

# Mapping Care Coordination for Children in Minnesota

SOUTHWEST/SOUTH CENTRAL REGIONAL REPORT

## Mapping Care Coordination for Children in Minnesota: Southwest Report

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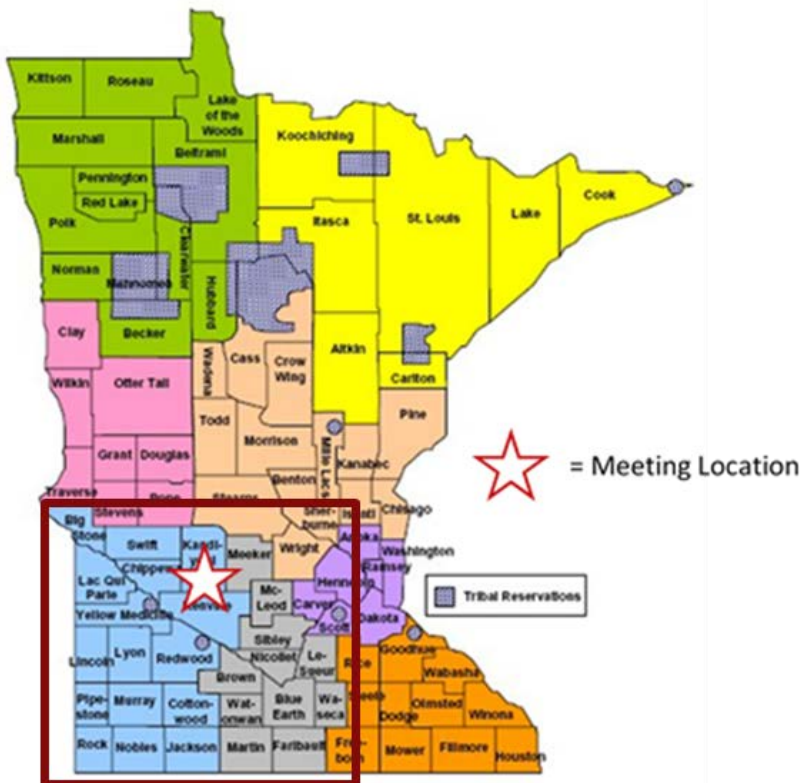
## Southwest / South Central Minnesota Findings

The following section details the findings of the regional care coordination systems mapping activities that occurred in the Southwest/South Central Region of the State. Separate reports for each of the other regions can be found on the [“Mapping Care Coordination in Minnesota” webpage](#) on the MDH CYSHN website.

### Regional Boundaries

The regional boundaries of the Southwest / South Central area of the state are highlighted in Figure 1 below. The meeting took place in Willmar, MN, which is denoted with a star on the map. Participants represented families, agencies, clinics, and organizations located within the counties in the box outlined in red on the map. The region stretched from the Iowa border on the south, to Swift and Kandiyohi counties in the north. The border stretches to South Dakota on the west, and then to Le Sueur and Blue Earth counties in the east.

Figure 1: Southwest/ South Central Region and Meeting Location



### Strengths and Challenges in Providing Care Coordination

In conducting systems mapping, it was important to begin by developing an understanding of what works well and what needs improvement in providing care coordination. The main themes from in strengths and challenges experienced around care coordination in Southwest / South Central Minnesota are listed below.

“Care coordination of CYSHN in Southwest / South Central Minnesota currently works because...”

- Agencies work together toward the best interests of the child and family
- There is good communication between agencies
- People are willing to come together to help and collaborate
- Care coordinators are very dedicated in their work with families
- Some agencies/providers are working together to break down barriers around data sharing
- Parents are doing the majority of the work in finding resources/coordinating care
- There are certified Health Care Homes in the region that have designated care coordinators

“Care coordination of CYSHN in Southwest / South Central Minnesota would be better if...”

