

Year 2015 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	

1.

A. Template Objective 1

By December 31, 2015, (insert number) families with children and youth with special health care needs (CYSHCN), providers, and the general public will receive brief contact services that support optimal health and well-being of CYSHCN from the (insert region) Regional Center for CYSHCN.

- B. An End of Year Summary Report, a SPHERE report and analysis of data collected in SPHERE as defined within the Data Source for Measurement to document: the number of families with children and youth with special health care needs (CYSHCN), providers and the general public who received brief contact services that support the health and wellbeing of CYSHCN from the Regional Center for CYSHCN.
- C. Acceptable value range for this objective is \$50 - \$100 for a brief contact for services that support the health and wellbeing of families of CYSHCN, providers, and the general public on behalf of the family, providers in general, and the general public. The MCH and CYSHCN Quality Criteria and Boundary Statement apply. This objective addresses all six CYSHCN National Performance Measures on the individual level. Individual and Household Interventions are set up with an infrastructure that assures timely assistance and interfaces with other broad local, regional and state system of care for children and youth with special health care needs (i.e., Wisconsin Healthiest Families and Keeping Kids Alive Initiatives). This work is a core service of every Regional Center and should align to create sustainable and effective linkages to improve CYSHCN health.

A Brief Contact is any contact with an individual or family that does not consist of an ongoing relationship. This activity is intended to more completely report significant time spent on professional consultation (not just a short phone call). Since SPHERE is intended to individually list clients, not providers, the brief contact data entry screen is the logical place to report this type of activity. The Regional Center for CYSHCN will provide Brief Contact - Professional Consultation on behalf of professional health care providers.

C.

- D. - Provide Brief Contact on behalf of children and youth with special health care needs, their families, providers, and the general public.

- Provide Brief Contact Professional Consultation on behalf of professional providers to coordinate health care delivery, public health, and community-based activities to promote healthy behavior across the life span.

- E. End of Year Summary Report and SPHERE Brief Contact Summary Report to include the data from the following screens: Brief Contact Summary (all appropriate fields including contacted by, activity method, county, program, services, funding, intervention(s), and information/service requested). Special note regarding data entry for Professional Consultation on the Brief Contact screen: Within the brief contact screen, select Consultation, fill in time spent, and use the Add Note field to list the name of the professional or the name of the organization, i.e., Dr. Paul Johnson or Dean Clinic Pediatrics Department.

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2.

A. Template Objective 2

By December 31, 2015, (insert number) children and youth with special health care needs (CYSHCN) and their families will receive consultation, referral and follow-up, and/or care coordination from the (insert region) Regional Center for CYSHCN and any subcontracted agencies.

- B. An End of Year Summary Report, a SPHERE report and analysis of data collected in SPHERE as defined within the

Year 2015 Template Objectives for CYSHCN Regional Center

Legend

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Data Source for Measurement to document: the number of children and youth with special health care needs and their families who received consultation, referral and follow-up, and/or care coordination from the Regional Center for CYSHCN and any subcontracted agencies.

- C. Acceptable value range for this objective includes: \$100 for consultation services per CYSHCN; \$175-\$225 for referral and follow-up services per CYSHCN; and \$300-\$400 for care coordination services per CYSHCN. The MCH and CYSHCN Quality Criteria and Boundary Statement apply to this objective. This objective addresses all six CYSHCN National Performance Measures on the individual level. This objective enables families to receive consultation, referral, and follow-up, and/or care coordination which in turn will help family's secure needed supports. The services are defined by the Minnesota Public Health Interventions framework. Consultation: seeks information and generates optimal solutions to perceived problems or issues through interactive problem-solving with a community, system, family, or individual, which the best options are selected and acted upon by the entity. Referral and Follow-up: assists individuals, families, groups, organizations, and communities to utilize necessary resources to prevent or resolve problems or concerns and may include developing resources that are needed, but unavailable to the population. The key to successful referral is follow-up; making a referral without evaluating its results is both ineffective and inefficient. Care Coordination/Case Management: optimizes self-care capabilities of individuals and families and the capacity of systems and communities to coordinate and provide services. Care coordination/case management will be provided as defined and described in the Minnesota Model of Public Health Interventions Manual, including the Basic Steps for Case Management, Individual/Family Practice Level, page 95. CYSHCN care coordination/case management is targeted to those CYSHCN and their families that need/request this comprehensive service.

