CYSHCN Workgroup

Logic Model Instructions:

Note: Remember to consider stakeholder input from meetings one and two when finalizing Strategies and Action Steps.

(1) Strategies: To be completed by Section Directors.

(a) For each priority, enter strategies in bright yellow cells. List up to 3 strategies for each priority. Strategies will stay the same over the next five years.

(b) Select corresponding Essential MCH Service from drop-down list in pale blue cell.

(2) Logic Model Table for each strategy: To be completed by Staff at the March 26th meeting.

Note: As you are developing action steps and listing outputs, keep in mind the end goal, the long-term outcome.

(a) For each strategy, enter action steps in pale orange cells. List up to 3 activities/action steps per strategy. Activities / action steps may change over the five years.

(b) Enter outputs, short-term outcomes, intermediate outcomes and long-term outcomes for each strategy. You do not necessarily need to have these for each action step; they may correspond to multiple (or all) action steps under a strategy.

Workplan Instructions:

(1) Enter the priority indicators in the lavendar cells. Select 1-3 indicators for each priority.

(2) Light gray dotted cells (like those at the left), with Activities/Action Steps and Strategies will fill in automatically from the Logic Model Spreadsheets.

(3) Fill in Responsible Party (light green cell) for each Strategy, if desired.

(4) Enter the expected Completion Date or timeline for each actiivty.

(5) Enter the Responsible Part for each activity, if not entered at Strategy level or different than Strategy Responsible Party.

Children & Youth with Special Health Care Needs Logic Model

VISION - Healthy Children in Healthy Families ***MISSION - Provide leadership to enhance the health of Kansas women and children in partnership with families and communities.***

GOAL STATEMENT: To enhance the health of all children and and youth with special health care needs across the lifespan.

PRIORITY OBJECTIVE #1: ***All CYSHCN receive coordinated, comprehensive care within a medical home.***

	Planned Activities/Action Steps	Outputs Immediate or by June 30, 2011	Short-Term Outcomes by Dec. 31, 2011	Intermediate Outcomes by Dec. 31, 2012	Long-Term Outcomes by June 20, 2015
1.1	***Strategy 1.1 :*** *Enter Strategy, Essential MCH Service, and Planned Activities below.*				
	Strategy:	***Mobilize community partnerships (between policy makers, health care providers, families, and the public) by coordinating services for eligible CYSHCN identified through Newborn Screening and linking children and families to providers and community services/resources.***			
	Essential MCH Service (select from list):	***4. Mobilize community partnerships to solve MCH issues***			
1.1.1					
1.1.2					
1.1.3					
1.1.4					
1.2	***Strategy 1.2 :*** *Enter Strategy, Essential MCH Service, and Planned Activities below.*				
	Strategy:	***Inform, educate, and involve families and providers about medical home components and initiatives to promote effective and successful systems change.***			
	Essential MCH Service (select from list):	***3. Inform/educate the public/families about MCH issues***			
1.2.1					
1.2.2					
1.2.3					
1.2.4					

	Planned Activities/Action Steps	Outputs Immediate or by June 30, 2011	Short-Term Outcomes by Dec. 31, 2011	Intermediate Outcomes by Dec. 31, 2012	Long-Term Outcomes by June 20, 2015
1.3	**Strategy 1.3 :** *Enter Strategy, Essential MCH Service, and Planned Activities below.*				
	Strategy:				
	Essential MCH Service (select from list):	<None Selected>			
1.3.1					
1.3.2					
1.3.3					
1.3.4					

PRIORITY OBJECTIVE #2: **CYSHCN receive services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.**

	Planned Activities/Action Steps	Outputs Immediate or by June 30, 2011	Short-Term Outcomes by Dec. 31, 2011	Intermediate Outcomes by Dec. 31, 2012	Long-Term Outcomes by June 20, 2015
2.1	**Strategy 2.1 :** *Enter Strategy, Essential MCH Service, and Planned Activities below.*				
	Strategy:	Enhance community partnerships by identifying community resources, integrating service delivery systems, and streamlining the transition process for children and youth.			
	Essential MCH Service (select from list):	4. Mobilize community partnerships to solve MCH issues			
2.1.1					
2.1.2					
2.1.3					
2.1.4					