- More staff was available to help families in the home
- More resources/services were available/accessible for families
- More stakeholders would share their care plans/etc. so that all the information can be pulled together
- It were less confusing on how to find / navigate services
- There were more identified care coordinators for specialty care in the region
- Stakeholders were less territorial and would collaborate more to help families rather than having families fall through the cracks because of territory issues
- Waiting lists would decrease
- “Everybody could get the whole picture of my kids rather than just the area they see.” – Parent
- There were a centralized “coordinator” of the care coordinators
- Parents were not always having to serve as the coordinator or go-between of the different care coordinators
- Everyone had access to and read through assessments/evaluations rather than having to duplicate them
- There is more transportation to services available
- The bigger agencies/health systems did not have to “refer within” and were able to refer to the services/providers that were best for the families

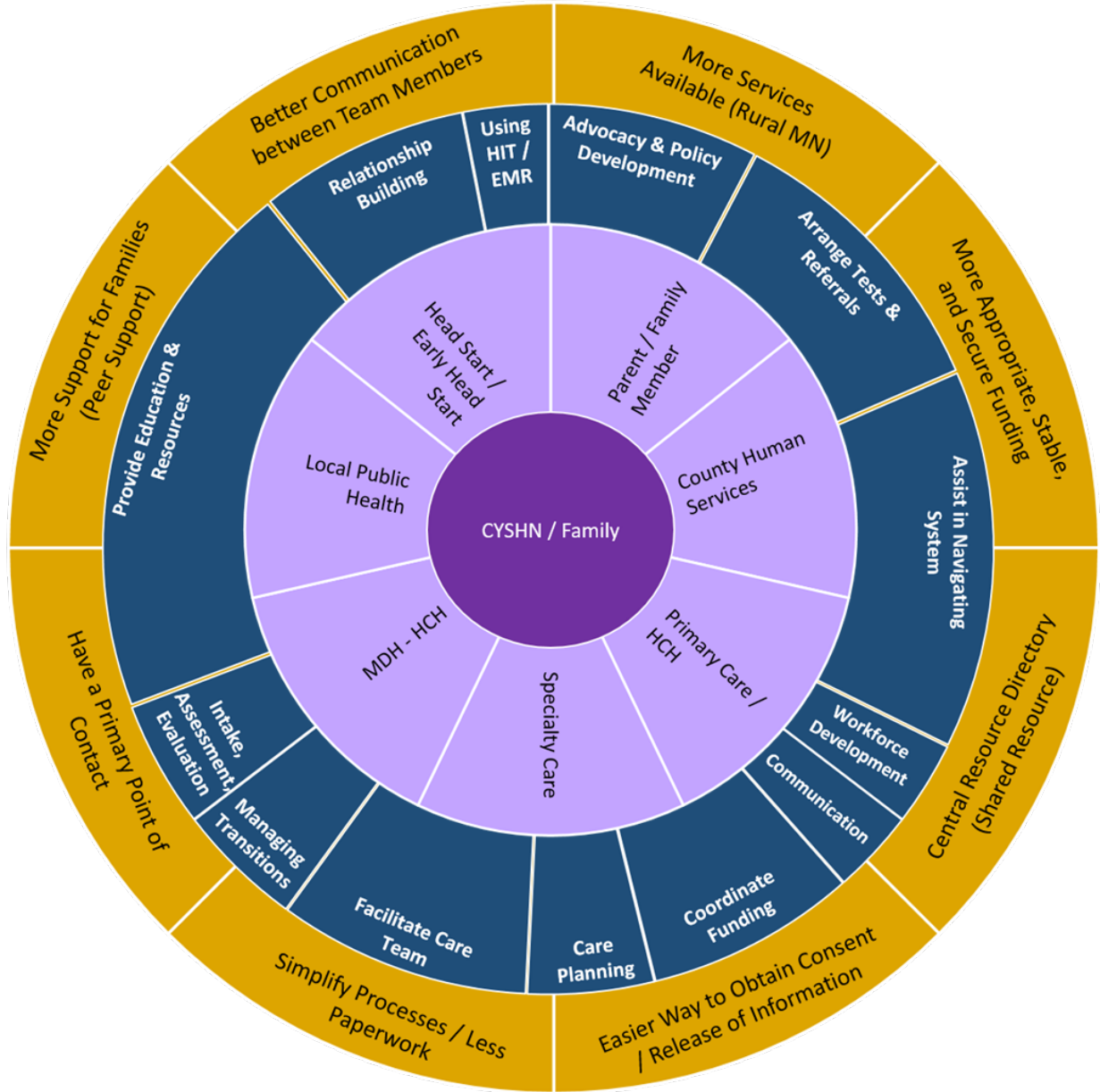
## Regional Care Coordination Framework

All participants completed individual systems support maps (see Statewide Summary for more details), and then all the maps were compiled to create a regional care coordination framework using the Circle of Care Modeling (CCM) approach. CCM was used to identify the different various partners providing care coordination services, their primary responsibilities, and their common wishes on how to improve the system. *The CCM approach positioned CYSHN and their families at the center of the system; the roles of care coordinators and their responsibilities were then modeled around the family.* By mapping out the various partners providing care coordination and their responsibilities, we were able to expand our understanding of what families are experiencing in care coordination, and were also able to determine areas where the infrastructure needs to be built up to improve care coordination for CYSHN and their families.