The required data elements for the Children and Youth with Special Health Care Needs Program are contained in the CYSHCN Intake Form, which has the required data elements highlighted.

- C.
- D.
- Provide Consultation services on behalf of children and youth with special health care needs to promote Medical Home, Parent to Parent matching, Family Advocacy and Engagement, Transition and other services.
 - Provide Referral and Follow-up on behalf of children and youth with special health care needs to promote Medical Home, Parent to Parent matching, Family Advocacy and Engagement, Transition and other services.
 - Provide Health Benefits Assistance as needed: 1) Assist callers in health benefits decisions, problem solving, and access to services from birth through the transition to adulthood. 2) Seek consultation from the Access/Health Benefits Counseling CYSHCN Statewide Initiative (ABC for Health) for challenging questions, and 3) Refer families with complex health benefits issues to the Access/Health Benefits Counseling CYSHCN Statewide Initiative and follow-up to assure services were received.
 - Collaborate with the Access/Health Benefits Counseling CYSHCN Statewide Initiative related to outreach and referrals to include: 1) Completion of the health benefits competency tool annually to identify staff training needs, and 2) Participation in training and technical assistance provided by the Access/Health Benefits Counseling CYSHCN Statewide Initiative to assure that staff maintain competencies in health benefits knowledge and skills.
 - Maintain a toll-free phone line, accessible walk-in space, and center-specific website to provide information, consultation, referral, and follow-up services.
 - Promote and utilize Wisconsin First Step to include sharing of regional resources.
 - Link parents from Wisconsin screening programs (e.g., newborn hearing, congenital disorders, birth defects, and developmental screening; including early intervention programs (ie. Birth to Three, Head Start, and DPI Early Childhood) to support services.

Year 2015 Template Objectives for CYSHCN Regional Center

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- Participate in monthly Information and Referral calls.

-Partner to organize and deliver at least two of the monthly Information and Referral calls.

- Promote and track implementation of the Consent to Release Medical Information for Referral to Regional Center for CYSHCN form and the Nourishing Special Health Care Needs pilot referral form.

- Optional Activity: Provide case management interventions for children and youth with special health care needs and complete a care coordination assessment, care plan, ongoing monitoring, and evaluation of the activities done within this plan to ensure effectiveness in meeting the child's and family's needs in coordination with the child's medical home.

- Optional Activity: 1) Administer agreements with Local Public Health Departments and/or Delegate Agencies, during the contract period, to provide referral and follow up and care coordination for children and youth with special health care needs and 2) provide subcontracted agencies with ongoing support and technical assistance to build local capacity within the LPHDs to serve CYSHCN with referral and follow-up.

- E. Required data for all interventions provided (consultation, referral and follow-up, and care coordination: End of Year Summary Report and SPHERE Individual/Household Report to include MCH Required Demographic Data, required CYSHCN data elements from the CYSHCN Intake Form and data from the following screens: Intervention: Screening, Subinterventions: Health Care Utilization (all fields) and CYSHCN Transition Assessment (required for ages 14 to 21 years).

Additional data for consultation: Data from the following SPHERE screen: Intervention: Consultation; Subintervention: Health Benefits OR Medical Home

Additional data for referral and follow-up: Data from the following SPHERE screen: Intervention: Referral and Follow-up, Subinterventions: Type/place and outcome.

Additional data for care coordination: Data from the following SPHERE screens: Intervention: Case Management, Subinterventions: CYSHCN Service Coordination/Assessment (all appropriate fields), CYSHCN Care Plan, CYSHCN Ongoing Monitoring; Intervention: Health Teaching, Subintervention: Topic(s) relevant to the services provided under this objective and Results; Intervention: Referral and Follow-up, Subintervention: Type/place and outcome.