	Planned Activities/Action Steps	Outputs Immediate or by June 30, 2011	Short-Term Outcomes by Dec. 31, 2011	Intermediate Outcomes by Dec. 31, 2012	Long-Term Outcomes by June 20, 2015
2.2	**Strategy 2.2 :** *Enter Strategy, Essential MCH Service, and Planned Activities below.*				
	Strategy:	**Inform and educate children and youth about available transition services and where/how to access these services.**			
	Essential MCH Service (select from list):	**7. Link women & children with services and assure quality systems of care**			
2.2.1					
2.2.2					
2.2.3					
2.2.4					
2.3	**Strategy 2.3 :** *Enter Strategy, Essential MCH Service, and Planned Activities below.*				
	Strategy:				
	Essential MCH Service (select from list):	**<None Selected>**			
2.3.1					
2.3.2					
2.3.3					
2.3.4					

PRIORITY OBJECTIVE #3: ***Financing for CYSHCN services minimizes financial hardship for their families.***

	Planned Activities/Action Steps	Outputs Immediate or by June 30, 2011	Short-Term Outcomes by Dec. 31, 2011	Intermediate Outcomes by Dec. 31, 2012	Long-Term Outcomes by June 20, 2015
3.1	***Strategy 3.1 :*** *Enter Strategy, Essential MCH Service, and Planned Activities below.*				
	Strategy:	***Link families to CYSHCN providers who are contracted with CYSHCN and accept negotiated reimbursement rates.***			
	Essential MCH Service (select from list):	***7. Link women & children with services and assure quality systems of care***			
3.1.1					
3.1.2					
3.1.3					
3.1.4					
3.2	***Strategy 3.2 :*** *Enter Strategy, Essential MCH Service, and Planned Activities below.*				
	Strategy:	***Ensure CYSHCN Clinic/Field staff assist families in applying for possible funding sources.***			
	Essential MCH Service (select from list):	***9. Evaluate effectiveness, accessibility, quality***			
3.2.1					
3.2.2					
3.2.3					
3.2.4					

	Planned Activities/Action Steps	Outputs Immediate or by June 30, 2011	Short-Term Outcomes by Dec. 31, 2011	Intermediate Outcomes by Dec. 31, 2012	Long-Term Outcomes by June 20, 2015
3.3	**Strategy 3.3 :** *Enter Strategy, Essential MCH Service, and Planned Activities below.*				
	Strategy:	**Support expansion of primary and specialty care services to minimize travel time and missed work/school days.**			
	Essential MCH Service (select from list):	**5. Leadership in setting priorities, planning and policy development**			
3.3.1					
3.3.2					
3.3.3					
3.3.4					

Children & Youth with Special Health Care Needs Workplan

VISION - Healthy Children in Healthy Families

MISSION - Provide leadership to enhance the health of Kansas women and children in partnership with families and communities.

GOAL STATEMENT: To enhance the health of all children and youth with special health care needs across the lifespan.

PRIORITY OBJECTIVE #1: ***All CYSHCN receive coordinated, comprehensive care within a medical home.***

Indicator(s) for Priority Objective #1

A.	Percentage of CYSHCN who receive care in medical home as defined by AAP
B.	Percentage of CYSHCN who receive care in medical home
C.	Percentage of CYSHCN aged 2-17 with problems requiring counseling who received mental health care
D.	Percentage of CYSHCN who receive BOTH routine preventive medical and dental care visits?
E.	Percentage of CYSHCN who had at least one unmet medical need
F.	Percentage of CYSHCN who have at least one need for specific health services
G.	Percentage of CYSHCN who have at least one need for family supportive services
H.	Percentage of CYSHCN who had difficulty getting a referral
I.	Percentage of CYSHCN who had difficulty getting a referral
J.	Percentage of CYSHCN aged 1-17 who at least one oral health problem in past 6 months
K.	Percentage of CYSHCN aged 6-17 who have medical, behavioral or other health conditions which interfere with their ability to attend school regularly, participate in sports or other activities, or make friends

	Activities/Action Steps	Completion Date for Activity	Responsible Party
1.1	***Mobilize community partnerships (between policy makers, health care providers, families, and the public) by coordinating services for eligible CYSHCN identified through Newborn Screening and linking children***		
1.2	***Inform, educate, and involve families and providers about medical home components and initiatives to promote effective and successful systems change.***		
1.3			

PRIORITY #2: ***CYSHCN receive services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.***