The systems mapping approach is described in the next section, and is incorporated into Figure 2. We begin by describing the various partners who provide care coordination, and then move to their primary

responsibilities in coordinating care. Finally, we explore wishes or opportunities for improvement at a systems-level; providing recommendations on how to build up the infrastructure to improve the provision of care coordination for CYSHN in Minnesota.

Figure 2: Southwest/ South Central Minnesota Care Coordination Framework



### Child and Family at the Center

For both the Statewide and Regional Care Coordination Frameworks, the child and family are placed at the center of the system. An [increasingly growing body of literature](#) points out that when the patient and/or family experience is placed at the center of care, more favorable outcomes are produced. By placing the child and family at the center of the framework, we are not only ensuring we think of their

needs and experiences first, but that we also actively partner with them first when determining what systems-level improvements need to be made.

### Roles of Partners

The next level of the Statewide Care Coordination Framework are the various roles of partners involved in care coordination. There were a total of 16 participants in the care coordination systems mapping meeting in Southwest / South Central MN. Participants represented the following areas: parents of CYSHN, primary care, local public health, specialty care, state agency staff, Head Start, and county human services. *There are many different players involved in providing care coordination, or many different types of coordinators from different service/support systems. Also of note is that families often reported that they are the main coordinator of their child’s care – or at times can be the “coordinator of all the coordinators.”*

A breakdown of the organizations/roles of participants by region is included below in Table 1. The first row of the table includes all the types of different stakeholder groups who participated in any of the five regional meetings. The second row includes the number who participated in the Southwest / South Central Regional Meeting. As you can see, there were some stakeholder groups missing in the region. These roles/organizations are not included in regional care coordination framework (Figure 2).

**Table 1: Care Coordination Systems Mapping Participant Organizations/Roles, by Region**

<b>Participant Organizations/Roles</b>	<b>Southwest/South Central</b>	<b>Percent</b>
Primary Care	5	<b>31%</b>
Parents	5	<b>31%</b>
Local Public Health	2	<b>13%</b>
Specialty Care	1	<b>6%</b>
Health Plans	0	-
MDH – Health Care Homes	1	<b>6%</b>
Education (District & State)	0	-
Head Start/Early Head Start	1	<b>6%</b>
County Human Services	1	<b>6%</b>
Mental Health	0	-
Family Organization	0	-
MN DHS	0	-
School Nurse	0	-
Interagency Early Intervention Committee	0	-
Home Care	0	-
<b>TOTAL</b>	<b>16</b>	

### Missing Partners

Table 2 above includes the various roles or organizations of the participants in the Southwest / South Central Minnesota Regional Meeting. As you can see, there were quite a few different stakeholder groups who were not present, including: health plans, education (including special education), mental health providers, human services providers, school nurses, interagency early intervention committees, and home care providers.

The participants in the meeting were also asked to list out other partners who were missing in the meeting. Responses included: local community-based services providers (e.g., Greater Minnesota Family Services), physicians/providers, youth with special health needs, other pediatric specialty providers/clinics, policy-makers (e.g., County Commissioners, Legislators, and School Board members), faith-based organizations, emergency responders, and local collaboratives.