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3.

- A. Template Objective 3

By December 31, 2015, the role of parents as partners in decision making and leadership will be strengthened and supported by the (insert region) Regional Center for Children and Youth with Special Health Care Needs.

- B. An End of Year Summary Report and SPHERE report as defined within the Data Source for Measurement to document:

1) activities implemented by the (insert region) Regional Center for Children and Youth with Special Health Care Needs that strengthen and support the role of parents as partners in decision making; and 2) outcomes that occurred as a result of implemented activities.

- C. The MCH and CYSHCN Quality Criteria and Boundary Statement apply to this objective. This is multiyear work focusing on the system changes that impact health outcomes. This objective addresses the CYSHCN National Performance Measure: Families of children with special health care needs will partner in decision making at all levels,

Year 2015 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	

and will be satisfied with the services they receive. Family Leadership strategies are intended to encourage more partnering in decision making between parents and providers by increasing opportunities for parents to attend trainings, present their family story, and bring the parent perspective to systems, councils, boards, and committees. Activities to strengthen individual parents as decision makers and facilitate parent leadership opportunities have long been foundational to the regional center infrastructure.

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D. For activities below, provide details based on agency capacity, funding and regional opportunities. This is ongoing, multiyear work, building on outcomes of previous years.

- Collaborate with WiSMHI to offer parent training that promote increased capacity for partnership and decision-making with their child's medical home team.

- Collaborate with the Family Health Leadership Hub CYSHCN Statewide Initiative (Family Voices) related to outreach, training, and identification of unmet needs, health disparities and barriers to services including sibling support activities (e.g., Did You Know, Now Your Know training).

- Respond to quarterly requests from Family Voices to add parents to the Family Action Network.

- Partner with the Parent Matching Program to assure that parents are linked to parent-to-parent and other natural support opportunities.

- Collaborate to offer support parent trainings to increase family leadership in your region and support the Wisconsin matching database.

- Collaborate with other entities to provide training for parents of CYSHCN on information and skill-building related to their children.

- Identify and facilitate linkages for parents of CYSHCN to promote parental involvement in decision-making within their local community's activities/initiatives (e.g., Wisconsin Healthiest Families, Keeping Kids Alive, Early Childhood coalitions, County Transition Coalitions, and Family Resource Center Boards) and/or within other organizations and systems of care to ensure CYSHCN are represented.

- Identify a minimum of one successful linkage: assess and document the system and or policy changes that occurred or were achieved as a result of this activity.

- Implement work plan activities identified in 2014 to strengthen and diversify family leadership in collaboration with the strategic plan developed by the Family Leadership Work Group

E. End of Year Summary Report and SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the audience focus, and the strategies/outcomes documented in the Results/Outcome field) and either Intervention: Coalition Building, Subintervention: Parent Leadership, Intervention: Community Organizing, Subintervention: Parent Leadership, or Intervention: Collaboration, Subintervention: Parent Leadership.

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4.

A. Template Objective 4

By December 31, 2013, local infrastructure building that supports and promotes Medical Home will be implemented by

Year 2015 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	

the (insert name) Regional Center for CYSHCN in partnership with the Wisconsin Medical Home Hub Statewide Initiative (WiSMHI).

- B. An End of Year Summary Report and SPHERE report as defined within the Data Source for Measurement to document:

1) activities implemented to build the infrastructure that supports and promotes Medical Home; and 2) outcomes that occurred as a result of the implemented activities.

- C. The MCH and CYSHCN Quality Criteria and Boundary Statement apply to this objective. This is multiyear work focusing on the system changes that impact health outcomes. Many children fall through the cracks due to the lack of a Medical Home. The federal Title V Maternal Child Health Bureau (MCHB) has identified six National Performance Measures and the second measure states that all children and youth with special health care needs will receive coordinated ongoing comprehensive care within a Medical Home. Wisconsin was selected as a leadership state by MCHB for its work in Medical Home and efforts to further spread the Medical Home approach are underway.

