

Wisconsin Care Coordination for Children and Youth Mapping Project

Executive Summary | July 2017

The Wisconsin Department of Health Services' Children and Youth with Special Health Care Needs (CYSHCN) Program received notification of funding for a three-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. To achieve the goal of having more children served within a medical home, the project was required to develop a state plan to serve as a road map in its efforts. A team of over 40 professionals and families was established to collaboratively 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. This team was designated the Wisconsin Medical Home Implementation Team, or MHIT. One activity recommended by MHIT members during the state plan development process was to complete a strength and gap analysis (mapping exercise) of current care coordination activities being implemented in different systems and organizations across the state and to disseminate the results. More specifically, the purpose of the mapping exercise was to answer the questions to the right.



1. What and how is care coordination being implemented for children and youth currently in Wisconsin?
2. What gaps exist?
3. What assets can we build upon and share?

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 autopopulate, 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.