Indicator(s) for Priority Objective #2

A.	Percentage YSHCN (12-17 years) who receive the services necessary to make appropriate transitions to adult health care, work and independence
B.	Percentage of recipients successfully transition from Part C to Part B
C.	Percentage YSHCN receive all anticipatory guidance for transition to adult health care
D.	Percentage YSHCN whose doctors usually or always encourage development of age appropriate self management skills
E.	Percentage of CYSHCN program (15 and older) participants who found an adult doctor
F.	Percentage of CYSHCN program (15 and older) participants who found an adult specialist
G.	Percentage of CYSHCN program (15 and older) participants who know when to report changes in their health
H.	Percentage of CYSHCN program (15 and older) participants who know how to get emergency help
I.	Percentage of CYSHCN program (15 and older) participants who can take responsibility for their health needs at home
J.	Percentage of CYSHCN program (15 and older) participants who can take responsibility for their health needs at school or work
K.	Percentage of CYSHCN program (15 and older) participants who can follow medical directons
L.	Percentage of CYSHCN program (15 and older) participants who have plans where to live as an adult
M.	Percentage of CYSHCN program (15 and older) participants who can arrange transportation
N.	Percentage of CYSHCN program (15 and older) participants who have information about school or tech training
O.	Percentage of CYSHCN program (15 and older) participants who have skills to live independently
P.	Percentage of CYSHCN physician who always or usually report that the treatment plan addresses youth development in assuming personal care/management and transition planning to adult medical providers?

	Activities/Action Steps	Completion Date for Activity	Responsible Party
2.1	***Enhance community partnerships by identifying community resources, integrating service delivery systems, and streamlining the transition process for children and youth.***		
2.2	***Inform and educate children and youth about available transition services and where/how to access these services.***		
2.3			

PRIORITY #3: ***Financing for CYSHCN services minimizes financial hardship for their families.***

Indicator(s) for Priority Objective #3

A.	Percentage CYSHCN whose families pay $1,000 or more out-of-pocket
B.	Percentage CYSHCN whose conditions cause financial problems for family
C.	Percentage CYSHCN whose families spend 11 or more hours a week providing health care
D.	Percentage CYSHCN whose conditions cause family members cut back or stopped working
E.	Percentage CSHCN (0-5 years) Parents who report at least one child care or employment issues
F.	Percentage CSHCN (0-5 years) Parents who report childcare effects employment
G.	Percentage CSHCN (0-5 years) Parents who made different arrangements for child care at the last minute due to circumstances beyond your control and had no problems
H.	Percentage CSHCN (6-11 years) who spends some time alone
I.	Percentage CYSHCN who have inadequate insurance
J.	Percentage CYSHCN have inadequate insurance
K.	Percentage CYSHCN parents whose out-of-pocket expenses are never or sometimes reasonable

	Activities/Action Steps	***Completion Date for Activity***	***Responsible Party***
3.1	***Link families to CYSHCN providers who are contracted with CYSHCN and accept negotiated reimbursement rates.***		

3.2	***Ensure CYSHCN Clinic/Field staff assist families in applying for possible funding sources.***		
3.3	***Support expansion of primary and specialty care services to minimize travel time and missed work/school days.***		

Children & Youth with Special Health Care Needs Indicators

PRIORITY OBJECTIVE #1: ***All CYSHCN receive coordinated, comprehensive care within a medical home.***

	Indicator	KS Measure	Year	Data Source
Medical Home	Percentage of CYSHCN who receive care in medical home as defined by AAP	49.3	2007	HRSA. Nation Survey of Child Health
	Percentage of CYSHCN who receive care in medical home	47.1	2005/2006	HRSA. Nation Survey of CSHCN
	Percentage of CYSHCN aged 2-17 with problems requiring counseling who received mental health care	71.6	2007	HRSA. Nation Survey of Child Health
	Percentage of CYSHCN who receive BOTH routine preventive medical and dental care visits	84.9	2007	HRSA. Nation Survey of Child Health
	Percentage of CYSHCN who had at least one unmet medical need	10.3	2007	HRSA. Nation Survey of Child Health
	Percentage of CYSHCN who have at least one need for specific health services	12	2005/2006	HRSA. Nation Survey of CSHCN
	Percentage of CYSHCN who have at least one need for family supportive services	3.2	2005/2006	HRSA. Nation Survey of CSHCN
	Percentage of CYSHCN who had difficulty getting a referral	11.4	2005/2006	HRSA. Nation Survey of CSHCN
	Percentage of CYSHCN who had difficulty getting a referral	12	2007	HRSA. Nation Survey of Child Health
	Percentage of CYSHCN aged 1-17 who at least one oral health problem in past 6 months	25.6	2007	HRSA. Nation Survey of Child Health
	Percentage of CYSHCN aged 6-17 who have medical, behavioral or other health conditions which interfere with their ability to attend school regularly, participate in sports or other activities, or make friends?	30.3	2007	HRSA. Nation Survey of Child Health