## Primary Responsibilities

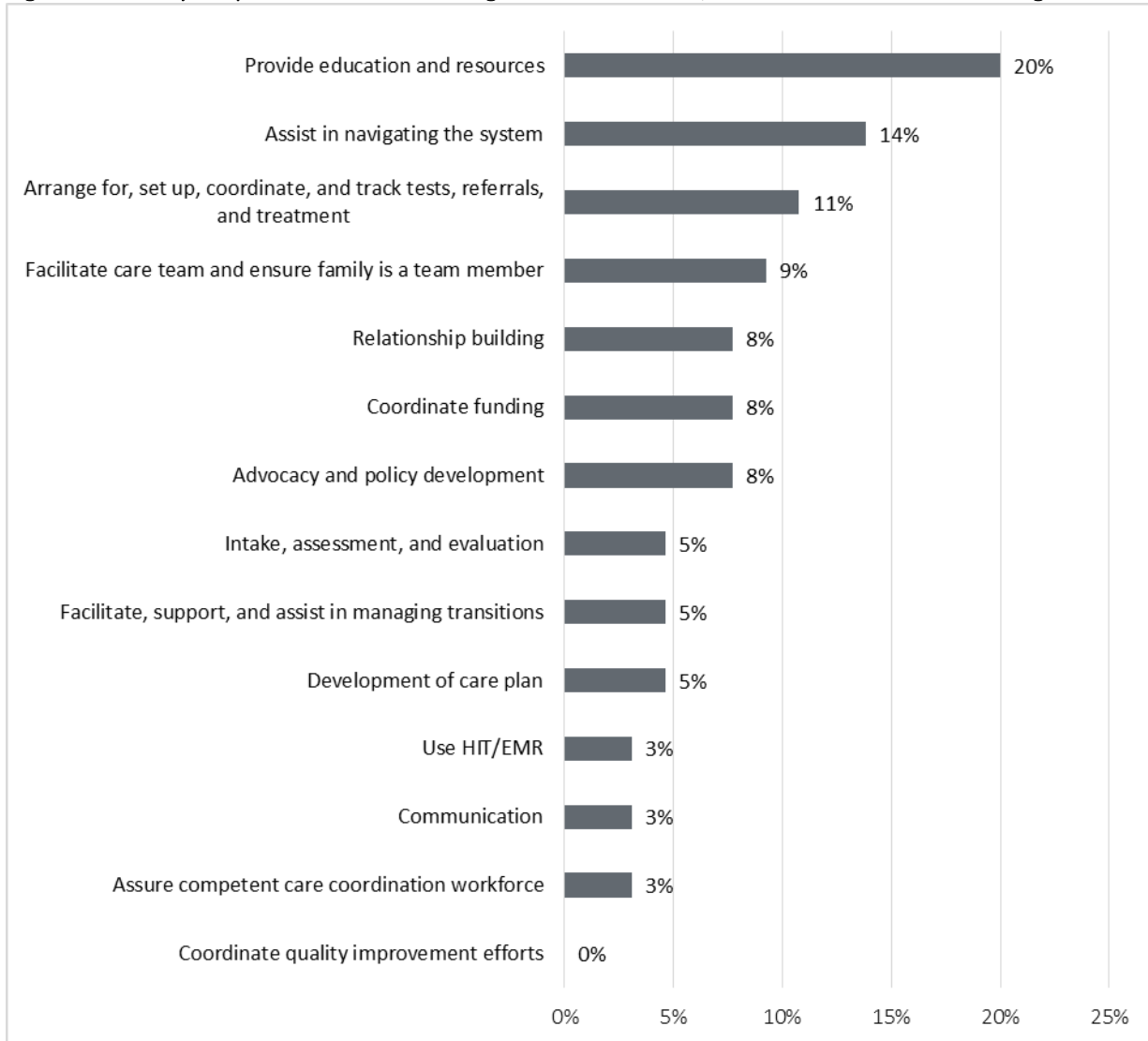
Moving out to the next level of the care coordination framework are the primary responsibilities of the providers of care coordination. Participants were asked to identify their top five responsibilities when it comes to providing care coordination for CYSHN. It is important to understand these responsibilities because they can help point toward the areas that care coordinators spend most of their time and effort. The responsibilities reported by the participants were aggregated utilizing an affinity diagramming process, and then were grouped into 14 different categories, including:

1. Advocacy and policy development
2. Arrange for, set up, coordinate, and track tests, referrals, and treatment
3. Assist in navigating the system
4. Assure competent care coordination workforce
5. Communication
6. Coordinate funding
7. Coordinate quality improvement efforts
8. Development of care plan
9. Facilitate care team and ensure family is a team member
10. Facilitate, support, and assist in managing transitions
11. Intake, assessment, and evaluation
12. Provide education and resources
13. Relationship building
14. Use health information technology/electronic medical record

Figure 3 provides the overall responsibilities reported by care coordinators in the Southwest / South Central Region. The most reported responsibility of care coordinators in the region was providing education and resources. Some of the more specific activities under providing education and resources included: educating self on diagnoses and programs; educating other staff, coordinators, and care team members; educating or coaching families; and sharing or providing information on resources or diagnoses to families. The second most reported responsibility was assisting families in navigating the system. This included activities such as helping to coordinate services, assisting with crisis prevention and management, guiding families so they can receive needed services and supports, and working to remove barriers experienced by families in navigating the system. Though coordinating quality improvement efforts was a common category of responsibility for care coordinators in other regions of the state, there were no coordinators who participated in the Southwest / South Central meeting who reported that as a primary responsibility.



