MISSISSIPPI STATE DEPARTMENT OF HEALTH
Child and Adolescent Health
Office of Health Services

REQUEST FOR PROPOSALS

INNOVATIVE PILOT PROJECTS
for
Children and Youth with Special Health Care Needs (CYSHCN)

Contact Info: Mail Submissions to:
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Funding Agency: The Innovative Pilot Projects for Children with Special Health Care Needs (CYSHCN) will be administered by the Child and Adolescent Health Services, Office of Health Services, Mississippi State Department of Health, supported by funding from Maternal Child Health Services Bureau, Health Resources and Services Administration

Title: Innovative Pilot Projects for Children and Youth with Special Health Care Needs (CYSHCN)

Dates:

Application Deadline: January 15, 2018
Notification of Award: January 19, 2018
NOTE: A notification of intent to apply by email is required prior to submission to facilitate contract process. A webinar or conference call is scheduled for December 11, 2017 at 10:00 AM to clarify and answer questions related to application process and program implementation

Overview:

Mississippi Department of Health Child And Adolescent Health Services announces availability of funds for Mississippi Children and Youth with Special Health Care Needs (CYSHCN) Innovative Pilot Projects. The award's purpose is to optimize the quality of life of CYSHCN in Primary Care and Community Settings aligning Medical Homes and Community Support Services with Title V CYSHCN Care Coordination services.
The overall aims of the pilot project are reflected in the following Healthy People 2020 goals/objectives and Mississippi Maternal Child Health Block Grant Objectives:

HP2020 Goal: Promote the health and well-being of people with disability
HP2020 Goal: Prevent illness and disability related to blood disorders and use of blood products
HP2020 Goal: Improve the healthy development, health, safety and well-being of adolescents and young adults
HP2020 Goal: Reduce the proportion of children diagnosed through newborn screening who experience developmental delay and require special education services
MICH-30.2 Increase the proportion of children with special health care needs who have access to a medical home (HP 2020)
MICH-31.2 Increase the proportion of children aged 12 to 17 years with special health care needs who receive their care in family-centered, comprehensive, coordinated systems (HP 2020)
DH-5 Increase the proportion of youth with special health care needs whose health care provider has discussed transition planning from pediatric to adult health care (HP 2020)
NOM 17.2 Increase the Percentage of children with special health care needs (CSHCN) receiving care in a well-functioning system (MCH Block Grant)

Background and Purpose:

Children with special health care needs (CSHCN) are "...those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." CYSHCN, making up approximately 16% of Mississippi's population, often require complex care across several medical specialties and are vulnerable to psychosocial and developmental difficulties. Having a medical home improves their access to services and enhances quality of life. Additionally, provision of optimal care requires linkages to community-based services as appropriate to meet the needs of the child and family across the life span.

The concept of the family centered medical home was first introduced by the American Academy of Pediatrics in 1967 in reference to the individual patient-provider relationship and the need for a centralized medical record home for CYSHCN. With further refinements and the consensus of four major medical organizations (Joint Principles of the Patient-Centered Medical Home) the patient/family-centered medical home now encompasses health care system components and blends comprehensive primary care, relationship-centered care, community resources, and patient quality of life. Care provided must be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. The Association of Maternal Child Health Programs (AMCHP) has developed a specialized set of standards for CYSHCN Medical Home. These standards emphasize the importance of the physician/provider led team approach and integrates the Title V Children with Special Health Care Needs program into the team to provide optimal services.

National Standards of Care for Children and Youth with Special Health Care Needs were also developed to assure access to comprehensive home and community-based services to provide support, education, respite, training, and transitional opportunities. These essential, empowering partnerships offer support and strengthen the resources of the children, youth, and their families. They range from condition-specific organizations and organizations with disability focus to out-of school care organizations/programs and faith-based programs, inclusive of children with special health care needs.

The purpose of this grant opportunity is two-fold. First, we would like to pilot an enhanced care coordination approach to a CYSHCN family-centered medical home in a primary care setting in Mississippi. We would like to determine the impact of MSDH Regional Care Coordination enhancements on patient adherence, plans of care, self-management, life course transitions, patient quality of life, and family satisfaction. It is anticipated that the primary care practice will engage the Title V CYSHCN program by making referrals for additional Care Coordination Services, which will positively impact the health of their clients. Care coordination is a highly organized process that facilitates the linkage of children and their families with appropriate comprehensive services and resources in order to achieve optimal health. It is estimated that care coordination in the medical home, on average, adds 11- 21 minutes to an individual CYSHCN patient encounter. (Antonelli 2008). MSDH Regional Care Coordinators, familiar with community and regional resources, can assist the Primary Care Provider with psychosocial evaluations of the patient in the home environment, provide additional education, assist the family with planning for transitions to school, work, adulthood, and adult medical care, evaluate the need for and link to community resources for transportation, appointment planning, mental health, vocational services, and respite care. Care Coordinators can assist with the development and implementation of a Shared Plan of Care between the patient/family and primary care provider/medical home.

Secondly, this funding provides an opportunity for community-based organizations serving children with and without special health care needs to develop innovative programming which aligns with the standards of care and provide outcome measures to document impact. Our aim is to build stakeholder/community capacity for creating family-driven Systems change and to implement change strategies which positively impact service delivery/accessibility for CYSHCN and ultimately improve quality of life, health, and well-being across the life span.
The funding may be used to enhance existing programs to provide optimal outcomes or to initiate new programs.

