Wisconsin Primary Health Care Association	Clinical and Quality Improvement Director
Mindy Hammond, RN	Gundersen Health System	Clinical Manager
Kia LaBracke	Wisconsin Chapter, American Academy of Pediatrics	Executive Director
Mala Mathur, MD, MPH	Group Health Cooperative	Pediatrician
Nancy Pontius	Children's Hospital of Wisconsin	Physician Liason
Robert Rohloff, MD	Children's Hospital of Wisconsin	Pediatric Physician-Southwest Pediatrics
Becky Wimmer	Wisconsin Academy of Family Physicians	Assistant Executive Director
Lisa Zetley, MD	Medical College of Wisconsin and Children's Hospital of Wisconsin	Assistant Professor of Pediatrics and Medical Director of Care for Kids Program
<b>Specialist Clinicians</b>		
Patricia Benoit, LMFT	Ministry Medical Group	Behavioral Health Specialist
Jennifer Kleven, MD	Gundersen Health System	Pediatric Hospitalist
Mary Schroth, MD	UW Health	Director, Pediatric Pulmonary Center Grant (AFCH)
Samantha Wilson, Ph.D.	Medical College of Wisconsin	Associate Professor of Pediatrics

NAME	ORGANIZATION	POSITION OR DIVISION
Existing Federal or State Medical Home Programs		
Tera Bartelt	Children's Hospital of Wisconsin	Special Needs Clinic Manager
Mike Boeder	Children's Hospital of Wisconsin	Director, Foster Care Medical Home Program
Holly Colby	Children's Hospital of Wisconsin	Director of Clinic Operations
Ryan Coller, MD	UW Health	MD, MPH
Mary Ehlenbach, MD	UW Health	CMS Innovation Grant - CYSHCN Complex Care
John Gordon, MD	Children's Hospital of Wisconsin	CMS Innovation Grant - CYSHCN Complex Care
Arianna Keil, MD *	Children's Hospital of Wisconsin	Wisconsin Statewide Medical Home Initiative Administrator
Colleen Lane	Children's Hospital of Wisconsin	Wisconsin Statewide Medical Home Communication/Data Specialist
Molly McGregor	Children's Hospital of Wisconsin	Wisconsin Statewide Medical Home Outreach Specialist
Gina Salazar	Children's Hospital of Wisconsin	Wisconsin Statewide Medical Home Administrative Assistant
Prerna Sinha, MD	Children's Hospital of Wisconsin	Special Needs Program Staff Physician
Michelle Urban, MD	Bureau of Milw Child Welfare	Medical Director
Naomi Westerman	Children's Hospital of Wisconsin	Wisconsin Statewide Medical Home Outreach Specialist
Department of Children and Families		
Leslie McAllister	Department of Children and Families	Home Visiting Coordinator
Department of Health Services		
Linda Benton	Wisconsin Department of Health Services	MCH Home Visiting Consultant MCH/DCF
Becky Chown	Wisconsin Department of Health Services	Division of Health Care Accountability and Access
Evelyn Cruz	Wisconsin Department of Health Services	Minority Health Officer
Kim Eithun Harshner	Wisconsin Department of Health Services	Office of Children's Mental Health
Terri Enters	Wisconsin Department of Health Services	Birth to 3 Program Coordinator
Sharon Fleischfresser, MD, MPH *	Wisconsin Department of Health Services	CYSHCN Medical Director