**Figure 3: Primary Responsibilities in Providing Care Coordination, Southwest / South Central Region**



**Infrastructure/Supports Needed to Improve Care Coordination (“Wishes”)**

The final level of the Care Coordination Framework includes the systems-level actions that are needed to be able to improve care coordination. The participants were asked to give the top three things that they “wish” for that could help improve care coordination. We focused on calling these “wishes” because we wanted to encourage participants to think “big” when brainstorming things that could improve care coordination. Sometimes when stakeholders are asked to think of things that can improve the system or make it more easily navigable, responses can be stifled because they only will think of the smaller level things rather than the bigger problems or solutions – calling them wishes increased the creativity and honesty of the responses. All the responses statewide were compiled and grouped using an affinity diagramming process – categories were then determined based on the groups. The top “wishes” in the Southwest / South Central Region included:

- **More appropriate, stable, and secure funding for services and care coordination:** Some of the wishes that fit within this category included: increased incentives for people to provide services, increased funding to be able to hire care coordinators, increased funding for middle class families who have incomes that are too high to qualify for Medical Assistance (Medicaid), and increased stability and sustainability in funding for services.
- **More services available for families:** Related to this category, participants wished for more accessible local (and regional) services and supports – specifically related to respite care, community activities for teens/young adults, and adaptive equipment.
- **Better communication/collaboration between care team members (including family):** Participants wished for increased understanding of the importance of partnerships and a willingness of all partners to help break down barriers or territorial attitudes. They also wished for increased partnerships between different agencies and more collaboration with parents.
- **More support for families / family-centered care:** Participants wished that there would be more family advocates in the region, and for more written materials in lower reading levels or multiple languages.
- **Central resource directory / shared resource:** Participants wished for a comprehensive resource list that includes as many agencies/organizations as possible.
- **Having a primary point of contact – “coordinator for the coordinators”:** This category included a wish related to having a primary care coordinator or a “point person” who would be the central contact for a family.
- **Simplify processes for obtaining financial assistance / services – less paperwork, less duplication:** This included having fewer barriers to qualify for services.
- **Easier way to obtain consent / Release of Information:** Participants wished for a universal release of information.

## Action Planning

After developing the Care Coordination Framework, participants were asked to take into consideration the various roles, responsibilities, and wishes discussed and brainstorm some concrete action steps that could be taken to improve care coordination. The action step planning was done at four levels to gather both short and long term steps as well as get at the different stakeholders involved in the steps. These four levels included: The overall action planning responses from the Southwest / South Central Region were grouped with those from other regions to create a set of major themes action steps. They were asked to think of four levels of action planning, including:

1. Things they can do right away, on their own, in the next week to month
2. Things they can take back to their organization/team to work on over the next 3 to 12 months
3. Things they can collaborate with someone else in their region over the next 6 to 12 months
4. Things that can be worked on at the broader state level over the next 1 to 2 years

For the first three levels, participants completed a worksheet in which they listed out action steps. Some common themes and examples from these levels are included in Table 2. Responses are not included in any specific rank. Those responses included more than once are bolded.

**Table 2: Southwest / South Central Action Planning Themes and Examples**

Action Planning Theme	Can be completed within 1 month, alone	Can be completed within 3-12 months, within organization/team	Can be completed within 6-12 months, with others in region
Taking information from meeting back to staff	<ul style="list-style-type: none"> <li>• <b>Bring information back to management and/or other staff within office/organization</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Follow-up and share additional resources learned about at the meeting with coworkers and/or management</b></li> <li>• Communicate back to my organization on the experiences shared by the families who attended</li> <li>• Have a discussion with others in my organization on the issues of not having places to refer to and not having care coordinators</li> <li>• Discuss issues with my organization on schools and family services not having enough resources</li> </ul>	
Education, providing training, and sharing information and resources	<ul style="list-style-type: none"> <li>• Work with staff on knowledge of resources</li> <li>• Learn more about Fetal Alcohol Spectrum Disorders</li> <li>• Learn more about Autism Spectrum Disorders</li> <li>• Learn more about resources available</li> </ul>	<ul style="list-style-type: none"> <li>• Work harder on community education</li> </ul>	