A State Performance Measure to address the need for a Medical Home for all children is in place as a follow-up to the Title V needs assessment. Wisconsin has a Medical Home Toolkit which has numerous resources for implementing this objective: <http://wimedicalhometoolkit.aap.org/>. The first step in establishing a Medical Home is to identify the children in the practice that have special health care needs. Evidence-based practice and the American Academy of Pediatrics recommend that early and periodic developmental screening be done on all children. The evidence-based tools for screening will be used and promoted (e.g., ASQ, PEDS) consistent with the American Academy of Pediatrics Developmental Surveillance and Screening of Infants and Young Children policy PEDIATRICS Vol. 108 No. 1 July

2001, pp. 192-195 or <http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;108/1/192>.

- C. Referral to Parent to Parent is consistent with the American Academy of Pediatrics Family-Centered Care and the Pediatrician's Role Policy Statement PEDIATRICS Vol. 112 No. 3 September 2003 or 08/26/2010 11:18 AM Page 12 of 21 DPH Grants and Contracts. Regional Centers for CYSHCN and local public health departments are in a position to facilitate local capacity building to address these outcomes.

- D. For activities below, provide details based on agency capacity, funding and regional opportunities. This is ongoing, multiyear work, building on outcomes of previous years.

Collaborate with the CYSHCN Medical Home Statewide Initiative (WiSMHI) to implement and evaluate regional spread and reach of the statewide medical home plan. Specifically work to assist with health system change opportunities.

- Outreach to Primary Care Practices throughout the region to increase awareness and promotion of Regional Center, WiSMHI and other CYSHCN Partner programs and resources. Utilize champions within the region to assist with promotion and trainings.

- Conduct a minimum of 3 primary care clinician outreach trainings (to include developmental screening, pediatric mental health screening, or pediatric mental health community resources trainings) following format established by WiSMHI. Materials will be provided by WiSMHI. WiSMHI will do a follow-up visit with practices (final review) in coordination with the Regional Center.

- Coordinate follow-up and technical assistance requests (apart from the above trainings) from local primary care provider practices in coordination with WiSMHI as needed.

- Ensure an updated list of relevant pediatric behavioral health community resources throughout the region exists and aligns with Wisconsin First Step resources.

- Promote Parent to Parent of Wisconsin, the Wisconsin Medical Home Toolkit and other medical home outreach

Year 2015 Template Objectives for CYSHCN Regional Center

Legend

A Objective Statement	D Input Activities	G For Your Information
B Deliverable	E Base Line for Measurement	
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opportunities including pediatric mental health screening tools trainings, and/or trainings in pediatric behavioral health community resources.

- Provide information and resources regarding medical home to professionals and families at outreach and training events throughout the region and at statewide events for which the Center has lead responsibility.

- Collaborate with local early childhood screening initiatives (i.e. local public health departments with MCH activities focused on child development, Learn the Signs Act Early, Home Visiting, Head Start, Foster Care).

E. End of Year Summary Report and SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the audience focus, and the strategies/outcomes documented in the Results/Outcome field) and Intervention: Collaboration, Subintervention: Medical Home.

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5.

A. Template Objective 5

By December 31, 2015, a regional outreach and partnership plan will be developed and implemented which supports a coordinated system of services for CYSHCN and their families and increases regional- awareness and utilization of the (insert name) Regional Center.

B. An End of Year Summary Report and SPHERE report as defined within the Data Source for Measurement to document:

1) the CYSHCN Regional Center outreach and partnership plan; 2) strategies implemented from the plan to support a coordinated system of services and increased awareness and utilization of Regional Center information, resources and services for; 3) outcomes that occurred as a result of the implemented strategies.