NAME	ORGANIZATION	POSITION OR DIVISION
Andrea Gromoske	Wisconsin Department of Health Services	Epidemiologist/Evaluator-Family Health Section
Linda Hale	Wisconsin Department of Health Services	MCH Division Director
Rachel Currans Henry	Wisconsin Department of Health Services	Division of Health Care Accountability and Access
Terry Kruse *	Wisconsin Department of Health Services	MCH Unit Supervisor
Susan Larsen	Wisconsin Department of Health Services	Policy Initiatives and Program Integrity Section
Susan Latton*	Wisconsin Department of Health Services	CYSHCN Initiatives Statewide Coordinator
Leah Ludlum *	Wisconsin Department of Health Services	MCH Consultant
Marlia Mattke	Wisconsin Department of Health Services	Division of Health Care Accountability and Access
Rebecca McAtee *	Wisconsin Department of Health Services	Division of Health Care Accountability and Access
Karen McKeown	Wisconsin Department of Health Services	State Health Officer
Elizabeth Oftedahl	Wisconsin Department of Health Services	CYSHCN Epidemiologist
Joanette Robertson	Wisconsin Department of Health Services	Children, Youth and Families Mental Health Coordinator
Makalah Wagner	Wisconsin Department of Health Services	Division of Health Care Accountability and Access
Lora Wiggins, MD	Wisconsin Department of Health Services	Medical Director, Wisconsin Medicaid
Department of Public Instruction		
Jennie Mauer	Wisconsin Department of Public Instruction	Wisconsin Head Start State Collaboration Director
Community Resource Professionals		
Heather Jordan	Great Lakes Intertribal Council	Tribal Nations Coordinator for Early Childhood Services
Laurice Lincoln	Wisconsin Department of Health Services	Birth to 3 Program State Lead
Nancy Randolph	Manitowoc County Human Services	Manager

NAME	ORGANIZATION	POSITION OR DIVISION
<b>Other MCH Funded Programs</b>		
Anne Bradford Harris, PhD *	UW-Madison Waisman Center	LEND Director
Karen Brandt	Gundersen Health System	Wisconsin First Step Database Coordinator
Katherine Cavanaugh	Children's Hospital of Wisconsin	Director, Southeast Regional Center for CYSHCN
Amy D'Addario	Children's Hospital of Wisconsin	ECCS Project Coordinator
Lynn Hrabik	UW-Madison Waisman Center	Systems Integration Grant Evaluation Coordinator
Kristina Jones	UW-Madison Waisman Center	Transition Hub Coordinator
Brynne McBride	ABC for Health, Inc.	Assistant Director
Mary Mundt-Reckase	Gundersen Health System	Wisconsin First Step Manager
Tracey Ratzburg	Children's Hospital of Wisconsin	Director, NE Regional Center for CYSHCN
Julia Stavran	Marathon County Health Department	Program Manager, Northern Regional Center for CYSHCN
Angela Weideman	Western Regional Center	Director, Western Regional Center for CYSHCN
<b>Wisconsin Council on Children and Families</b>		
Jon Peacock	Wisconsin Council on Children and Families	Research Director
<b>Children's Health Alliance of Wisconsin</b>		
Matt Crespin	Children's Health Alliance of Wisconsin	Associate Director
Karen Ordinans	Children's Health Alliance of Wisconsin	Executive Director
<b>Private Payers</b>		
Monica Allen, APSW, CCM	Molina Healthcare of Wisconsin	Supervisor, Utilization Management
Dana Lauer	United Healthcare Community Plan	Program Manager
Lynn M. Kryfke, RN, MSN	Children's Community Health Plan	Director, Health Plan Clinical Services

\*Indicates Medical Home Systems Integration Grant Management Team member.



# Appendix 2: MHIT Vision and Mission

## MHIT VISION AND MISSION

**Vision:** All children and youth in Wisconsin will receive care within a medical home to promote optimal health and support families.

**Mission:** In collaboration, the MHIT and other statewide partners will develop, promote, implement and evaluate a state plan to increase the number of Wisconsin children and youth served within a medical home, particularly those with special health care needs. Implementation of the plan will be sustained through members' integration of plan elements into their work and organizational priorities.

## COMMON DEFINITIONS

**Medical Home:** A comprehensive way of providing health care to children and youth, medical homes are most commonly composed of primary care clinicians (such as pediatricians, family physicians, pediatric nurse practitioners and physician assistants), care team members, and family members. In a medical home, care is coordinated based on family priorities. It is also accessible, continuous, comprehensive, compassionate and culturally effective. There is growing evidence that care provided within the medical home model supports the Institute for Healthcare Improvement's Triple Aim, including improved patient and family experience, overall improvement in population health, and for certain patient populations, reduced cost of care.

