MHIT Meeting Minutes
August 21, 2017

In-person attendees: Tera Bartelt, Becky Burns, Kim Eithun Harshner, Sharon Fleischfresser, Anne Harris, Peggy Helm-Quest, Lynn Hrabik, Arianna Keil, Naomi Kowald, Colleen Lane, Elizabeth Oftedahl
By phone attendees: Sharon Barkley, Brigit Frank, Penny Funk, Brad Holman, Robin Mathea, Mary Mundt-Reckase, Jenny Podevels, Tracey Ratzburg, Julia Stavran

Welcome and Overview

- Introductions
- History

This is the last MHIT meeting. The MHIT served as an essential group of stakeholders for Wisconsin's Medical Home Systems Integration Project, designed to ensure more children receive care within a medical home. The Medical Home Systems Integration Project began in 2014 with grant funding from the Health Resource & Services Administration (HRSA) to the Wisconsin Department of Health Services (DHS) Maternal Child Health (MCH) Children & Youth with Special Health Care Needs (CYSHCN) Program who contracted with the Wisconsin Medical Home Initiative at Children's Health Alliance of Wisconsin (CHAW). Wisconsin is one of 16 states funded for this program. The focus of the project is to increase by 20% the number of Wisconsin children served within a medical home. To meet this goal, this group brought together a broad cross-sector of professionals to generate the *Wisconsin State Plan to Serve More Children and Youth within Medical Homes Including Those with Special Health Care Needs*.

There are three focus areas:

1. Understanding & Promotion
2. Performance & Quality
3. Financing (especially for Care Coordination)

Objectives Focused on:
Common Messages & Tools
Care Coordination Mapping (state of the state regarding Care Coordination)

All states involved in this program must:

1. Implement Shared Plans of Care
2. Integrate care for children with special healthcare needs
3. Develop a shared resource (we chose to focus on pediatric behavioral health resources)

Care Coordination Innovation Series
Care Coordination Mapping Project
Presenter: Lynn Hrabik, Evaluation Coordinator, UW-Madison Waisman Center

Materials related to this presentation can be found at: http://www.wismhi.org/wismhi/About-Us/System-Integration/Medical-Home-Implementation-Team

The *Wisconsin Care Coordination for Children and Youth Mapping Project* is a strength and gap analysis (mapping exercise) of current care coordination activities that are being implemented in different systems and organizations across the state.

This exercise looked at:

1. What and how is care coordination being implemented?
2. What assets exist and how can we build on them?
3. What gaps exist and how can we address them?

Interviews were conducted with a diverse group of systems, providers, and family representatives from across the state to answer these questions. A total of 40 interviews were conducted between October 2015 and December 2016. Here are some key findings.

- Due to resource limitations, care coordination services were routinely offered at a level designed to ensure more families could receive at least some care coordination. Most models are designed to build family skill and confidence in taking on their own child's care coordination over time.

- Having access to information about what services/supports were available and where to receive them shortly after the diagnosis and continuing through the lifespan was a consistent challenge cited by families. More than one parent indicated that dealing with insurance issues is the most challenging aspect of having a child with special health needs.

- No provider or system representatives indicated that they knew of an existing model that would fully cover the cost of pediatric care coordination for all children.

- Electronic health records (EHRs) can facilitate the use of care plans when there are templates within the system, when they can auto-populate, and when they can be shared in locations where others can access them. The lack of flexible EHRs creates more work for providers to create, update and share care plans. All families indicated that they had access to written plans or medical summaries in some form, and that they were the ones who facilitated communication between providers about their child's care needs, including providing copies of written care plans.

Follow Up from May Meeting

"Small Steps toward the Goal" form

Large group conversation related to the presentation and question: *What would it take for us to provide care that is coordinated in a way that helps to ensure all kids' optimal health?*

What is a Medical Home? Brochure

This brochure is now available in English and Spanish. More information on the brochure can be found at: http://www.wismhi.org/wismhi/Clinicians/Family-Partnership

- Organizations may download and customize the brochure by adding their logo and contact information.
- To order hard copies of the brochure, visit WI DHS' Publications Library, and enter publication #P-01747

Celebration of and Reflection upon our Achievements

The focus of the project is to increase by 20% the number of Wisconsin children served within a medical home. This includes all Wisconsin children.

1. Wisconsin State Plan
2. Plan Objective Priorities
    a. Common tool (What is a Medical Home? brochure)
    b. Care Coordination Mapping Activity
3. Care Coordination Innovation Series

Future Possibilities and Wrap-Up

Thank you for your valuable contributions to the Medical Home Implementation Team (MHIT). If you are interested in participating in groups working on related topics, consider reaching out to the contacts listed below for more information.

1. Maternal Child Health Quality Network
   Contact: Gabrielle Rude, Director of Practice Transformation, Wisconsin Collaborative for Healthcare Quality
   grude@wchq.org

2. Partnership for Value Based Coordinated Care
   Contact: Kristen Grimes, Director of Strategic Partnerships, Children's Health Alliance of Wisconsin
   kgrimes@chw.org