MAPPING CARE COORDINATION SOUTHWEST/SOUTH CENTRAL REGIONAL REPORT

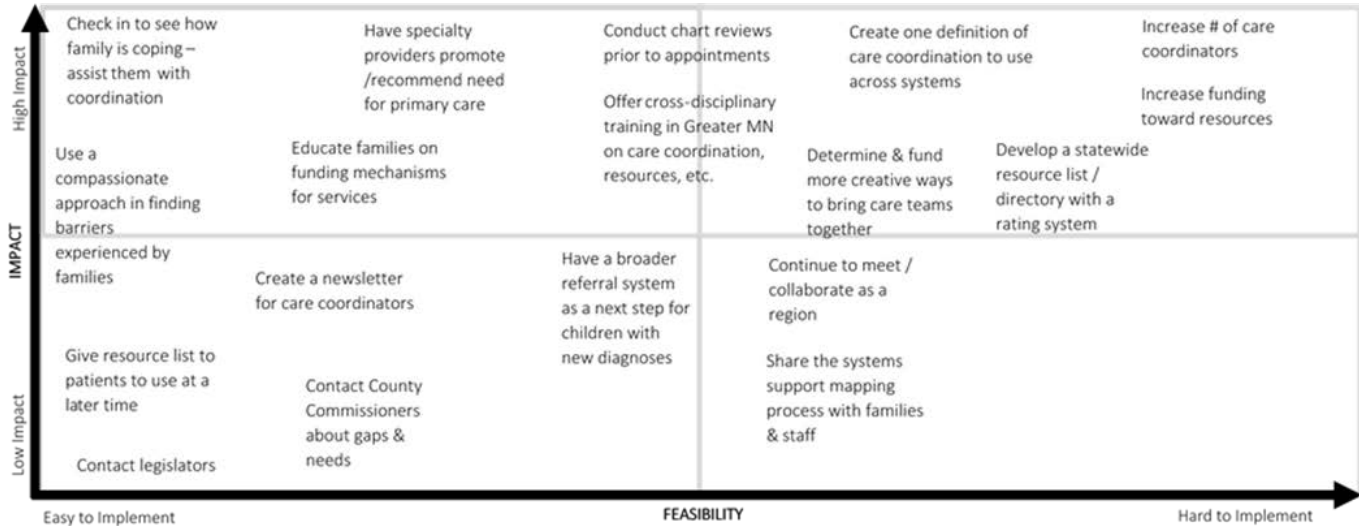
Action Planning Theme	Can be completed within 1 month, alone	Can be completed within 3-12 months, within organization/team	Can be completed within 6-12 months, with others in region
Involving families, learning about their needs, and promoting family-centered care	<ul style="list-style-type: none"> <li>• Working together with families to promote patient-centered care</li> <li>• Continue to try to support and educate families</li> </ul>		<ul style="list-style-type: none"> <li>• Encourage more patient-centered care principles</li> </ul>
Improving internal clinic/agency/organization care coordination processes	<ul style="list-style-type: none"> <li>• Have staff I supervise brainstorm ideas of how we can be more effective on care coordination</li> </ul>	<ul style="list-style-type: none"> <li>• Work harder at taking on some of the family's responsibility of coordination</li> <li>• Continue to brainstorm ways to make our internal care coordination more effective</li> <li>• Discuss need for more care coordinators at organization and the importance of holding interdisciplinary team meetings with the patient/family</li> <li>• Build in time for chart reviews before appointments</li> </ul>	

