

Inputs	Outputs	Intermediate Outcomes	End Outcomes
<p>Specialized Services Unit Manager (1 FTE)</p> <p>Family Liaison Specialist ; Social Work Consultant; CSC Program Manager; NCOHD Director; NCOHD Program Manager;</p> <p>EI Branch CSPD Coordinator (C/TA)</p> <p>Regional Child Health Nurse Consultants (.5 of</p>	<p>Children with Special Health Care Needs are defined as those who have or at risk for chronic physical, developmental, behavioral, or emotional conditions that require health and related services of a type or amount beyond that required to children generally. It is estimated that 16-18% of children ages birth to 21 fit within this definition. (MCHB, 2001)</p> <p>7.1.1.1. An in-depth analysis of the NC SLAITS data for CSHCN will be completed by end of FY 05-06 to determine characteristics associated with comprehensiveness and satisfaction with systems of care among NC CSHCN. (Partners-MCHB; State Center; C & Y)</p> <p>7.1.1.2. Ensure ongoing, consistent SSU participation and/or staff support to the following: the Commission for Children with Special Health Care Needs, the NC Pediatric Society, NC Partnership for Children, Family Resource Health Line, Family Support Network, NC Interagency Coordinating Council, Exceptional Children’s Advocacy Center, NC Developmental Disabilities Council, State Collaborative for Children and Families, the Early Childhood Comprehensive Systems Grant Task Force, and the Behavioral Health Committee. (Partners-Listed Above)</p> <p>7.1.1.3/7.2.1.1. Work with the NC-ICC and its committees (e.g., Children and Families, Transition, etc.) to improve services for children 0-5 with special needs and their families during FY 05-06 and 06-07. Participate in eligibility re-definitions. (Partners-EI; ICC; DCD; ECC; DMA)</p> <p>7.1.1.4. Participate in and provide leadership,</p>	<p>7.1.1. By 2007, systems of care for children with special health care needs and their families are optimized through partnerships among public, private and family sectors at the local, state and federal levels.</p> <p>Baseline Data: Calendar Year: Data Source: (Developmental)</p>	<p>7.1 By 2010, 83% of children and youth with special health care needs will have prevention, intervention and treatment systems of care that are:</p> <ul style="list-style-type: none"> • Accessible • Family centered • Culturally appropriate, and • Inclusive. <p>Baseline Data: 80.6% Calendar Year: 2001 Data Source: SLAITS Survey</p> <p><i>Measurement Sources:</i> Use SLAITS Survey to assess progress comparing baseline data from 2001 to subsequent 5 year data points.</p> <p>Family Experiences Survey to assess baseline data collection in FY06 and again in FY2010. (Developmental)</p> <p>Additional sources of data: Health Check/Health Choice Special Needs Screening Process; YRBS (for middle and high school students with disability if screening questions</p>

LOGIC Model for Core Indicator #7 Improved Health of Children with Special Needs

Inputs	Outputs	Intermediate Outcomes	End Outcomes
<p>5 FTE)</p> <p>Best Practice Nurse Consultants (C/TA)</p> <p>State PT Consultant (1 FTE)</p> <p>Regional Physical Therapy Consultants (4 FTE)</p> <p>Newborn Hearing Screening Program Manager (.5 of 1 FTE)</p> <p>Regional Speech Language Consultants (.5 of 8 FTE)</p> <p>Regional Child Audiology Consultants (.5 of 7 FTE)</p> <p>Regional Genetics Consultants (.2 of 6 FTE)</p> <p>(Community Transition</p>	<p>technical support, and resources to statewide family support/family involvement initiatives during FY 05-06 and FY 06-07. (CI 11) (Partners-FSN; ECCS; NCFHRL; Helpline; FAC)</p> <p>7.1.1.5/7.1.5.4. Develop, expand, and review/revise strategies and mechanisms that assure that Family Advisory Council members function as liaisons between parents in local communities and C&Y during FY 05-06 and FY 06-07. (CI 11) (Partners-FAC; Community Liaisons)</p> <p>7.1.1.6. Work with a wide variety of stakeholders and partners to plan and implement the statewide Early Childhood Comprehensive System Planning Grant for children ages 0 to 5 during FY 05-06. (CI 11) Partners-DCD; More at Four; EI; CAI; IOM;UNC-CH; Smart Start; DPI; Parent Reps; UNCG; FSN; DMA</p> <p>7.1.1.7. Identify specific strategies and mechanisms for enhancing prevention, intervention and treatment for CSHCN through the Healthy Childcare and Medical Childcare initiatives by the end of FY 05-06. (CI 8) Partners: DCD; UNC-CH; Chapel Hill Peds; NCPS; Smart Start; DMH; Comm Care;</p> <p>7.1.1.8. Identify specific strategies and mechanisms for enhancing prevention, intervention and treatment for CSHCN through the School Health initiative by the end of FY 05-06. (CI 9) Partners: DPI; CHN; SHN; CFTeams; EI; DMH; DSS</p> <p>7.1.1.9. Identify specific strategies and mechanisms for enhancing prevention, intervention and treatment for CSHCN through well child and adolescent clinics, addressing both physical and socio-emotional health by the end of FY 05-06. (C I5) Partners: HD; DMH; DSS; NCPS; SBSL</p>		<p>regarding disability are included consistently in the future).</p>

