

**Application:**

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| **1. Contact Information** | | | | | |
| **Healthcare Organization:** | | **Type: Private, FQHC, RHC, Other**  ***(Please circle)*** | | | |
| **Executive Director/Chief Executive Officer:** | | **Email Address:** | | | |
| **Chief Financial Officer:** | | **Email Address:** | | | |
| **Lead Project Contact:** | | **Email Address:** | | | |
| **Address:** | | | | | |
| **City:** | **County:** | **State:** | | **Zip Code:** | |
| **Phone Number:** | | **Fax Number:** | | | |
| **2. Describe the overall organizational structure and services provided. Include a list of the counties served, number of sites, services provided, number of providers, etc.** | | | | | |
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| **3. Describe the staff you have in place to execute the CYSHCN Cares 2** **Children and Youth with Special Health Care Needs Care Coordination award, including the roles and responsibilities of project staff? One person may serve in more than one role. Describe any positions for which you would need to hire new staff.** | | | | | |
| Responsibility for key tasks such as:   1. Leadership of the project (Senior Leader): 2. Project team members (Team Leader, Data Analyst, Provider Champion, Clinical Expert, Care Coordinator, Parent Consultant): 3. Care Coordinator (Social Worker): 4. Parent Consultant (Parent must have a child with a special health care need): 5. Who will communicate with partners? 6. Who will attend the Learning Sessions? 7. Who will be responsible for monitoring the project’s on-going progress? 8. Who will be responsible for preparing reports and program evaluation? | | | | | |
| **4. Electronic Health Records: Describe your IT Support.** | | | | | |
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| Are you currently using Electronic Health Records? | | | | | |
| Name of EHR Vendor? | | | | | |
| Do you have IT Support? (onsite or contractual) | | | | | |
| Do you use third party software to run your quality reports (ex. I2I, crystal reports)? If so, please provide name and contact information. | | | | | |
| Do you have any challenges with retrieving data from your EHR? | | | | | |
| **5. Explain how your organization is currently using Health Information Technology (HIT) to improve services for CYSHCN patients.** | | | | | |
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| **6. Demographic Characteristics** | | |  | |  |
| *Please provide information about the patient population served* | | | **1/01/18 – 12/31/18** | | **1/01/19– 12/31/19** |
| **Total number of children (Birth – 21 years of age) with and without special health care needs served:**  **a)** | | |  | |  |
| **Unduplicated number of Children and Youth (Birth – 21 years of age) with Special Health Care Needs (CYSHCN) served:** *\*Registry on CYSHCN-Codes are provided in Appendix for traditional and expanded criteria*  **b)** | | |  | |  |
| Male **c)** | | |  | |  |
| Female **d)** | | |  | |  |
| **\*Total of c+d should equal number in row b** | | |  | |  |
| Black  **e)** | | |  | |  |
| White **f)** | | |  | |  |
| Hispanic **g)** | | |  | |  |
| Other **h)** | | |  | |  |
| **\*Total of e+f+g+h should equal number in row b** | | |  | |  |
|  | | |  | |  |
| **Total number of CYSHCN users with medical home:** | | |  | |  |
| **Total number of CYSHCN users with dental home:** | | |  | |  |
| **Primary Insurance Status**  *Please provide the CYSHCN patients health insurance status for all included in row b above* | | | | | |
|  | | |  | |  |
| Medicaid Fee-For-Service | | |  | |  |
| MSCAN Managed Care Organizations (MCO) | | | **XXXXX** | | **XXXXX** |
| 1)Magnolia Health Plan | | |  | |  |
| 2) UnitedHealthcare | | |  | |  |
| 3) Molina | | |  | |  |
| CHIP | | | **XXXXX** | | **XXXXX** |
| 1) UnitedHealthcare | | |  | |  |
| 2) Molina | | |  | |  |
| Commercial Insurance | | |  | |  |
| Other Insurance | | |  | |  |
| Uninsured/Self Pay | | |  | |  |
| Unknown | | |  | |  |
| **\*Total of all rows in this section should equal the number in row b** | | |  | |  |
| *The CYSHCN-Codes Registry is provided for traditional and expanded criteria* | | | **Number of CYSHCN Patients**  **(Birth – 21 Years)** | | |
|  | | | **1/01/18 – 12/31/18** | | **1/01/19– 12/31/19** |
| (Example: Cystic Fibrosis ICD-10 code # \_\_\_\_\_\_\_\_\_\_\_”) | | | 5 | | 8 |
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| **7. Describe your existing internal and external (referral) process for assisting CYSHCN patients.** | | | | | |
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| **8.  How does your facility provide dental services?  If your facility does not provide direct services, describe how you are currently partnering with a Dentist who provides the services.** | | | | | |
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| **9. Discuss how the Parent Consultant/Community Health Worker will be a member of the Clinical Team and how they will participate in all aspects of the CYSHCN Cares 2?** | | | | | |
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| **10. Please describe what type(s) of patient education resources are currently being offered to CYSHCN Parents/ Caregivers?** | | | | | |
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| **11. Provide documentation of relevant partnerships, Stakeholder Collaborations, and Family Engagement.** | | | | | |
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1. **Application Review Process:**

