MISSISSIPPI STATE DEPARTMENT OF HEALTH
Office of Child and Adolescent Health

REQUEST FOR APPLICATIONS

CYSHCN

PROGRAM

Children and Youth with Special Health Care Needs

CYSHCN Cares *2*

Contact Info:

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Children and Youth with Special Health Care Needs Program
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Funding Agency: The Children and Youth with Special Health Care Needs (CYSHCN) Cares 2, Care Coordination Learning Collaborative will be administered by the Mississippi State Department of Health, Office of Health Services, Office of Child Health – Children and Youth with Special Health Care Needs Program and supported by funding from Health Resources and Services Administration Title V Maternal Child Health Bureau.

Dates:

Request for Applications Release Date: July 2, 2020
Required Informative Question and Answer Session: July 9, 2020 (10:00 a.m. - 11:00 a.m.)
Notification of Intent to Apply: July 16, 2020
Application Deadline: July 30, 2020
Notification of Award: August 6, 2020
Total Funding Available Annually: Approximately $600,000
Number of Annual Awards: Up to 6 awards
Year 1 Award: $100,000
Subsequent Years Average Annual Award: $100,000
Successful applicants may reapply for additional years of funding, contingent upon availability of funding and adherence to requirements.
Project Period: August 2020 - June 30, 2020

Eligibility Requirements:

1) A pediatric or family practice, private practice, Federally Qualified Health Center or Rural Health Center, which self-identifies as a medical/dental home.

2) Serve a practice population of CYSHCN (Eligible Diagnoses and Diagnostic Codes will be provided).

3) Healthcare organizations must have a HIPAA and HITECH compliant Electronic Health Records (EHR)

Overview:

Mississippi State Department of Health (MSDH), Children and Youth with Special Health Care Needs (CYSHCN) Program announces availability of funds for the CYSHCN Cares 2, Care Coordination Learning Collaborative. The award's purpose is to optimize the quality of life of CYSHCN by aligning medical/dental homes and community support services.

Background:

Children and youth with special health care needs (CYSHCN) 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". See Appendix of CYSHCN diagnoses. CYSHCN, making up approximately 24.4% 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. A **medical home** is defined as an approach to providing comprehensive primary care that facilitates partnerships between patients, clinicians, medical staff, and families. A medical home extends beyond the four walls of a clinical practice. It includes specialty care, educational services, family support and more. 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.

CYSHCN should also have access to a dental home. The dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and includes referral to dental specialists when appropriate. This definition was developed by the Council on Clinical Affairs and adopted in 2006. This document is an update of the previous version, revised in 2015.

Healthcare 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 integrate 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:

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. This Request for Applications address 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 2.0.

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

- Identification, Screening, Assessment, and Referral
- Eligibility and Enrollment in Health Coverage
- Access to Care
- Medical Home
- Community-Based Services and Supports (includes Family Professional Partnerships)
- Transition to Adulthood
- Health Information Technology
- Quality Assurance and Improvement

Purpose:

The purpose of this request for application is to enhance care coordination within family-centered medical/dental homes for CYSHCN. Care Coordination is a highly organized process that facilitates the linkage of children and their families with appropriate comprehensive services and resources. It is estimated that care coordination in the medical/dental home, on average, adds 11-21 minutes to an individual CYSHCN patient encounter (Antonelli 2008). Care coordinators familiar with community and regional resources can assist the primary care providers with shared plans of care, psychosocial evaluations, education, transition planning and other resources. It is anticipated that the CYSHCN Cares 2 will foster optimal health by focusing on communication and coordination across systems of care.

Scope of Work:

This request for application provides an opportunity to increase capacity and synergy among healthcare systems and community organizations and services while remaining family centered.

Successful applicants will support the goals of the CYSHCN Cares 2 initiative by accomplishing the following objectives within the project period:

- Securing a Care Coordinator (Social Worker) as provided by the MSDH CYSHCN Program.

- Securing a Parent Consultant as provided by the MSDH CYSHCN Program. **The Parent Consultant must be a new hire or contract worker specifically for this grant. *CYSHCN Parent Consultant must have a child with a special health care need.*

- Allowing time and accommodations for Parent Consultants to participate in the required 4-day CYSHCN Parent Consultant's Community Health Worker Training, monthly calls/webinars, and family engagement activities. *The learning format may be virtual or live due to the COVID-19 pandemic.

