Blazing the Trail of Reform for Children and Youth with Special Health Care Needs (CYSHCN):
Wisconsin’s Path to System Integration for CYSHCN
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Wisconsin Department of Health Services
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Wisconsin CYSHCN Program and Collaborators Network

Program goal: CYSHCN are identified early; receive high quality coordinated care; and receive, with their families, the supports they need.

Regional Centers for CYSHCN
First Step
Wisconsin Statewide Medical Home Initiative
Youth Health Transition
Family Voices of Wisconsin
Parent-to-Parent of Wisconsin
ABC for Health, Inc.
Great Lakes Inter-tribal Council
Wisconsin Overview

More than one in six children have a special health care need (approximately 200,000 children).

This outcome was evaluated using five measures from the 2009–2010 National Survey of Children with Special Health Care Needs: child has at least one personal doctor or nurse, received family-centered care in the previous 12 months, has no problems getting referrals when needed, has usual sources of sick and well care, and receives effective care coordination.


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Wisconsin Medical Home

Medical Home by Subgroup

By household income as measured by Federal Poverty Level [FPL] (percent meeting the outcome)
- 400% FPL or more (51.1)
- 300–399% FPL (48.4)
- 200–299% FPL (43.5)
- 0–199% FPL (38.0)

By type of insurance (percent meeting the outcome)
- Private insurance only (50.5)
- Public insurance only (35.4)
- Both public and private insurance (37.7)
- Uninsured (NA*)

* Sample sizes too small to meet standards for reliability or precision

Disparities

African American/Black children are less likely to have a medical home than other children.
- 47% White
- 31% Hispanic
- 28% African American/Black

Children with emotional, behavioral or developmental (EBD) issues are less likely to have a medical home.
- 49% With no EBD issues
- 35% With EBD issues


Fleischfresser NASHP 10-21-15
In Wisconsin, the percentage of parents reporting that they are partners in decision making varies by ethnicity, medical home status, and presence of emotional, behavioral, or developmental (EBD) issues.


In Wisconsin, the percentage of parents reporting that they can easily access community-based services varies by ethnicity, medical home status, and presence of emotional, behavioral, or developmental (EBD) issues.

Components of Medical Home

<table>
<thead>
<tr>
<th>Accessible</th>
<th>State</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a personal doctor or nurse</td>
<td>96.4%</td>
<td>93.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family-Centered Care (% who Report &quot;Usually&quot; or &quot;Always&quot;)</th>
<th>State</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor spends enough time</td>
<td>80.1%</td>
<td>77.5%</td>
</tr>
<tr>
<td>Doctor listens carefully</td>
<td>69.7%</td>
<td>87.7%</td>
</tr>
<tr>
<td>Doctor provides needed information</td>
<td>84.0%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Doctor helps parent feel like partner in care</td>
<td>88.0%</td>
<td>87.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comprehensive</th>
<th>State</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had no problems getting referrals when needed</td>
<td>77.5%</td>
<td>76.6%</td>
</tr>
<tr>
<td>Has a usual source for both sick and well care</td>
<td>88.4%</td>
<td>89.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coordinated (% Among CYSHCN Receiving 2 or More Types of Services)</th>
<th>State</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received effective care coordination, when needed</td>
<td>58.7%</td>
<td>56.0%</td>
</tr>
<tr>
<td>Received any help with arranging or coordinating care</td>
<td>18.3%</td>
<td>21.4%</td>
</tr>
<tr>
<td>Very satisfied with communication between doctors, when needed</td>
<td>67.4%</td>
<td>62.7%</td>
</tr>
<tr>
<td>Very satisfied with communication between doctors and school, when needed</td>
<td>59.0%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Culturally Effective (% who Report &quot;Usually&quot; or &quot;Always&quot;)</td>
<td>State</td>
<td>Nation</td>
</tr>
<tr>
<td>Doctor is sensitive to family customs and values</td>
<td>91.9%</td>
<td>88.9%</td>
</tr>
</tbody>
</table>


Wisconsin Medical Home Systems Integration Grant (MH SIG)

Goal: Increase the number of Wisconsin CYSHCN who receive care within a medical home by 20% by September 2017 (from 44.1% to 52.9%).

- Medical Home Implementation Team (MHIT): state plan development, implementation, evaluation
- Family Leadership Team: family leadership capacity-building to advocate for coordinated care and family partnership within a medical home
- Shared Resource Team: statewide, online resource development
Wisconsin Medical Home State Plan

Children, Youths, and Families -- Clinicians -- Systems

Understanding and Promotion

Performance and Quality

Financing

Better Health

Better Care

All children and youth in Wisconsin, including those with special health care needs, will receive care within a medical home.

