

Program: Children with Special Health Care Needs (CSHCN)

Division: Community Health Intervention Prevention

Goal: To assure that children and youth with special health care needs achieve the healthiest life possible.

PROCESS →

← **OUTCOMES** →

Resources	Activities	Outputs	Outcomes(short, intermediate, long-term)	Measurement
<p>Families: parent/children</p> <p>Staff: Program Supervisor Public Health Nurses Registered Dietitian Clerical Support</p> <p>Settings: BFHD Schools Doctor's office Home(s) Natural Environment Therapy Offices</p> <p>Funding: MCH Block Grant</p> <p>Collaboration: Partnerships with other organizations and community programs DOH CSHCN office Parent 2 Parent Division of Developmental Disability (DDD)</p>	<p><u>Client/Clinical</u></p> <p>1. Provide support to client and family through office and home visits and coordination of care (Program Theory?)</p> <p>2. Act as an advocate for and help clients connect with community resources</p> <p>3. Participate in client care planning meetings: IFSP & IEP</p> <p><u>Parent/Provider Outreach</u></p> <p>1. Teach family & parent skill to become their child's own care coordinator</p> <p>2. Inform and provide parents educational materials regarding child's condition</p> <p>3. Refer clients to State website</p>	<p># of visits with families & # of direct service hours</p> <p># of referrals from hospitals, agencies and MDs</p> <p># of children who received care coordination (i.e. linked to necessary services and resources</p> <p># of written care plans developed</p> <p># of community meetings attended</p> <p># TCG codes</p> <p># of regional meetings attended</p> <p># of provider consultations</p> <p># of HICFA processed</p> <p># of clients at each level of</p>	<p><u>Process Outcome</u></p> <p>Children with developmental delay are identified early</p> <p>The family-centered medical home model is the standard of care in BFHD</p> <p>Community resources addressed clients needs</p> <p>Regional information and resources are made available to the community (activity?)</p> <p>Meetings included key stakeholders and conducted in a timely manner</p> <p>Information of website addressed clients needs</p> <p>Utilized motivation interviewing information</p> <p>Information provided was current, accurate & understandable for client.</p>	<p>Client satisfaction survey Omaha</p> <p>Value and barrier discussion</p> <p>Chart Review (appropriate action taken)</p> <p>Improve care coordination(OMAHA)</p> <p>Review meeting minutes quarterly</p> <p>Call log and review triage process</p> <p>Updating referral list</p> <p>Client survey satisfaction</p> <p>Client survey (OMAHA)</p>

<p>DSHS Therapists School districts PCP/Specialists</p> <p>Benton-Franklin Infant Toddler Early Intervention Program (ITEIP)</p> <p>Tools: Denver II MCHAT (autism screenings) NCAST assessment Region X</p> <p>Tier Survey</p>	<p><u>Program Development</u></p> <ol style="list-style-type: none"> 1. Attend CSHCN regional meetings 2. Attend monthly staff meetings 3. Enroll all eligible children into (CHIF) 4. Authorize hearing aids for Medicaid clients 5. Implement (triage) tier system to prioritize level of case management needed <p><u>Community</u></p> <ol style="list-style-type: none"> 1. Make referrals to providers 2. Present to community partners, health care providers, BOH re: CSHCN program and services. 3. Attend regional quarterly (Yakima) meeting 4. Develop a functioning medical home team 	<p>case management</p> <p># of members on medical home team</p> <p># of meetings</p> <p># of children enrolled</p> <p># of hearing aids processed</p> <p># of children served (CHIF)</p> <p># of providers</p> <p># of referrals</p> <p># of presentations</p> <p># of clients</p>	<p>Meetings aligned with program goals</p> <p>Eligible children enrolled according to protocol</p> <p>Authorization of hearing aids was appropriate and timely</p> <p>Process was efficient</p> <p>Appropriate referral; client was satisfied</p> <p>Team is functioning and is efficient</p> <p><u>Impact Outcome</u></p> <p>Detection and Early Intervention for health problems</p> <p>Community resources are utilized efficiently</p> <p>Child and Families are satisfied with CSHCN program</p> <p>Parent organizations are supported</p> <p>Communication among service providers is strengthen</p> <p>Health system barriers are addressed at a community systems level</p>	
---	---	--	--	--

			<p>CSHCN deliverables are met</p> <p>Prevent health problems/prevent complications</p> <p>Improve care coordination and care</p> <p><u>Population Outcome</u></p> <p>Families receive care in Benton-Franklin Counties</p> <p>Children with chronic conditions receive optimum health care</p> <p>Detect and/or prevent health problems in order to optimize the quality of life in Children with Special Health Care Needs</p> <p>in an effort to promote referrals and increase knowledge</p> <p>Understanding of materials using current information</p> <p>Increase ability to hear</p> <p>Increase access to care</p> <p>Children with DD were screened early</p>	
--	--	--	---	--