- Working with MSDH CYSHCN Program staff and CYSHCN Cares 2 Consultant to select a multidisciplinary team for CYSHCN including care coordinators, physicians, providers, and parent consultants that support protocols. The Senior Leader is generally an executive within the organization. The ideal senior leader has ultimate authority to allocate time and resources needed to achieve the team's aims. In addition, this individual has administrative authority over all areas affected by the changes the team will test and champion the spread of successful changes throughout the organization.

- Developing a registry of CYSHCN by age using ICD 10 and DSM-5 codes with the ability to track referrals, appointments, and missed appointments by using EHR.

- Participating in one (1) Kick-off meeting, three (3) Learning Sessions, and quarterly lunch and learning sessions/conference calls/webinars. The Senior Leader is encouraged to attend all learning sessions; however, it is expected that they attend at least the first and fourth sessions. Learning sessions provide an opportunity for team members to share experiences, enhance learning, and expand the implementation of successful change concepts. Additionally, the senior leader will attend a minimum of one team meeting per month in the clinic and review each monthly report generated by the CYSHCN Cares 2 Clinical Teams.

- Devoting time to healthcare systems improvement activities learned, hold monthly clinical team meetings with the entire CYSHCN Cares 2 Clinical Team, and apply skills learned. Document in monthly progress reports.

- Participating in all aspects of the CYSHCN Cares 2 activities, integrate work of the initiative into the overall organization, and continue reporting on all measures.

- Providing the MSDH CYSHCN Program with performance and process data.

- Notify the CYSHCN Program and Consultant of the multidisciplinary team's turnover and changes within 10 days and succession plans to continue participating in the initiative.

- Submitting monthly data and quarterly narrative reports on healthcare systems and organizational changes along with invoices to the MSDH CYSHCN Program.

Required Measures for Reporting:

A. Increase the proportion of children with special health care needs who have access to a medical home (MICH-30.2/HP2020)

- Percent of children age 0-21 with special health care needs receiving care in a medical home (MICH-30.2/HP2020)
- Percent of children age 0-21 receiving developmental screenings (Health Maintenance/Bright Futures/EPSDT)
- Percent of children age 0-21 with special health care needs receiving care in a dental home.
- Percent of children age 0-21 with special health care needs referred for annual dental visits

B. Increase use of team-based care with health systems (i.e. nurses, social workers, specialists, and care coordinators/parent consultants-community health workers

- Percent of children age 0-21 with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems (MICH -31.2/HP2020)

C. Increase the number of children with special health care needs transitioning from pediatric to adult healthcare (DH-5)

- Percent of children age 0-17 and youth18-21 with special health care needs who talked to the healthcare team about the special health care need, as he or she becomes an adult. (DH-5)
- Percent of children age 0-17 and youth 18-21 who health care team has encouraged them to become more independent in managing the special health care need (DH-5)

D. Increase family engagement

- Percent of children age 0-21 with special health care needs who have a shared care plan documented in the EHR

Application:

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.

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:

a) Leadership of the project (Senior Leader):
b) Project team members (Team Leader, Data Analyst, Provider Champion, Clinical Expert, Care Coordinator, Parent Consultant):
c) Care Coordinator (Social Worker):
d) Parent Consultant (Parent must have a child with a special health care need):
e) Who will communicate with partners?
f) Who will attend the Learning Sessions?
g) Who will be responsible for monitoring the project's on-going progress?
h) Who will be responsible for preparing reports and program evaluation?

4. Electronic Health Records: Describe your IT Support.
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.

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 <u>and</u> 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

7. Describe your existing internal and external (referral) process for assisting CYSHCN patients.

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.

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?
10. Please describe what type(s) of patient education resources are currently being offered to CYSHCN Parents/ Caregivers?
11. Provide documentation of relevant partnerships, Stakeholder Collaborations, and Family Engagement.

A. 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)

Application Sections	**Points**
Organizational Capacity	15
Project Management	15

Data Collection/Reporting	50
Collaborations	10
Project Resources	10
Total Points	**100**

A. 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

B. 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.