Action Planning Theme	Can be completed within 1 month, alone	Can be completed within 3-12 months, within organization/team	Can be completed within 6-12 months, with others in region
Improving communication and collaboration with others	<ul style="list-style-type: none"> <li>• Discuss with coworkers how to better collaborate with other resources in region</li> <li>• Seek out local resources to develop contacts</li> <li>• Attempt to team up with Southern Prairie Care</li> <li>• Make follow-up calls/emails to contacts made today in order to support and encourage relationship building</li> <li>• Reach out to county service workers</li> <li>• Make referrals</li> </ul>	<ul style="list-style-type: none"> <li>• Speak with school social worker, teachers, and other school staff about things that may come up and how to best work through them</li> <li>• Start working more with Southern Prairie Care</li> <li>• Educate outside resources on use of our clinic care plan</li> <li>• Share contacts with interagency early intervention council</li> <li>• Talk to PACT for Families about how to increase collaboration to help utilize all resources for partners and families</li> <li>• Find out name of some organizations available in our area</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Better collaborate with Gillette Children’s Specialty Healthcare to better serve families we both serve</b></li> <li>• Better collaborate with Southern Prairie Care</li> <li>• Better collaborate with Sanford clinic contacts</li> <li>• <b>Better collaborate with Head Start to build better understand of school system</b></li> <li>• Better collaborate with Family Voices of Minnesota</li> <li>• Better collaborate with local public health</li> <li>• Make contact with clinic medical home coordinator</li> <li>• Work with Interagency Early Intervention Council regional group</li> <li>• Form MOUs or contracts between local public health and human services to help hold both parties more accountable</li> <li>• Continue to meet with service providers with out-of-home placement team</li> </ul>
Improving resource directories and databases	<ul style="list-style-type: none"> <li>• <b>Find more resources available that would be helpful for my patients – especially those outside of my agency</b></li> <li>• Update my resource list</li> </ul>	<ul style="list-style-type: none"> <li>• Give pediatric nurses direct phone numbers of resources</li> <li>• Education to staff on resources</li> <li>• Develop a “master list” of resources</li> </ul>	<ul style="list-style-type: none"> <li>• Make a list of resources to save time</li> <li>• Share resources with other parents and providers</li> </ul>

Action Planning Theme	Can be completed within 1 month, alone	Can be completed within 3-12 months, within organization/team	Can be completed within 6-12 months, with others in region
Further implementing systems support mapping with families, practices, and organizations		<ul style="list-style-type: none"> <li>Share my map with family and friends</li> <li>Show staff the systems support mapping tool so they can use with families</li> </ul>	<ul style="list-style-type: none"> <li>Share our parent maps with PACT for Families and discuss with them how it might be beneficial to conduct a mapping session as a part of the needs assessment for the collaborative</li> </ul>
Promoting care coordination and better defining roles of care coordinators (both at clinic/organization and at a systems level)	<ul style="list-style-type: none"> <li>Promote care coordination model at agency</li> <li>Continue to reach out to providers / organizations to promote care coordination</li> </ul>	<ul style="list-style-type: none"> <li>Creating a clearer message around how we can support families through care coordination</li> </ul>	<ul style="list-style-type: none"> <li>Encourage more care coordination</li> </ul>

Finally, participants were asked to identify state-level action steps that could be taken to improve care coordination for families of CYSHN. They then placed these action steps on an action priority matrix based on their perceptions of the potential level of impact and feasibility of the items. A summary matrix of is included in Figure 4.

Figure 4: Systems Mapping Action Priority Matrix



## Appendix: Data Tables from Figures/Charts

Table 3: Primary Responsibilities in Providing Care Coordination (Data from Figure 3)

<b>Primary Responsibility Group</b>	<b>Percent</b>
Arrange for, set up, coordinate, and track tests, referrals, and treatment	11%
Provide education and resources	20%
Coordinate quality improvement efforts	0%
Assist in navigating the system	14%
Relationship building	8%
Intake, assessment, and evaluation	5%
Communication	3%
Development of care plan	5%
Coordinate funding	8%
Facilitate care team and ensure family is a team member	9%
Assure competent care coordination workforce	3%
Advocacy and policy development	8%
Facilitate, support, and assist in managing transitions	5%
Use health information technology / electronic medical records	3%

Systems Mapping Action Priority Matrix (Data from Figure 4)

	1 Easy to Implement	2	3	4	5 Hard to Implement
4 High Impact	Check in to see how family is coping – assist them with coordination	Have specialty providers promote/recommend need for primary care	Conduct chart reviews prior to appointments	Create one definition of care coordination to use across systems	Increase # of care coordinators
3	Use a compassionate approach in finding barriers experienced by families	Educate families on funding mechanisms for services	Offer cross-disciplinary training in greater MN on care coordination, resources, etc.	Determine and fund more creative ways to bring care teams together	Increase funding toward resources
2	Give resource list to patients to use at a later time	Create a newsletter for care coordinators	Have a broader referral system as a next step for children with new diagnoses	Continue to meet/collaborate as a region	Develop a statewide resource list/directory with a rating system
1 Low Impact	Contact legislators	Contact county commissioners about gaps and needs		Share the systems support mapping process with families and staff	