Proposals should address one or more of the National Standards of Care for Children with Special Health Care Needs and/or Standards of Care for Medical Home of Children and Youth with Special Health Care Needs

AMCHP standards of Care for Medical Home

1. Provision of Access to health care services 24 hours/day for well, acute, and chronic care
2. Provision of heath care services that encourage the family to share in decision making and provide feedback on services provided
3. Perform Comprehensive health assessments
4. Provide an integrated, team-based model of care coordination
5. Develop, maintain, and update a comprehensive integrated plan of care that has been developed with the family and other members of a team, addresses family care clinical goals, encompasses strategies and actions needed across all settings, and is shared effectively with families and among and between providers
6. Conduct activities to support CYSHCN and their families in self-management
   Of the child's heath
7. Promote Quality of life, healthy development, and healthy behaviors across all life stages
8. 8. Integrate care with other providers and ensure that information is shared effectively with families and among and between providers
9. Perform care tracking, including sending of proactive reminders to families and clinicians of services needed, via a registry or other mechanism.

10. Provide care that is effective, and based on evidence, where applicable

National Standards of Care for Children and Youth with Special Health Care Needs

1. Identification, Screening, Assessment, and Referral
2. Eligibility and Enrollment in Health Coverage
3. Access to Care
4. Medical Home
5. Community-Based Services and Supports (includes Family Professional Partnerships)
6. Transition to adulthood
7. Health information Technology
8. Quality Assurance and Improvement

Design:

To summarize, you may choose **ONE** of the two Major options for your proposal.

Option 1) Enhancing the Medical home for CYSHCN by developing more intensive care coordination for CYSHCN or a specific population within CYSHCN (EX: hearing impaired, Sickle cell disease, cerebral palsy, craniofacial abnormalities) in conjunction with MSDH Regional Care Coordinators. Strategies, which may be incorporated into these designs include, but are not limited to, 1) Developing a CYSHCN Registry for Practice, 3) Assessing Quality of Life pre and post integration of services, 4) Conducting Social Determinants of Health (including Food insecurity) needs assessments to determine most critical needs , Innovative strategies ,5) Self-management training for a selected population, (EX: hearing impaired, Sickle cell disease, cerebral palsy, craniofacial abnormalities),OR 6) Integrating a formal transition program into practice

Option 2) Developing an innovative community-based program, targeting/including children with special health care needs, using an evidence based approach to improving their Quality of life. Specific populations may be identified as discussed. Examples of innovative programs include (but are not limited to) determining level of readiness to transition and providing support and education, providing evidence-based self-management programs, promoting quality of life by fostering leadership skills and/or job training skills, provision of training to parents on developmental milestones, expectations of chronic disorders, development of anti-bullying program for children with special health care needs, development of obesity prevention (or components of physical activity , nutrition and coping) program for children with special health care needs, conducting a needs assessment of children/families with special health care needs, developing a parent mentor training program, provision of summer camp experience to foster youth development, resiliency, coping, and/or self-management skills, development of a parent navigation program, or a conference relating to school-based needs for Children with special health care needs.

Eligibility Requirement:

For Option 1, A Pediatric or Family Practice private practice, Federally Qualified Community Health Center or Rural Health Center, School-Based Clinic, which self-identifies as a Medical Home. At least fifteen [15 %] percent of practice population should fall within the CYSHCN population definition. (See Appendix) The population of CYSHCN in Mississippi is estimated 16.4% (2009 NSCYSHCN)

For Option 2: A CYSHCN-focused resource organization, Community based, faith-based, Non-profit, or Out of school care organization providing care to CYSHCN or a selected population within CYSHCN

Scope of Work

The Children and Youth with Special Health Care Needs- Mississippi State Department of Health integrates systems across agencies, organizations, and community services while remaining family-centered In its efforts to provide services across the state which will foster optimal health, development, and quality of life among CYSHCN in Mississippi. This request for proposals provides an opportunity to further increase capacity and synergy among systems actively serving this population. Priority will be given to applications with rural catchment areas and who demonstrate a history of effective partnerships and authentic family engagement

Awardee Deliverables include:

1) Baseline data (Registry) on CYSHCN (Codes are provided in Appendix for traditional and expanded criteria) Unduplicated number of CYSHCN served; Total number of users with medical home and dental home
2) Plan for referrals to or establishing relationship with MSDH-CYSHCN program
3) Self or Agency assessment of CYSHCN Medical home status or Family-Centeredness status as applicable
4) Quarterly Progress Reports. Participation in online or virtual/online quarterly training or conference call.
5) Final Evaluation report including Outcome Data related to stated goals and objectives, including changes in knowledge, attitude, behaviors, and skill development.
6) Evidence of use of evidence-based curriculum /approach/tools
7) Documentation of relevant partnerships, Stakeholder Collaborations, and Family engagement
8) Plan for Sustainability
9) Evidence of Compliance with regulatory authorities/parent organizations as applicable

MSDH will provide:

1) Ongoing technical Assistance. One or more site visit(s) for technical assistance can be arranged.
2) Assistance with Referral Monitoring
3) Approval of evaluation tools, curriculums used
4) Access to regionally/nationally approved programs, strategies
5) Recommendations for pertinent, brief online trainings

Award Information

The total funding available for this project is $375,000 over a three- year period. The award is conditional based on 1) evidence of satisfactory progress in meeting goals by the subgrantee ,2) advancing the overall aims of MSDH CYSHCN Title V program and 3) the availability of funds. Applications will be objectively reviewed and scored according to criteria listed in the request for proposal relative to the goals and objectives, detailed budget, program plan and collaboration planning (in-kind support). Scoring grid is in the next section.

