National Resource Center
FOR PATIENT/FAMILY-CENTERED MEDICAL HOME

Meeting the Care Needs of CYSHCN and Their Families: Implementation of Equitable Care Coordination
Webinar
April 28, 2022
Suggested Resources Handout

Resource	Description
• **CARE Medical Home Series for families - Notebook and Curriculum**	• The C.A.R.E. Medical Home Series for Families was developed to support families who have children or youth with special health care needs. It is a series of four presentations and discussions: ○ **C**aring for the Whole Family ○ **A**ssembling a Care Notebook ○ **R**equesting a Shared Plan of Care ○ **E**xploring Care Mapping
• **Social Determinant of Health Screener Recommendation**	• The American Academy of Pediatrics does not recommend any specific screener. Many of the health systems the Wisconsin team works with have adopted one of various screeners, including Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), Accountable Health Communities (AHC), and Health Leads, a screener embedded in the Electronic Medical Record and many others. • Visit the Screening Technical Assistance and Resource Center for more screening options.

• **Care coordination modules and brochures developed by the Wisconsin team**	• This information is housed on Family Voices of Wisconsin website, FamilyVoicesWI.org. Much of it is on the *Coordinating Your Child's Health Care* page of the website.
	• Other items, like our *Care Mapping* video are in our Resource Library.
	• Finally, guidelines have been created for a care coordination training. These are not currently on the Family Voices of Wisconsin website but will be added to the care coordination webpage in the future:
	  ○ Engaging Families in Care Coordination
	  ○ Care Coordination Case Study

• **39 Cards**	• Goal Cards were developed during Wisconsin's participation in the Collaborative Improvement and Innovation Network (CoIIN) to Advance Care for Children with Medical Complexity project. The cards were implemented to help the family and care team break down the many complex needs that a child with medical complexity may have into smaller, achievable goals. The 39 cards are available in hard copy or a website in English or Spanish.
• **National Academy for State Health Policy (NASHP) Care Coordination Standards**	• The Care Coordination Standards outline the core, system-level components of high-quality care coordination for CYSHCN. These standards are designed to help state officials and other stakeholders develop and strengthen high-quality care coordination for children with the goal of identifying and assessing the need for care coordination, engaging families in the care coordination process, building a strong and supportive care coordination workforce, and developing team-based communication processes to better serve children and families.

• **Pediatric Care Coordination Curriculum, 2nd Edition**	• The Pediatric Care Coordination Curriculum, 2nd Edition is designed to build capacity among diverse partners and collaborators (American Academy of Pediatric Chapters, Maternal and Child Health Title V/Children and Youth with Special Health Care Needs programs, pediatricians, families, and others) through the following activities:
	  ○ Effective implementation of key components of care coordination
	  ○ Collaborative communication within inter-professional care teams
	  ○ Investment in technology solutions
	• The Getting Started guide provides an overview of the curriculum and an at-a-glance of the 5 modules included in the curriculum.

• **Pediatric Integrated Care Survey**	• The Pediatric Integrated Care Survey is a family-reported survey instrument that measures family experiences of care integration. This tool can be used to inform quality improvement and interventions to improve care integration. It is also available in Spanish. A user manual has been developed to walk users through the tools and subsequent modules.
• **Care Coordination Measurement Tool**	• The Care Coordination Measurement Tool enables assessment of value in health delivery models by measuring the activities of care coordination, necessary resources to implement those activities, and resulting outcomes. An implementation and adaptation guide is available to support users.

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