Lower Cost through Improvement

Wisconsin MH SIG

Builds on existing Wisconsin efforts

– CYSHCN Program’s Regional Centers and Collaborating Partners infrastructure

– Maternal and Child Health’s Early Childhood Systems Initiative with local health departments

– Division of Health Care Access and Accountability (DHCAA) Children with Special Needs grant: Special Needs Program for Children with Medical Complexity (Health Care Innovation Award Round Two)

– DHCAA, Division of Long-Term Care and Department of Children and Families: Care4Kids
Care4Kids

- Medicaid program for children in out-of-home care
- Authorized in 2014 under an Alternative Benefit Plan (ABP) state plan amendment (TN#13-034). ABPs are allowed in federal law under §1937 of the Social Security Act (2010)
  - Alternative Benefit Plans must cross walk all benefits with Benchmark Plan and Medicaid State Plan
- Implemented January 1, 2014, in six southeast Wisconsin counties
- Current enrollment: about 2,800 children
- Children can remain enrolled 12 months post permanency per Medicaid eligibility

Care4Kids Covered Services

- An Out-of-Home Care Health Screen within 2 business days of entering care
- A Comprehensive Initial Health Assessment within 30 days of entering care
  - Includes a mental health and/or developmental screen
- A Comprehensive Health Care Plan within 60 days of enrollment
- A mental health evaluation (if needed)
- All Medicaid-covered benefits with some carve-outs similar to HMO
- A comprehensive dental evaluation within 3 months of entering care
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) at enhanced periodicity
- A health care coordinator
Care4Kids Health Care Coordination

Creation of a Health Care Coordination (HCC) team

- Health care information gathering and organizing
- Health care recommendations and referral tracking
- Facilitation of coordinated health care delivery
- Information sharing among health care providers

Care4Kids Quality Measures

<table>
<thead>
<tr>
<th>Current Measures</th>
<th>Event-driven measures</th>
<th>Measures TBD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time-driven measures</strong></td>
<td><strong>Event-driven measures</strong></td>
<td><strong>Outcomes Measures</strong></td>
</tr>
<tr>
<td><strong>Start = Year 1</strong></td>
<td><strong>ED and Inpatient Care</strong></td>
<td>• Member satisfaction</td>
</tr>
<tr>
<td>Prepare and set infrastructure</td>
<td>Follow-Up after Hospitalization for Mental Illness within 30 days (FUH-30)</td>
<td>• Impact of trauma-informed care on member outcomes</td>
</tr>
<tr>
<td>1st year for which performance data would be used for baselines</td>
<td>Ambulatory care (ED utilization)</td>
<td>• C4K impact on education/school absenteeism</td>
</tr>
<tr>
<td>Analyze data Set goals for the next year</td>
<td>Inpatient utilization</td>
<td></td>
</tr>
<tr>
<td>1st year with performance goals</td>
<td>Metabolic monitoring for antipsychotic Rx, psychotropic Rx</td>
<td></td>
</tr>
</tbody>
</table>

- Acute health screen within 2 business days
- Comprehensive assessment (30 days)
- Lead screen
- Developmental/mental health screen
- Developmental/mental health assessment
- Comprehensive Health Care Plan
- Preventive well child checks (EPSDT)
- Dental exams
- Immunizations
Special Needs Program (SNP) for Children with Medical Complexity

- A care coordination and medical co-management program for children with medical complexity and high tertiary center resource use
- Partnership between:
  - Wisconsin Medicaid;
  - Children’s Hospital of Wisconsin and Medical College of Wisconsin (Milwaukee, Wisconsin) and;
  - American Family Children’s Hospital (Madison, Wisconsin)
- Implemented September 1, 2014
- Projected enrollment: 1,800 lives touched over 3 year grant period
- Center for Medicare and Medicaid Innovation, Health Care Innovation Award Round Two (HCIA2) Awardee

SNP Care Coordination Innovations

- Intensive model – for children with the highest tertiary center resource use
- Ambulatory model – for children with moderately high tertiary center resource use and high community resource needs
- Tiered level of services based on the child’s needs and time in program
- Utilize lay navigators and care coordination assistants to expand capacity of nurse case managers and facilitate collaboration with community agencies
SNP Quality Measures

- **Process measures**
  - Referrals, post-discharge phone call, care coordination activities
- **Outcomes measures**
  - Resource utilization and cost, family impact survey, provider impact survey
- **Evaluation**
  - Independent evaluation conducted by Mathematica Policy Research

Systems Integration Academy (SIA)

- **Technical assistance support from National Academy of State Health Policy and National Improvement Partnership Network**
- **State strategy teams:**
  - Integration
  - Cross-system care coordination
  - Shared resources
Learnings

- Broad support in concept for Medical Home among families, providers, state agencies, and payers
- Lack of common definitions and messaging related to Medical Home and care coordination

• Care coordination within and across systems identified as priority
• Need for quality improvement infrastructure at the practice level
• Title V role as facilitator of system integration

Next Steps

• Care coordination mapping and gap analysis.
  – Identify existing care coordination activities, funding streams, and gaps.
• Care coordination training development and dissemination.
• Apply SIA Aims to CYSHCN Collaborators Network work and practice-based/health care system QI grants.
• Explore SIA Aims application to Care4Kids and Special Needs grant.
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