**Children and Youth with Special Health Care Needs (CYSHCN):** The federal Maternal and Child Health Bureau defines CYSHCN as "those who have a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

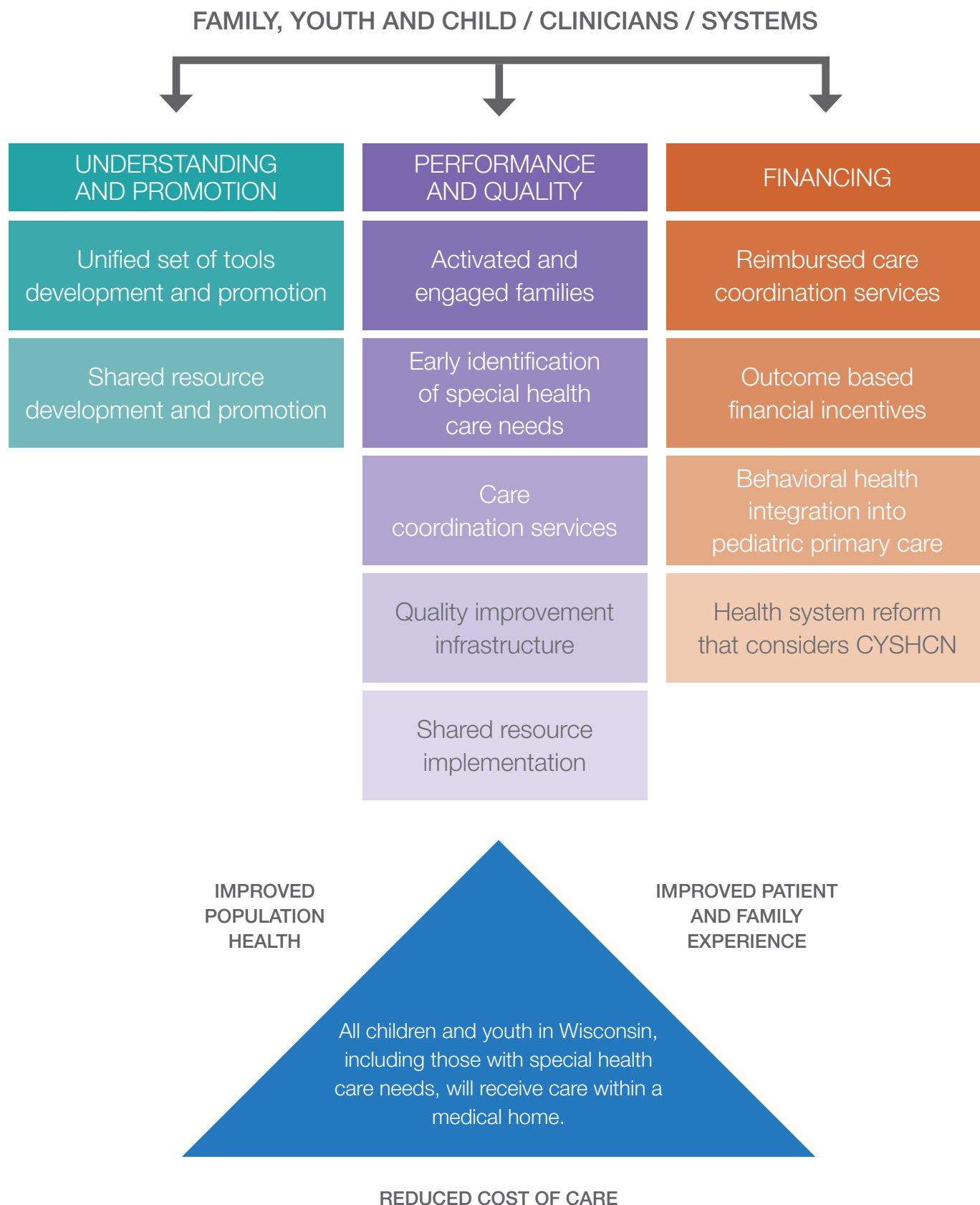
The CSHCN Screener<sup>®</sup> (a parent-based survey tool) was designed to reflect this definition. Children with a positive screen on this instrument are those up to age 18 with prescription medication dependence, above-average use of services, and/or functional limitations expected to last or lasting at least 1 year. The National Survey of Children with Special Health Care Needs (2009-2010) estimated approximately 200,000 Wisconsin children have special health care needs according to these criteria.

