

## Year 2017 Template Objectives for CYSHCN Regional Center

### Legend

A Objective Statement	D Input Activities	G For Your Information
B Deliverable	E Base Line for Measurement	
C Context	F Data Source for Measurement	

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### Objective 1: Medical Home

- A. By December 31, 2017, the Regional Center for CYSHCN will implement and evaluate strategies to increase the number of children with a medical home.**
- B. A Mid-Year and End of Year Summary RedCap Report and a completed work plan to document: a) activities implemented to increase the number of children with a medical home, and b) outcomes that occurred as a result of the implemented activities.
- C. The MCH/CYSHCN Program Parameters apply to this objective. This work will address the Title V National Performance Measure 11: Percent of children with and without special health care needs having a medical home.
- D. Implement and evaluate the effectiveness of the following strategies and activities for Medical Home:**
- 1. Provide Information/Referral/Assistance to families, providers, and community agencies (ADRC's, Birth-to-Three, home visiting, CCOTs, local public health, county health and human service and others).**
    - Promote CYSHCN Regional Center through various marketing approaches to promote Information/Referral/Assistance services and resources offered by Regional Centers and/or information about services/providers/eligibility criteria, etc. to reach all populations (including underserved).
    - Identify and establish a consistent statewide approach to implement medical home common messages during informational calls using the concept of "teachable moments."
    - Link individual families to existing medical home and other (i.e., ABC of Health, P2P, Family Voices, Transition) supports and services. Follow up with individual families to determine the outcome of referrals.
  - 2. Provide Medical Home Trainings:**
    - Designate a minimum of two staff to participate in Training Institute to become trained in providing "Partnering with Your Child's Doctor," Medical Home 101, 102 and 103 modules, and "Did You Know, Now You Know" online curriculum to families and community partners.
    - Organize, facilitate and deliver online "Did You Know, Now You Know" training to families. Participate in coaching and reflection of how trainings were conducted to guide future trainings.
    - Organize, facilitate and deliver 101, 102 and 103 trainings to **families**. Participate in coaching and reflection of how trainings were conducted to guide future trainings.
    - Organize, facilitate and deliver "Partnering with Your Child's Doctor" to families and or community partners. Participate in coaching and reflection of how trainings were conducted to guide future trainings.
    - Optional: Organize, facilitate and deliver the Medical Home training (101, 102 and 103) to **community** and key partners (e.g., local health departments, regional Early Childhood Collaborating Partners, WIC, B-3, and Home Visiting) to pilot and evaluate benefit and value.  
(Note: Coaching will be provided by content experts i.e., WisMHI, YHTI, Family Voices)
  - 3. Promote care coordination within and across systems and organizations in Wisconsin.**
    - Use the approved DHS referral form and promote use of form with community partners.
    - Identify behavioral health and other relevant resources and provide ongoing updates to First Step.

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---

#### **4. Expand Medical Home Quality Improvement (QI) pilot projects involving pediatric practices/health systems by developing, promoting and sustaining practice and system infrastructure through continuous quality improvement approaches with health care systems.**

- Promote and support practices/health care systems in each region to develop QI grant proposals/applications for the 2018 Medical Home QI grants. (Minimum goal of one per region)
- Coordinate and deliver ongoing technical assistance to past and current QI grantees (including Tribal Health Centers) in partnership and coordinated with the Wisconsin Medical Home Hub.
- Serve as Family Engagement and Community Resources advisors to funded grantees in the Region.
- Provide ongoing support to youth/family members of the QI teams.
- Participate in Medical Home QI Grantee meetings and learning calls.
- Provide health care systems with information about behavioral health resources and referral opportunities in their community.
- Provide information about Child Psychiatry Consultation Program services to QI grantees, in collaboration with the CPCP, to promote behavioral health resources. (Region Specific)