**Phase I Review:** All eligible applications will be initially reviewed for completeness and responsiveness by an assigned review panel. Incomplete applications and applications that are non-responsive to the eligibility criteria will not advance to Phase II review. Applicants will be notified that the application did not meet eligibility and/or published submission requirements.

**Phase II Review:** An objective review panel will evaluate complete and responsive applications according to the criteria listed in the criteria section of the RFA. Applicants will be notified electronically if the application did not meet eligibility.

**Applicants may receive up to 100 points as follows:**

**Organizational Capacity (15)** – The extent to which the applicant:

* + Describes the type of organization applying, its organizational structure. (10)
  + Describes the services provided. (5)

**Project Management (15)** – The extent to which the applicant:

* + Describes who will have day-to-day responsibility to execute the CYSHCN Cares 2 award for key tasks

such as: leadership of the project; CYSHCN Cares 2 team members, monitoring of the project’s on-going progress; preparation of reports; program evaluation; communication with partners. (10)

* + Describes the staff’s ability to participate in all phases of the CYSHCN Cares 2, including Learning

Sessions. (5)

**Data Collection and Reporting (50)** – The extent to which the applicant:

* Clearly articulates the Health Information Technology support, including IT staff and EHR vendor

information. (10)

* Describes how the organization is currently using Health Information Technology to identify patient

population and use data to improve CYSHCN patient health outcomes. (10)

* Describes any challenges with retrieving data from your EHR. (5)
* Provides data at a population level. (20)
* Describes how CYSHCN data is currently being reported and to what organizations. (5)

**Collaboration (10)** – The extent to which the applicant:

* + Describes internal and external referral processes in place for assisting CYSHCN patients? (3)
  + Describes established partnerships with dentists or facilities that provide dental services?  (2)
  + Describes how the Parent Consultant/Community Health Worker will be a member of the Clinical Team and participate in all aspects of the CYSHCN Cares 2? (5)

**Project Resources (10)** – The extent to which the applicant:

* Describes types of patient education offered to CYSHCN and caregivers (attach sample). (5)
* Describes relevant partnerships, Stakeholder Collaborations, and Family Engagement? (5)

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| **Application Sections** | **Points** |
| Organizational Capacity | 15 |
| Project Management | 15 |
| Data Collection/Reporting | 50 |
| Collaborations | 10 |
| Project Resources | 10 |
| **Total Points** | **100** |

1. **Submission Requirements**

**Please direct specific inquiries to CYSHCN Program at (601) 576-7281. All applications must be received**

**on or before July 30, 2020 by 5:00 p.m.** Late or incomplete applications will not be considered. Applicants are

responsible for ensuring that the application is received by the deadline.

**Applications should be mailed or faxed to address provided below:**

**Mississippi State Department of Health**

**CYSHCN Program, Osborne 200**

**P.O. Box 1700**

**Jackson, MS 39215-1700**

**Or**

**Fax to (601) 576-7296**

**ATTN: Dornette Thompson LMSW**

1. **Award Administration Information**

The award is conditional based on:

1) Evidence of satisfactory progress in meeting goals by the sub-grantee

2) Advancing the overall aims of MSDH CYSHCN Title V Program

3) The availability of funds.

Applications will be objectively reviewed and scored according to criteria listed in the request for application relative to the goals and objectives, detailed budget, program plan and collaboration planning (in-kind support). Scoring grid located on page 10.

**Type:** Sub-grantee

Selected applicants will enter into a sub-grantee contractual relationship with MSDH, the Agency. A contract, form 115, business associate agreement, and W-9 form will be provided at the time of notification of selection for award and will be conditional pending the Agency’s final approval. Upon receipt of an award notification, MSDH will begin the process of finalizing and executing the contract between the Agency and selected sub-grantee. The contract is not effective until it has been approved by the Agency and signed by the State health Officer or 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.