C. The MCH and CYSHCN Quality Criteria and Boundary Statement apply to this objective. This is multiyear work focusing on the system changes that impact health outcomes. This objective addresses the CYSHCN National Performance Measure: Community-based service systems will be organized so families can use them easily. Regional Centers for CYSHCN hold an enormous amount of expertise through their highly qualified staff, dedication to quality and extensive resources. There is a need to assure that internal and external partners recognize and value that expertise. Regional Centers need to foster relationships with their internal organizational leaders and external CYSHCN partners so that more families can ultimately know about and have access to the supports and services that may improve the quality of their lives.

C.

D. For activities below, provide details based on agency capacity, funding and regional opportunities. This is ongoing, multiyear work, building on outcomes of previous years.

-Implement partnership tool(s) as requested by the CYSHCN Program.

- Collaborate with other Regional Centers for CYSHCN and statewide hubs to develop and implement outreach activities with the new ACA Navigators to support enrollment trouble shooting and maintenance for eligible CYSHCN in the health insurance marketplace. Participate in applicable training. (This specific outreach activity may or may not be included in your 2015 Partnership Reflection and Planning Tool).

- Based on Center's Partnership Reflection and Planning Tool, identify and implement strategies to strengthen one or more of the partnerships you identified such as: establish more linkages with community partner or coalition, identify pressing and or emerging issues, exchange information and resources, gather local input regarding unmet needs,

Year 2015 Template Objectives for CYSHCN Regional Center

Legend

A Objective Statement	D Input Activities	G For Your Information
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enhance the understanding of the multiple services available in the region, disseminate information to regional stakeholders on key issues, and or build relationships between partners to assure cultural reach.

-Review, compile, analyze and share unmet needs identified through brief contact referrals and contribute to a coordinated response by the CYSHCN network.

E. End of Year Summary Report and SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the goals and objectives and partners documented in the results/Outcome field) and Intervention: Collaboration, Subintervention CYSHCN Partnership.

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6.

A. Template Objective 6

By December 31, 2015, the transition of youth from childhood to adult life will be supported and promoted with an emphasis on health related services by the (insert region) Regional Center for Children and Youth with Special Health Care Needs in partnership with the Youth Health Transition Hub Statewide Initiative.

B. An End of Year Summary Report and SPHERE report as defined within the Data Source for Measurement to document:

1) Activities implemented to support and promote youth health transition and 2) Region-wide system improvements in health transition services and coordination of care and 3) outcomes that occurred as a result of the implemented activities.

C. The MCH and CYSHCN Quality Criteria and Boundary Statement apply to this objective. This is multiyear work focusing on the system changes that impact health outcomes. This objective addresses the CYSHCN National Performance Measure: All youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. As background information this objective was built on groundwork of the statewide Community of Practice on Transition.

C.

D. For activities below, provide details based on agency capacity, funding and regional opportunities. This is ongoing, multiyear work, building on outcomes of previous years.

- Facilitate regional participation in the Hub's Statewide Youth Health Transition Learning Community to include participation in technical assistance calls that the Transition Hub Statewide Initiative may host.

- Collaborate with the Transition Hub Statewide Initiative to disseminate and advance best practice information and research; promote resources/tools; assist in planning and facilitating regional training opportunities to promote successful transition of youth with SHCN from pediatrics to adult health care to include sibling issues of support.

- Assist the Hub in effective dissemination of the Youth Health Transition Toolkit.

- Collaborate with the Transition Hub Statewide Initiative to implement and evaluate regional spread and reach of Youth Health Transition.

-Identify a regional transition champion to promote practice/health system transition QI activities.

- Identify and inform the Transition Hub of regional transition needs.

Year 2015 Template Objectives for CYSHCN Regional Center

Legend

A Objective Statement	D Input Activities	G For Your Information
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- Collaborate with Family Voices of Wisconsin on Youth Transition training as applicable.

Optional Activity: Facilitate or host professional education opportunities in youth health transition among partners including grand rounds and/or clinic team presentations and conference presentations.

- E. End of Year Summary Report and SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the strategies documented in the Results/Outcomes, and include the Intervention: Collaboration with the Subintervention Youth Leadership.
- F.
- G.