Type: Subgrantee

Selected applicants will enter into a subgrantee contractual relationship with MSDH. A contract and W-9 form will be provided at the time of notification of selection for award and will be conditional pending final agency approval. Upon award notification, the agency will begin the process of finalizing and executing the contract between the agency and selected subgrantee. The contract is not effective until it has been approved by the agency and any applicable regulatory board, signed by the Executive Director or her designee, and the selected vendor has been notified by the agency in writing that the contract has been fully executed and is a Final Award. This solicitation, and any pending contract, is subject to cancellation at the agency's discretion prior to the issuance of a Final Award.

Number of annual awards: 4-5

Approximate Average Annual Award: $25,000

Innovative Pilot Project (IPP-CYSHCN) grants shall be awarded for the following periods: Year One: February 1, 2018- June 30, 2018 & July1,2018-December 31, 2018; Year Two: January 1, 2019-December 31, 2019, Year Three: January 1, 2020-December 31, 2020. Successful applicants may reapply for additional years of funding, contingent upon availability of funding and adherence to requirements.

Format:

Length of proposal should not exceed six(6)typewritten pages, exclusive of appendices.
Components of the proposal should include the following:

COMPONENT	DESCRIPTION	Points Available
Introduction	Who You Are :Overall Organizational structure Why this CYSHCN project is important to you You should also include any existing partnerships for referrals and/or collaborations for quality care. Include (brief) Electronic Health Record description if applicable and HIPAA/Privacy policy List Current Education efforts, transition plans, plans of care, if applicable	20
Background and Need	Identify Option 1 or Option 2 as your choice Include estimate of number/percentage of CYSHCN eligible patients/families (or reach) and discuss why your practice or organization would be a good fit. Describe Project Team, Roles and Responsibilities (Who will do what and who will be responsible for communicating with District Coordinators and Project officer [and how]) What you hope to accomplish with this pilot project (Overall Goal)	20
Overall Project Summary (Include Objectives; See below)	Summary of Project, including **AIMS (long-term**) and **measurable objectives.** **Option 1**: Choose at least two measures to track which reflect components of the CYSHCN Medical Home. (if applicable) Include Plan for Integrating services of Public Health District Coordinators into established PCP practice team to enhance service delivery See Referral Form for appropriate areas of collaboration with District Care Coordinators **Option 2:** Include why plan is evidence-based, how plan will improve quality of life and how you will measure outcomes (tools)	30
Timeline	When you will have things done (Sample Gant Chart in Appendix)	10
Sustainability Plan	How will you continue the services after the end of the grant?	10
Budget / Budget Justification	Include CVs /Biographical Sketches of Staff Budget is limited to program related items__ Personnel, supplies, services, travel Funding. Budget cannot be used for clinical services, staffing for clinical services, research, construction, or lobbying.	10
Total	Logic Model (Optional)	100 points

INTENT to APPLY

Name

Organization

Address

I Hereby notify Mississippi Department of Health, Child And Adolescent Health Services of my intent to complete application for the Innovative Pilot Projects for Children and Youth with Special health Care Needs.

Option 1 ☐

Option 2 ☐

Date:

Please return by Email to :
Gerri.Cannon-Smith@msdh.ms.gov

APPENDIX:
MSDH Child and Adolescent Health Universal Referral Form
Examples of Objectives
Examples of Timelines
Application related ICD-10 Codes

BDR	GR	PHRM

MSDH use only

Child & Adolescent Health Referral Form

Per federal regulations and state policies, referrals should be made as soon as possible, but not later than seven (7) days, after determining an infant, toddler, or child is in possible need of services.

Child's Name: _____ _____ _____ Sex: ☐ Male ☐ Female
First *M* *Last*

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____ CPS Custody/CAPTA: ☐ Y ☐ N

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White ☐ 2 or more

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Parent(s)/Legal Guardian(s) Name: _____ Phone: _____
Last, First ☐ *Home* ☐ *Cell* ☐ *Work*

Physical Address: _____ Phone: _____
☐ *Home* ☐ *Cell* ☐ *Work*

City: _____ County: _____ Zip Code: _____ Phone: _____
☐ *Home* ☐ *Cell* ☐ *Work*

Primary Care Provider/Pediatrician: _____ Medicaid Client: ☐ Y ☐ N

Referral Source (Relationship): _____ Phone: _____

Referral:

☐ First Steps Early Intervention (Ages 0-3 Years) ☐ CYSHCN Services (Ages 0-21 Years)

Referral Concerns:

ESTABLISHED DIAGNOSIS

- ☐ Blood Disorders
  Specify: _____
- ☐ Cardiac Disorders
  Specify: _____
- ☐ Craniofacial Disorders
  Specify: _____
- ☐ Endocrine Disorders
  Specify: _____
- ☐ Ear/Nose/Throat Disorders
  Specify: _____
- ☐ Eye Disorders
  Specify: _____
- ☐ Genetic/Chromosomal Disorders
  Specify: _____
- ☐ Malformation of Organ System
  Specify: _____
- ☐ Neurological Disorders
  Specify: _____
- ☐ Orthopedic Disorders
  Specify: _____
- ☐ Perinatal/Neonatal Disorders
  - ☐ Congenital Infection (e.g., CMV, HSV, Rubella, Syphilis, Zika Virus)
  - ☐ Very Low Birth Weight (<1500 g)
  - ☐ Very Preterm Birth (<32 weeks)
  - ☐ Other: _____

