

FOR EVERY CHILD WITH SPECIAL NEEDS AND THEIR FAMILIES

"Medical Home means that I am welcoming kids into my practice with special healthcare needs and my practice is willing to make changes in how we care for those kids, over time, to improve their care, to make their care more efficient, and more comprehensive."

Medical Home Learning Collaborative Physician, Dane County



National Performance Measure 2¹

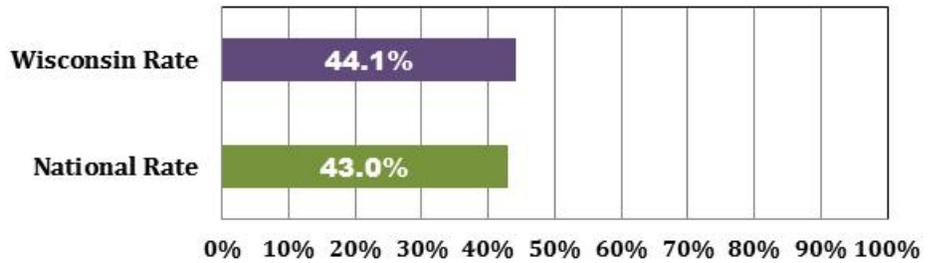


WISCONSIN DISPARITIES

- African American/Black children are less likely to have a medical home than other children.
 - 47%** White
 - 31%** Hispanic
 - 28%** African American/Black
- Children of parents with a high school education are less likely to have a medical home.
 - 48%** More than a high school education
 - 30%** High school education
- 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

Medical Home

Children and Youth with Special Health Care Needs (CYSHCN) receive coordinated, ongoing, comprehensive care within a Medical Home



Why is this important?

The American Academy of Pediatrics (AAP) defines a Medical Home as a system of care for children that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. The Medical Home assures families have a home base for a child's care throughout the life course.

Key components of a Medical Home include care coordination services; collaboration between primary, specialty, and sub-specialty providers; and partnership between the primary care provider and other community providers serving CYSHCN and their families.

The Medical Home provides preventive services, immunizations, growth and developmental assessments, appropriate screening, patient and family counseling on health and psychosocial issues, and ensures continuity of care from infancy through transition into adulthood.

¹ 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.

Wisconsin Medical Home by Subgroup

The percentage of CYSHCN who have a medical home varies by the type of special health care need, family structure, household income and type of insurance.

By type of special health care need (percent meeting the outcome)

- Managed by prescription medications (53.0)
- Above routine need/use of services (41.0)
- Prescription medications and service use (44.5)
- Functional limitations (29.4)

By family structure (percent meeting the outcome)

- Two-parent biological or adoptive family (50.0)
- Two-parent family, at least one step-parent (38.8)
- Mother only—no father present (37.6)
- All other family structures (25.4)

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

Data Source: Data in this report are from the National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website www.childhealthdata.org

Wisconsin Medical Home Initiative

Medical home is measured by components that include having a personal doctor or nurse; having a usual source of both sick and well care; feeling the doctor spends enough time, listens carefully, provides needed information, makes parents feel like partners in their child's health care, and is sensitive to family customs and values; receiving referrals when needed; and receiving effective care coordination when needed.

The Children and Youth with Special Health Care Needs Program contracts with the **Wisconsin Statewide Medical Home Initiative (WISMHI)** to lead medical home improvement and provide training in collaboration with state, regional and community partners.

As of October 2014, there have been 16 pediatric mental health screening trainings and 168 developmental screening trainings for primary care providers around the state (see map).

Primary care practices reported after training they were more likely to screen their patients for developmental delays using standardized screening tools, more likely to refer for services, and were more knowledgeable about community resources.

2013 and 2014 Activities

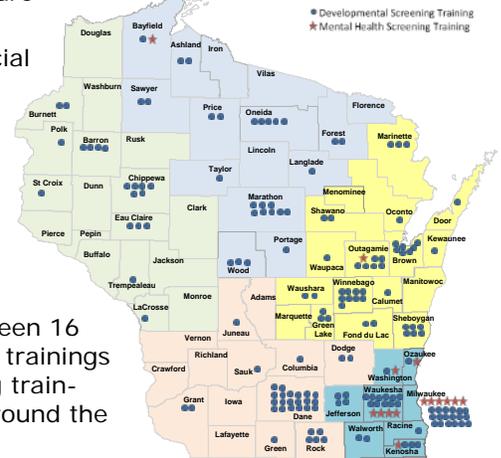
WISMHI Outreach Activities:

In addition to clinician and care team member trainings on developmental screening and pediatric mental health screening, WISMHI also:

- Creates and distributes the Medical Home Minute, a monthly e-newsletter to 600+ primary care clinicians and care team members featuring relevant state and national resources to promote a medical home approach.
- Worked to develop the Child Psychiatry Consultation Program (CPCP), a telephone consultation line for Wisconsin primary care clinicians. The Assembly Bill for the CPCP was introduced and passed in the Health Committee in October 2013, passed the full assembly unanimously in November, and passed the senate and was signed into law by Governor Walker in February 2014.

At the Regional Centers for CYSHCN:

- Following training and support from WISMHI and a Regional Center for CYSHCN, more pediatric sites are providing routine screening of children's development using the Ages and Stages Questionnaire-3:
 - All Mayo Clinic primary care pediatric sites in the Chippewa Valley. (*Western Regional Center for CYSHCN*)
 - All Affinity and Prevea primary care pediatric sites in the Fox Valley. (*Northeast Regional Center for CYSHCN*)
- In Marathon County, Marshfield Clinic Health System initiated developmental screening system-wide with support from the Developmental Screening Action Team. (*Northern Regional Center for CYSHCN*)
- Education and training on effective practices to strengthen parent partnerships and connect families to community supports was provided to 38 medical residents. (*Southern and Southeast Regional Centers for CYSHCN*)



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Special Health Care Needs
<https://www.dhs.wisconsin.gov/cyshcn/>