PRIORITY #2: ***CYSHCN receive services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.***

	Indicator	KS Measure	Year	Data Source
Transitioning	Percentage CYSHCN (12-17 years) who receive the services necessary to make appropriate transitions to adult health care, work and independence	41.2	2005/2006	HRSA. Nation Survey of CSHCN
	Percentage of recipients successfully transition from Part C to Part B	100	2009	Infant toddler program data.
	Percentage YSHCN receive all anticipatory guidance for transition to adult health care	32.4	2005/2006	HRSA. Nation Survey of CSHCN
	Percentage YSHCN whose doctors usually or always encourage development of age appropriate self management skills	78	2005/2006	HRSA. Nation Survey of CSHCN
	Percentage of CYSHCN program (15 and older) participants who found an adult doctor	25	2009	CYSHCN special survey
	Percentage of CYSHCN program (15 and older) participants who found an adult specialist	26	2009	CYSHCN special survey
	Percentage of CYSHCN program (15 and older) participants who know when to report changes in their health	54	2009	CYSHCN special survey
	Percentage of CYSHCN program (15 and older) participants who know how to get emergency help	66	2009	CYSHCN special survey
	Percentage of CYSHCN program (15 and older) participants who can take responsibility for their health needs at home	51	2009	CYSHCN special survey
	Percentage of CYSHCN program (15 and older) participants who can take responsibility for their health needs at school or work	51	2009	CYSHCN special survey
	Percentage of CYSHCN program (15 and older) participants who can follow medical directons	54	2009	CYSHCN special survey
	Percentage of CYSHCN program (15 and older) participants who have plans where to live as an adult	42	2009	CYSHCN special survey
	Percentage of CYSHCN program (15 and older) participants who can arrange transportation	39	2009	CYSHCN special survey
	Percentage of CYSHCN program (15 and older) participants who have information about school or tech training	28	2009	CYSHCN special survey
	Percentage of CYSHCN program (15 and older) participants who have skills to live independently	36	2009	CYSHCN special survey
	Percentage of CYSHCN physician who always or usually report that the treatment plan addresses youth development in assuming personal care/management and transition planning to adult medical providers?	35.9	2009	CYSHCN special survey

PRIORITY #3: ***Financing for CYSHCN services minimizes financial hardship for their families.***

	Indicator	KS Measure	Year	Data Source
Impact on Families	% CYSHCN whose families pay $1,000 or more out-of-pocket	21.9	2005/2006	HRSA. Nation Survey of CSHCN
	% CYSHCN whose conditions cause financial problems for family	21.4	2005/2006	HRSA. Nation Survey of CSHCN
	% CYSHCN whose families spend 11 or more hours a week providing health care	8	2005/2006	HRSA. Nation Survey of CSHCN
	% CYSHCN whose conditions cause family members cut back or stopped working	20.1	2005/2006	HRSA. Nation Survey of CSHCN
	% CSHCN (0-5 years) Parents who report at least one child care or employment issues	47.4	2007	HRSA. Nation Survey of Child Health
	% CSHCN (0-5 years) Parents who report childcare effects employment	14	2007	HRSA. Nation Survey of Child Health
	% CSHCN (0-5 years) Parents who made different arrangements for child care at the last minute due to circumstances beyond your control and had no problems	44	2007	HRSA. Nation Survey of Child Health
	% CSHCN (6-11 years) who spends some time alone	18.2	2007	HRSA. Nation Survey of Child Health
	% CYSHCN who have inadequate insurance	24.7	2007	HRSA. Nation Survey of Child Health
	% CYSHCN have inadequate insurance	30.1	2005/2006	HRSA. Nation Survey of CSHCN
	% CYSHCN parents whose out-of-pocket expenses are never or sometimes reasonable	18.9	2007	HRSA. Nation Survey of Child Health