OTHER CONCERNS

- ☐ Autism Spectrum Disorder
- ☐ Exposure to Toxic Substances
  - ☐ Lead (≥ 15 µg/dL)
  - ☐ Prenatal exposure to alcohol
  - ☐ Prenatal exposure to drugs (prescription and non-prescription)
- ☐ Mental/Behavioral Health Concern
  Specify: _____
- ☐ NICU ≥ 10 days
- ☐ Nutritional Concern
  - ☐ Growth Restriction
  - ☐ Failure to Thrive
  - ☐ Swallowing/Feeding Problem
- ☐ Sensory Impairment
  - ☐ Hearing Impairment
  - ☐ Visual Impairment
- ☐ Suspected Developmental Delay
  - ☐ Physical: *Specify*
    - ☐ Fine Motor
    - ☐ Gross Motor
  - ☐ Communication: *Specify*
    - ☐ Receptive
    - ☐ Expressive
  - ☐ Cognitive
  - ☐ Adaptive/Daily Living
  - ☐ Social-Emotional
- ☐ Other: _____

COORDINATED CARE NEEDS

Use ONLY for referrals for CYSHCN Services

- ☐ Community Agency Referral (e.g., mental health needs, other health supports)
- ☐ Follow-up for Missed Appointments (e.g., well child, chronic dx, subspecialist)
- ☐ Insurance Application Assistance
- ☐ Legal/Judicial Issues or Concerns
- ☐ Pharmaceutical Assistance
- ☐ Referral to Subspecialty
- ☐ Respite Care
- ☐ Self-Management Assessment
- ☐ Shared Plan of Care
- ☐ Social Service Referral (e.g., food, housing)
- ☐ Transition Planning/Services
  - ☐ Independent Living/Workforce
  - ☐ Medical Transition to Adult Care
  - ☐ Other: _____
- ☐ Transportation
- ☐ Other: _____

Comments:

Date Received by EIP: _____/_____/_____ Who Received Referral: _____ District Assigned to: _____

Date Received by CYSHCN: _____/_____/_____ Who Received Referral: _____ Assigned CC: _____

Mail: Mississippi State Department of Health, 570 East Woodrow Wilson, P.O. Box 1700, Jackson, MS 39215

Phone: Early Intervention: 601-576-7427 or 1-800-451-3903 / CYSHCN: 601-576-7281 or 1-800-844-0898

Fax: Early Intervention: 601-576-7540 / CYSHCN: 601-5767296

Form No. 1037
New 4/1/2017

Innovative Pilot Projects for CYSHCN

February 1, 2018 - December 31, 2018

Sample Time Line-(Gant Chart)

ITEM	Month 1 Quarter 1	Month 2 Quarter 1	Month 3 Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comments
Select Team/Program Implementation Group							REQUIRED
Orientation/Training							
Select CYSHCN using ICD-9-ICD-10 Codes							
Set Up Registry							REQUIRED
Develop Registry Tracking							
Meet With MSDH Regional CareCoordinators							EXPECTED
Develop Protocols Including Referral Protocols							
Medical Home Self-Assessment or Organizational Readiness							
Quarterly Report							
Chart reviews/ Assessment reviews							REQUIRED
Chart Review for Preventive Health Visits or other Baseline Data Needed							
Chart Review or Assessements for Transition Planning or Self-Management Skills or other Objectives							
Pre and Post Tests and other Assessments as needed for documentation of goals/objectives							
Track Preventive Health Visits , Transisitons Plans, Self-Management Skills and/other objectives							
Track Referrals							
Satisfaction Surveys							
Final Evaluation Report (with Sustainability Plan							REQUIRED
Add Other Objectives							

Table1

Example of Objectives Including Time frame	Grant Proposal Potential Aims	Relevant or Matching AMCHP Standards	Examples of Strategies that can be used in your Design Plan (They will depend on the objectives you create)
By the end of the first month (November 2016), we will have completed a list of active CYSHCN	Medical Home Registry for CYSHCN **(Required)**	#8.Integrate care with other providers and ensure that information is shared effectively with families and among and between providers #9.Perform care tracking, including sending of proactive reminders to families and clinicians of services needed, via a registry or other mechanism.	Using list of codes provided and codes of patients known to practice, Develop Registry of CYSHCN by age, These can be further categorized by need.
By the end of the first month, the PCP team will have met with District Care Coordinators and a referral mechanism documented And in place.	Integration of Care Coordination (Expected)	#3. Provide an integrated, team-based model of care coordination	Select a CYSHCN project team; set regularly scheduled meetings Develop a protocol for deciding which patients will need additional services. (For Example) Patients with sickle cell anemia may need assistance with monitoring of school activities, cognitive development; adolescents over 14 will need transition to adult care plan Develop/implement strategy for tracking referrals within Electronic health record or other System Determine how Shared Plan of Care Will be implemented with Family. Will Provider complete a portion (medical)and Care Coordinator complete the rest(psychosocial)? Will Provider and Family complete all of it and have it reinforced by Care Coordinator?