E. See detailed information as identified in the 2017 Regional Center work plan.

F. RedCap and completed work plan

#### **Objective 2: Transition**

- A. By December 31, 2017, the Regional Center for CYSHCN, will implement and evaluate strategies to increase the number of adolescents who receive services necessary to transition to adult health care.
- B. Mid-Year and End of Year Summary RedCap Report and a completed work plan to document: a) activities implemented to increase the number of youth with successful transition to adulthood, and b) outcomes that occurred as a result of the implemented activities.
- C. The MCH/CYSHCN Program Parameters apply to this objective. This work will address the Title V National Performance Measure 12: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.
- D. Implement and evaluate strategies to support YSHCN and their families to have planned transitions to adult health care:**
  - 1. Provide Information/Referral/Assistance to families, providers, and community agencies (ADRCs, CCOTs, local public health, county health and human service and others).**
    - Promote CYSHCN Regional Center through various marketing approaches to promote Information/Referral/Assistance services and resources offered by Regional Centers and/or information about youth health transition services/providers/eligibility criteria, etc. to reach all populations (including underserved).
    - Identify and establish a consistent statewide approach to implement youth health transition common messages during informational calls using the concept of “teachable moments.”
    - Link individual families to existing resources and other (i.e., ABC of Health, P2P, Family Voices, Medical Home) supports and services. Follow-up with individual families to determine the outcome of referrals.
  - 2. Provide Youth Health Transition trainings.**

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- Designate a minimum of two staff to attend the Training Institute to become trained in providing Youth Health Transition common messages to individual families, and training on components of Youth Health Transition to families and community partners.
- Schedule, engage in outreach and assist with implementing “What’s After High School” Trainings in collaboration with Family Voices of Wisconsin.
- Plan and deliver components of Youth Health Transition Training(s) to families and/or community organizations using common set of transition tools created and/or revised by Youth Health Transition Initiative.

### 3. Promote care coordination within and across systems and organizations in Wisconsin.

- Use the approved Youth Health Transition materials for youth and families (e.g. workbook, checklist), created and revised by the Youth Health Transition Initiative, with youth and families, individual health practices, and in health care systems.
- Coordinate and establish linkages with CESA-based Transition Improvement Grant Coordinators and County Communities on Transition (CCoT) networks, school special education and services staff, transition staff and school nurses, Aging and Disability Resource Centers to ensure that health transition information is included, and to promote the Got Transition Six Core Elements and common messaging and materials from the Youth Health Transition Initiative.

### 4. Expand Transition Quality Improvement (QI) pilot projects involving pediatric and adult practices/health systems by developing, promoting and sustaining practice and system infrastructure through continuous quality improvement approaches within health care systems.

- Promote and support practices/health care systems (pediatric and adult) in each region to develop QI grant proposals/applications for the 2018 Transition QI grants. (Minimum goal one per region)
- Coordinate and deliver on-going technical assistance to past and current QI grantees (including Tribal Health Centers) in partnership and coordinated with the Transition Hub.
- Participate in QI Transition Grantee meetings and learning calls.
- Serve as Family Engagement and Community Resources advisors to funded grantees in the Region.
- Provide ongoing support to youth/family members of the QI teams.

E. See detailed information as identified in the 2017 Regional Center work plan.

F. RedCap and completed work plan

### Objective 3: Family Engagement and Leadership

- A. **By December 31, 2017 the Regional Center for CYSHCN, in collaboration with Family Voices of Wisconsin, Parent to Parent, the CYSHCN Collaborators Network and others, will implement and evaluate strategies to strengthen family engagement and leadership.**
- B. An End of Year Summary Report to document: a) activities implemented to strengthen family engagement and leadership, and b) outcomes that occurred as a result of the implemented activities.
- C. The MCH/CYSHCN Program Parameters apply to this objective. Title V defines family and consumer partnership as: “The intentional practice of working with families for the ultimate goal of positive

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outcomes in all areas though the life course.” Family engagement reflects a belief in the value of the family leadership at all levels from an individual, community and policy level.

#### **D. Implement Family Leadership work plan**

- Implement and evaluate region-specific work plan activities with expertise from Family Voices and Parent-to-Parent (within the CYSHCN Network Family Engagement and Leadership Work Plan) to ensure youth/families are actively engaged at all levels (individual, practice and community, and policy) through collaboration, partnerships and shared leadership.
- Participate on regular technical assistance and check in calls conducted by Family Voices of Wisconsin.
- Participate in Leading Together as outlined in your region-specific work plan, in collaboration with Family Voices of Wisconsin.

E. See information as identified in the multi-year work plan.

F. Work plan