# Appendix 3: Evaluation Measures listed by Objective

EVALUATION METHOD	DATA SOURCE	OBJECTIVE
Clinician survey/ assessment	Referral/Release tool users	2.C.4
	Medical Home Care Coordination Measurement Tool	2.C.5, 3.C.1
Database query	SPHERE database	1.F.3, 2.F.1, 2.F.2, 2.C.4, 2.S.2
Document review	Act Early State Plan	2.S.1
	Child Psychiatry Consultation Program reports	3.S.3
	DHS's CYSHCN Program and Birth to 3 agreement	2.S.2
	EPSDT Memo and other state policy documents	2.S.6
	Family Voices family training materials/participant lists	2.F.3, 2.F.4, 2.F.5, 3.F.1
	MHIT agenda/minutes/participant lists/products	1.F.1, 1.F.2, 1.C.1
	Medical home QI pilot project applications/reports	1.C.2, 2.C.1, 2.C.4, 2.C.5, 2.S.4, 2.S.5, 3.C.1, 3.S.1, 3.S.2
	MH SIG work plans/reports/agenda/minutes	1.S.1, 1.S.2, 2.F.5, 2.S.3, 2.S.4, 2.S.5, 3.C.1, 3.S.2, 3.S.3
	Regional Centers for CYSHCN and Collaborators Network work plan/reports	1.S.3, 2.C.3, 2.S.2
	Shared Resource work group agenda/minutes/participant lists/products	2.C.3
WiSMHI clinician training materials/participant lists	1.C.3, 2.C.3, 3.C.2	
WiSMHI family training materials/participant lists	2.F.2, 3.F.1	
Family survey	FCCA or FECC	2.F.3

EVALUATION METHOD	DATA SOURCE	OBJECTIVE
Online user survey	First Step resource website	1.F.4, 1.S.4
PDSA cycle tests	Care4Kids	1.C.2, 2.C.2, 2.S.5
	Medical home QI pilot projects	2.C.1
Stakeholder interviews	Care Coordination mapping/gap analysis	3.S.1
Training pre/post tests	Family Voices: family training	1.F.4, 2.F.1, 2.F.3, 2.F.4, 3.F.1
	WiSMHI clinician training	1.C.3, 2.C.2
	WiSMHI family training	1.F.3, 2.F.1, 2.F.2, 3.F.1
Website audit	Family Voices website	1.F.2
	Parent 2 Parent website	1.S.3
	Regional Centers for CYSHCN	1.S.3
	Statewide primary care clinician organization websites (e.g., AAP)	1.C.3
	WiSMHI	1.S.3
Website analytics	Family Voices	1.F.3

# Appendix 4: Theory of Change Diagram



#### References

1. Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey. 2009-2010 National Survey of Children with Special Health Care Needs. Available at: <http://www.cdc.gov/nchs/slaits/cshcn.htm>
2. Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey. 2011-2012 National Survey of Children's Health. Available at: <http://www.cdc.gov/nchs/slaits/nsch.htm>
3. Wisconsin Children and Youth with Special Health Care Needs Medical Home Report, 2013. Available at: [www.dhs.wisconsin.gov/publications/P0/p00615a.pdf](http://www.dhs.wisconsin.gov/publications/P0/p00615a.pdf)
4. Council on Children with Disabilities and Medical Home Implementation Project Advisory Committee, Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems, *Pediatrics*, 2014; 133(5): e1451 -e1460. Available at: <http://pediatrics.aappublications.org/content/133/5/e1451.full>
5. National Consensus Framework for Systems of Care for Children and Youth with Special Health Care Needs Project. Standards for Systems of Care for Children and Youth with Special Health Care Needs, 2014. Available at: <http://www.amchp.org/AboutAMCHP/Newsletters/member-briefs/Documents/Standards%20Charts%20FINAL.pdf>

Wisconsin Children and Youth with Special Health Care Needs Program  
1 W. Wilson, P.O. Box 2659  
Madison, Wisconsin 53701-2659

This publication was supported by funding from the U.S. Health Resources and Services Administration, Maternal and Child Health Bureau, through grant number 70MC27553, Integrated Community Systems for Children with Special Health Care Needs.

P-01149 (12/2015)