Example of Objectives Including Time frame	Grant Proposal Potential Aims	Relevant or Matching AMCHP Standards	Examples of Strategies that can be used in your Design Plan (They will depend on the objectives you create)
By the end of the first quarter, Medical home assessment will be completed. To be reassessed at beginning of 4th quarter	**(Requirement)**	Standards 1-10	Make arrangement to complete formal assessment with or without MSDH assistance
By the end of the third quarter, 70% of eligible CYSHCN will have received a preventive health screening		#8.Perform care tracking, including sending of proactive reminders to families and clinicians of services needed, via a registry or other mechanism.	Develop a system to flag CYSHCN as they schedule appointments Monitor missed appointments. Refer as necessary for assistance with missed appointments
By the end of the third quarter, 75%of CYSHCN who have had a routine wellness screening Will have a family centered (Shared)plan of care on file	Increase the number/percent of family centered Shared plans of care for CYSHCN population in my practice	#5.Develop, maintain, and update a comprehensive integrated plan of care that has been developed with the family and other members of a team, addresses family care clinical goals, encompasses strategies and actions needed across all settings, and is shared effectively with families and among and between providers	Patients flagged as CYSHCN will have Shared Plan of Care form and referral form added to chart Referral to Care Coordinators as necessary to home visit/assist as necessary
By the end of the second quarter 50 % of Preventive / EPSDT screens in eligible clients (due that quarter) Will be completed. By the end of the fourth quarter, 70 % of the Preventive /EPSDT screens in eligible clients that are due that quarter will be completed.	Increase the number of CYSHCN with routine preventive health screenings and Anticipatory guidance **(Reporting Requirement)**	#1.Provision of Access to health care services 24 hours/day for well, acute, chronic, care #2.Provision of heath care services that encourage the family to share in decision making and provide feedback on services provided #3.Perform Comprehensive health assessment #7.Promote Quality of life, healthy development, and healthy behaviors	Initially document baseline data. Plan to increase each quarter. Consider barriers to care Refer to Care Coordination to assist with transportation , family education, other needs

Example of Objectives Including Time frame	Grant Proposal Potential Aims	Relevant or Matching AMCHP Standards	Examples of Strategies that can be used in your Design Plan (They will depend on the objectives you create)
By the end of the year, 60 % of CYSHCN will have shared plans of care completed **(Be realistic based on baseline estimate)** By the end of the third quarter, 75% of CYSHCN will have received a psychosocial assessment (Determine whether this is needed for a few/ many/most of clients in practice or done routinely)	Increase the number of CYSHCN with Family Centered/Shared Plan of Care	#5.Develop, maintain, and update a comprehensive integrated plan of care that has been developed with the family and other members of a team, addresses family care clinical goals, encompasses strategies and actions needed across all settings, and is shared effectively with families and among and between providers	Charts can be reviewed Prior to scheduled visits and appropriate forms added as needed. Additional 5-10 records From the Registry can be reviewed weekly. Those without plans can be scheduled and/or referral made and Tracking initiated
By the end of the third quarter, 75% of CYSHCN seen during the past three quarters will have an annual Oral health visit scheduled By the end of the fourth quarter, 70 % of CYSHCN seen during the year will have an oral health visit completed	Improve the oral health care of CYSHCN Increase the proportion of CYSHCN with annual visits to dental home **(Required)**	#3.Perform Comprehensive health assessments #7.Promote Quality of life, healthy development, and healthy behaviors across all life stages	Document in record Dental Home Refer for annual dental visits Schedule appointments and follow up any missed appointments Refer as necessary
By the end of the fourth quarter, there will be a 20 % increase over baseline in the number of adolescent CYSHN who have an age appropriate **transition plan**	Provide adequate transition to adult care for CYSHCN **(Required Reporting)**	#5.Develop, maintain, and update a comprehensive integrated plan of care that has been developed with the family and other members of a team, addresses family care clinical goals, encompasses strategies and actions needed across all settings, and is shared effectively with families and among and between providers	Select a month (if not done initially__ recommended) to Review adolescent charts. Work monthly to increase Number with transition plans. Referrals can be made With required turnaround time and method for documentation . May be done in conjunction with Shared Plan of Care

Example of Objectives including Time frame	Grant Proposal Potential Aims	Relevant or Matching AMCHP Standards	Examples of Strategies that can be used in your Design Plan (They will depend on the objectives you create)
In this section are other topics which can be converted to objectives depending on your project plan and specific population ***You may develop additional ones to fit your clinic setting and patient needs***			You may consider 1) Establishing baseline, 2) ncreasing by small increments (15% increase) over baseline initially as you continue to evaluate your population needs Decide what components are needed to be in place to complete measurements. Please document on Quarterly reports PDSA cycles used as applicable
# of CYSHCN of Transition Age (≥ 14 yrs who have been screened for depression	**Recommended**	#3.Perform Comprehensive health assessments #6.Conduct activities to support CYSHCN and their families in self-management of the child's heath #8.Provide care that is effective, and based on evidence, where applicable	Coordinate Transition Plans with Depression screening
# of CYSHCN who received Nutrition education based on BMI Percentile (At Risk for Obesity or Obese)		#10Provide care that is effective, and based on evidence, where applicable	Review BMI and BMI percentile at each visit. Counsel/refer appropriately for each category_ _Normal , Overweight, Obese, Excessively Obese
# of Referrals for CMP Care Coordination Services	**(Required Reporting)**	#4.Provide an integrated, team-based model of care coordination	Review options for referrals on Referral form as patient needs are assessed Or based on regular meetings/phone calls with Care Coordinators

Example of Objectives Including Time frame	Grant Proposal Potential Aims	Relevant or Matching AMCHP Standards	Examples of Strategies that can be used in your Design Plan (They will depend on the objectives you create)
# of home visits received /referred		#4.Provide an integrated, team-based model of care coordination	Assess the need for a home visit for patients with complex medical/psychosocial/behavioral issues
# Urgent Visits annually		#1Provision of Access to health care services 24 hours/day for well, acute, chronic, care	Opportunity to assess preventive health visits and self-management skills
# of Hospitalizations annually		#1Provision of Access to health care services 24 hours/day for well, acute, chronic, care	Opportunity to assess preventive health visits, self-management skills, and resources
# of Hospitalizations prevented Annually		#1Provision of Access to health care services 24 hours/day for well, acute, chronic, care	Opportunity to assess preventive health visits, self-management skills, and resources
# qualified for Respite Care / # wh received Respite care		#10Provide care that is effective, and based on evidence, where applicable	Opportunity to assess preventive health visits, self-management skills, and support network resources
IFSP/ IEP/504 Plan		#4.Provide an integrated, team-based model of care coordination	Opportunity to assess school and environmental
# of referrals to food bank		#4.Provide an integrated, team-based model of care coordination	Opportunity to assess preventive health visits and support network resources
# of Referrals for medical-Legal intervention		#4.Provide an integrated, team-based model of care coordination	Opportunity to assess preventive health visits, self-management skills, and support network resources
Family Satisfaction with Care		#6Conduct activities to support CYSHCN and their families in self-management of the child's heath #7Promote Quality of life, healthy development, and healthy behaviors across all life stages	Promotion of Quality of Life, healthy development, and healthy behaviors across all life stages
You may create other additional objectives as appropriate for your Practice/ patient population			

Table 2: Examples of Objectives

Example of Objectives including Time frame	**Grant Proposal Aims**	**Relevant or Matching Standards**	**Examples of Strategies that CAN be used in your Design Plan** **(They will depend on the objectives you create)**
By the end of the second month, we will have enrolled 50% of eligible participants into the pilot program	Develop an effective transition planning program for all adolescent students enrolled in our programs	Identification, Screening, Assessment, and Referral Transition to Adulthood	Determine qualifications for the pilot program [eg.age/condition(s)] Recruit from your clients ,partners ,community. Develop a Registry Develop training Curriculum; Define specific activities to support and advance each level
By the end of the fourth month, all registered students will have *completed a Transition Readiness* survey	Develop an effective transition planning program for all students *enrolled in our programs*	Transition to Adulthood	Conduct surveys and assess level of readiness to transition *Evaluate self-management skills* for day to day management, emergency situations, disasters Group students by readiness level; Provide opportunities for role play; field trips Partner with other organizations for job placement training
By the end of the ninth month, 75% of those enrolled Have increased level of readiness to transition	Develop an effective transition planning program for all students enrolled in our programs	Transition to Adulthood	Evaluate at specific intervals
By the end of the eleventh month, 75% of students $\geq$ 18 years, will have made an appointment to see an adult primary care or subspecialty provider	Develop an effective transition planning program for all students enrolled in our programs	Transition to Adulthood	Build in and track specific milestones Allow older ;students to mentor/train younger students

By the end of the third month, Parents will have completed first three program modules	Develop a Parent-to-Parent Training Academy	Community- Based Services and Supports	After selection of evidence-based curriculum or customizing curriculum, recruiting participants and assigning staff, initiate training. You may want to first conduct focus groups to determine needs of parents related to navigation of medical system, navigation of school system, technology issues, mental health, and coping skills. Choose assessment instruments and curriculum accordingly.
By the end of the ninth month, each parent guide will be assigned a newly enrolled or referred parent	Develop a Parent-to-Parent Training Academy	Community- Based Services and Supports Promotion of Quality of Life, healthy development, and healthy behaviors across all life stages	Develop matching criteria for parents (Strengths & Challenges) Use of Parent satisfaction of experience surveys Reassess annually to make improvements
By the end of the 9th month, 75 % of participants will demonstrate the following self-management skills: _Asthma Action Plan _Disaster Plan _Scholl Plan _Proper use of Inhaler _Use of Peak flow meter readings _Controller Vs. Acute medications _Trigger Avoidance	Implementation of Asthma Self-Management Training	Community- Based Services and Supports Promotion of Quality of Life, healthy development, and healthy behaviors across all life stages	Demonstrate use of evidence-based curriculum for setting and age range after selection of participants Describe theoretical basis Develop evaluations based on stated skill-based objections

Eligible Diagnoses and Diagnostic Codes for Enhanced Care Coordination Pilot Project

GroupName	Diagnosis	ICD-10 Code
Traditional Categories		
Blood disorders	Hemoglobin C/Beta Thalassemia	D58.2
	F/S Beta Thalassemia	D56.1 / D56.5
	Hemoglobin Disorder	D58.2
	Hemoglobin S/Beta Thalaseemia	D57.4
	Hemoglobin C	D38.2
	Hemoglobin SC Disease	D57.2
	Hemophilia	D66, D67
	Other Hemoglobinopathies	D58.2
	Sickle Cell Disease	D57
	Thalassemia	D56
	Von Willebrand Disease	D68
Cardiac disorders	Aortic Stenosis	Q25.3
	ASD - Atrial Septal Defect	Q21.4
	AV Canal - Atrioventricular Canal	Q21.2
	Bicuspid Aortic Valve	Q23.1
	Coarctation of the Aorta	Q25.1
	Complex congenital heart Disease	Q24.6
	Congenital Heart Anomaly	Q24.6
	Hypoplastic Left Heart	Q23.4
	Hypoplastic Right Heart	Q22.6
	Marfan Syndrome	Q87.4
	PDA - Patent Ductus Arteriosus	Q25.0
	Pulmonary Stenosis	Q22.1
	SVT - Superventricular tachycardia	I47.1
	TAPVR - Total Anomalous Pulmonary Venous Return	Q26.2
	TOF - Tetralogy of Fallot	Q21.3
	Transposition of the Great Arteries	Q20.3
	Tricuspid Atresia	Q22.4
	VSD - Ventriculoseptal Defect	Q21.1
	WPW - Wolf-Parkinson-White Syndrome	I45.6

Group Name	Diagnosis	ICD-10 Code
	Congenital Malformations of Cardiac Chambers and Connection	Q20
	Rental Artery Stenosis	Q27.1
	Congenital Malformations of Circulatory, Unspecified	Q28.9
	Congenital Subaortic Stenosis	Q24.4
	Congenital Malformation of Heart	Q24.9
	Interruption of Aortic Arch	Q25.21
	Other Atresia of Aorta	Q25.29
	Congenital Malformation of Aorta Unspec	Q25.40
	Absence and Aplasia of Aorta	Q25.41
	Congenital Aneurysm of Aorta	Q25.43
	Other Congenital Malformations of Aorta	Q25.49
	Situs Inversus	Q89.3
Craniofacial disorders	Apert Syndrome	A23.1
	Cleft Lip/Palate	Q35-Q37
	Cranial deformity	Q75
	Craniosynostosis	Q75
	Goldenhar Syndrome	Q87.0
	Congenital Malformation Affecting Facial Apperance	Q87.0
	Other severe facial anomalies	Q87.0
	Pierre Robin	Q87.0
	Treacher-Collins syndrome	Q75.4
Endocrine disorders	CAH-Congenital Adrenal Hyperplasia	E25.0/E25.9
	Diabetes Mellitus due to underlying Condition	E08
	Type Diabetes 1 Mellitus	E10
	Congenital Hypothyroidism	E03.0-E03.1
ENT disorders	Hearing Loss	H90-H91
	Malformations of the ear	Q16/ other Q15.8
	Congenital Absence of (ear) Auricle Causing Hearing Loss	Q16
	Congenital Malformation of Ear Causing Impairment of Hearing	Q16.9
	Other Congenital Malformations of Ear	Q77
	Sensorineural Hearing Loss	H90.2.

Group Nam	Diagnosis		ICD-10 Code
Eye disorders	Aphakia		H27.0
	Congenital Cataracts		H26.0
	Eye Prosthesis		Q12.0
	Eye Surgery		H05.421/H05.422
	Glaucoma		H40
	Legal Blindness, as Defined In USA		H54.8
	Retinopathy of Prematurity		H35.1
	Blindness and low Vision		H54.8
	Legal Blindness, as Defined In USA		H54.8
	Retinopathy of Prematurity		H35.1
	Presence of Artificial Eye		Z97.0
Genetic disorders	2-Methylbutyryl-CoA Dehydrogenase deficiency		E71.310,311,312
	Adrenoleukodystrophy		E71.511
	Biotindase		D81.810
	CAH - Congenital Adrenal Hyperplasia		E25..0/E25.9
	Chromosomal Anomaly		O28.5
	Cystic Fibrosis		E84
	Down Syndrome		E90
	Galactosemia		E74.21
	Hunter Syndrome		E76.01
	Hypomelanosis Of Ito		L81.6
	Marfan Syndrome		Q87.4
	MCAD		E71.311
	MSUD - Maple Syrup Urine Disease		E71.0
	Neurofibromatosis		Q85.00
	Other Metabolic Disorders		213.228/E88
	PKU - Phenylketonuria		E70.0
	PPA – Propionic Acidemia	E71.121	
	Rubinstein-Taybi Syndrome	Q87.2	
	Sanfilippo Syndrome	E76.22	
	Tuberous Sclerosis	Q 85.1	

Group Name	Diagnosis	ICD-10 Code
Congenital and/or Genetic Disorders	Turner syndrome	Q96
	TYR I – Tyrosinemia Type I	E75.5/E75.09
	Fetal Alcohol Syndrome	Q86.0
	Congenital Viral Diseases	P35
	Congenital Cytomegalovirus Infection	P35.1
	Congenital Toxoplasmosis	P37.1
	Prune Belly	Q79.4
	Ehlers Danlos	Q79.6
	Sanfilippo Syndrome	E76.22
	Cystic Fibrosis	E84.11
	Hurler's Syndrome	E76.01
	Pompe Disease	E74.02
	Other Glycogen Storage Disease	E74.09
	Mitochondrial Metabolism Disorder	E88.4
	Trisomy 18 and Trisomy 13	Q91
	Other Trisomies	Q92
	Phakomatoses, NEC Unspecified	Q85.8 -Q85.9
	Other Liped Storage Disorders	E75.5
	Other GM2 gangliosidosis	E75.09
	Noonan Syndrome	Q87.1
	VATER syndrome	C24.1
	Velocardiofacial Syndrome	Q80.0
	Fragile X	Q99.2
	Fetal Hydantoin Syndrome	Q86.1
	Chromosome Abnormalities	Q99.8
	Williams Syndrome	E05.90 / E05.91
	Marfan Syndrome	Q87.4
	McCune Albright Syndrome	Q87.81
	Multiple congenital anomalies	Q89.7- other 89.8
	Disorders of Metabolism	E88
	Juvenile Dermatoymyositis	M33.0

Group Name	Diagnosis	ICD-10 Code
Rhematoid Disorders	Juvenile rheumatiod arthritis	M08.0
	Other Rheumatiod	M06
Genitourinary System	Ambiguous Genitalia	Q56.0
	Congenital and acquired malformations of the Urinary tract	Q60/Q64
	Congenital Malformation of Male Genitalia	Q56
	Other Specified Congenital Malformation of Female Genitalia	Q52.8
	Congenital malformations of the Genital tract	Q50-56-Q43.8, Q49.9
	Neurogenic Bladder	K59.2
	Renal Agenesis	Q60
	Renal dysplasia/hypoplasia	Q61.4
	Hydronephrosis	Q62
	Hypospadias	Q54
	Polycystic Kidney Infantile Type	Q61.1
Malformations of Other organ systems	Laryngeal cleft	Q31.2
	Hirschsprung's disease	Q43.1
	Congenital Malformations of Musculoskeletal System	Q79.8
	Congenital Tracheomalacia	Q32.0
	Other Specified Congenital Malformations of Digestive System	Q45.8
	Gastroschisis	Q79.3
	Congenital Diaphragmatic Hernia	Q79.0
	Congenital malformations of the Gastrointestional tract	Q40.9
	Dysmorphism	Q86.8
	Congenital malformation of Respiratory System	Q34.9
	Tracheo-esophageal fistula	Q39.1 / Q39.2
Neurological disorders	Brachial plexus palsy	G54.0
	Cerebral Palsy	G80
	Demyelinating Disorder	G35 / G37
	Encephalocele	Q01
	Erbs Palsy	G80

Group Name	Diagnosis	ICD-10 Code
Neurological Disorders	Fetal Alcohol syndrome	Q86.0
	Hydrocephalus	G91
	Mitochondrial Disorder	E88.40
	Neurocutaneous syndrome	Q85.9
	Neurofibromatosis	Q85.0
	Sacral Agenesis	Q62.4
	Seizures(Epilepsy)	G40
	Spina Bifida Occulta	Q76.0
	Spina Bifida	Q05
	Spinal Deformities	Q89.9
	Static Encephalopathy	E51.2
	Spastic Diplegia	G80.1
	Spastic Hemiplegia	G81.1
	Spastic Quadriplegia	G80.0
	Lumbar Myelo	Q05.02
	Microcephaly	Q02
	Congenital Hydrocephalus	Q03
	Congenital Brain Disoders	Q04.9
	Spinal Cord Injury	P11.5
	Static Encephalopathy	E51.2
	Cerebral Palsy	G80
	Tethered Cord	Q06.8
Orthopedic disorders	Achondroplasia	Q77.4
	Congenital Malformation of Limbs	Q74
	Acquired limb deformity	M21.9 / M21.90
	Amniotic band syndrome	M76.31/M76.32
	Amputee	Z89.9
	Arthrogryposis	Q74.3
	Congenital Malformation of Limbs	Q74
	Benign bone tumors	D16
	Blount Disease	M92.9

Group Name	Diagnosis	ICD-10 Code
Orthopedic Disorders	Bone Cyst	M85.4 / M85.5
	Club Foot/Feet	W21.1
	Congenital Amputation	V49.73
	Congenital Kyphosis	Q76.41
	Congenital limb malformation	Q74.9
	Syndactyly	Q70
	Heel Cord Contracture	M24.50
	Congenital Hip Dislocation	Q65.
	Leg Length Discrepancy	D17.23 / D17.24
	Legg-Calve-Perthes Disease	M91.11 / M91.12
	Osteochondroma	M42
	Congenital Malformation of Limbs	Q74
	Osteogenesis Imperfecta	Q78.0
	Rickets	E55.0/E83.32
	Scoliosis	M41
	Congenital Deformity of Spine	Q67.5
	Skeletal dysplasias	M85.1
	Osteochondrodysplasia with Defects of Growth Tubular Bones and Spines	Q77.8
	Other Osteochondrodysplasias	Q78
	Osteogenesis Imperfecta	Q78.0
	Congenital Deformities of Feet	Q66.5
	Spinal Deformities	Q89.9
	Polysyndactyly	Q70.4
Skin / subcutaneous / vascular tissue disorders causing disrupted function	Burn,Severe	T20
	Hemangiomas	D18
	EEC Syndrome - Ectrodactyly-Ectodermal Dysplasia-Clefting Syndrome	Q82.4

Group Name	Diagnosis	ICD-10 Code
Expanded List of Chronic Disorders (Eligible for this Grant)	Unspecified Severe Protein- Calorie Malnutrition	E43
	Childhood Obesity	E66.9
	Pervasive Developmental Disorders	F84 - F84.8
	Autiam Spectrum Disorder	F84
	Asperger's	F84.5
	Prediabetes	R73.03
	Diabetes, Type II	E 11.8
	Attention Deficit Disorder	F90.9
	Asthma	J45
	Congenital Zika Syndrome	
	Disorders Originating in the Perinatal Period (Substance Use)	P04 /P96