LOGIC Model for Core Indicator #7 Improved Health of Children with Special Needs

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<p>Coordinators) (11 Contract positions)</p> <p>C and Y Best Practices Unit Manager (C/TA)</p> <p>C and Y Health and Wellness Unit Manager (C/TA)</p> <p>C and Y Newborn Hearing and Genetics Unit Manager (C/TA)</p> <p>C and Y School Health Unit Manager (C/TA)</p> <p>C and Y Operations Unit Manager (C/TA)</p> <p>C and Y Branch Medical Consultant (.5 of 1 FTE)</p> <p>ECCS Grant Manager (1 FTE) (Contract staff)</p> <p>(State Center for Health Statistics Staff)</p>	<p>Centers; DMA; Comm Care; Private Providers; Families</p> <p>7.1.1.10. Identify specific strategies and mechanisms for enhancing access to prevention, intervention and treatment for CSHCN through Children’s Special Health Services clinics, Children’s Special Health Services Rules, Purchase of Medical Care and other CSHS Programs by the end of FY 05-06. Partners: Private Prov; POMC; DMA; HD; Medical Centers; Families; CDL; DMH</p> <p>7.1.1.11. Explore linkages between the CSHCN Program and the ACCESS II and III pilot sites with the goal of establishing demonstration activities for enhancing quality of care for CSHCN within ACCESS by end of FY 05-06. Partners: NCPS; Comm Care; Private Providers; Families; VO; DMH</p> <p>7.1.1.12. Identify and strengthen the age-specific activities and strategies that the Community Transition Coordinator Program, Special Infant Care Follow-Up Clinics, Children’s Developmental Services Agencies and Child Service Coordination Program contribute to a coordinated system of prevention, intervention and treatment for CSHCN during FY 05-06. Partners: HD; Medical Centers; DMA; DMH; EI</p> <p>7.1.1.13. The Child Service Coordination Program will be available on an ongoing basis in every county via the Local Health Department or other provider to offer case management/care coordination for families of children at risk for or diagnosed with developmental delays ages 0-5. Partners: HD; EI DMA; DMH; NCPS</p> <p>7.1.1.14. Evaluate and revise the Child Service Coordination Program through the revision of the DMA Bulletin during FY 05-06.</p>		

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<p>(Local Health Department Staff -CSC, child health, mental health, school health)</p> <p>(Family Advisory Council)</p> <p>(Commission for Children with Special Health Care Needs)</p> <p>Funds for stipends and travel for Family Advisory Council members and other family participants.</p> <p>Title V MCH Block Grant</p> <p>ECCS Grant</p> <p>NCODH Cooperative Agreement</p> <p>State Appropriations</p> <p>DHHS Call to Action and the NC Office on Disability and</p>	<p>Partners: DMA; Private Providers; CMS</p> <p>7.1.1.15. State and Regional Consultants are dedicated to improving the service system in the following ways: increasing awareness among families, private therapists, and provider agencies regarding resources that are available at the state and community level and how to access those supports on an ongoing basis. Regional variation in demographics, resources and service systems result in differences in Regional Consultant Work Plans. These ongoing activities include, but are not limited to:</p> <ul style="list-style-type: none"> • Orientation for new provider agencies regarding funding mechanisms for CSHCN • Technical assistance regarding practice innovations, selection and purchase of Assistive Technology equipment. • Consultation to community therapists regarding the needs of families. <p>Partners: Private Prov; DPI; ATRCs; Medical Centers; NCPS; Families</p> <p>7.1.1.16. Regional Therapists and Consultants contribute to Monitoring and Quality assurance efforts on an ongoing basis through the following:</p> <ul style="list-style-type: none"> • Ensuring that care is provided in a family-centered way • Ensuring medical necessity • Ensuring the appropriateness of the therapeutic approach for equipment requested • Ensuring the child/family has the ability to utilize assistive technology and that such equipment meets their needs and goals • Promote trans-discipline approaches in providing supports for children/families. • Assist with transitions between service systems and/or private providers. <p>Partners: Private Prov; DPI; ATRCs; Medical Centers; NCPS; Families</p>	<p>7.1.2. By 2007, 73% of children with special health care needs and their families will receive family centered care that is sensitive to their cultural values and customs, as measured</p>	

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<p>Health/C&Y plan to reduce health disparities</p>	<p>7.1.2.1. Identify and develop additional resources that promote relating to families in culturally appropriate ways and provide use these tools as the basis of technical assistance to therapists, providers and families during FY 05-06. Partners: NCCC; OMH; DMH; CDL</p> <p>7.1.2.2. Select and retain members of the Women’s and Children’s Health Section Family Advisory Council that reflect a variety of diversity indicators (racial/ethnic, geographic, age of child, type of special need, etc.) during FY04-05 and FY 05-06. Partners: EI; Families; Family Liaison; ECAC; FSN</p> <p>7.1.2.3. The Family Advisory Council will advise the Children and Youth Branch through an annual work plan for FY 05-06 and FY 05-06 regarding mechanisms for enhancing family centered practice, such as:</p> <ul style="list-style-type: none"> • participate in the process of hiring and orienting Child and Youth Branch staff • provide training to Child and Youth staff on being family centered, accessibility, inclusion and cultural competence. <p>Partners: EI; Families; Family Liaison; ECAC; FSN</p> <p>7.1.2.4. The Children and Youth Branch will partner with the Early Intervention Branch through its Comprehensive System of Personnel Development Coordinator, contracts, and other staff, NC-Interagency Coordinating Council, Exceptional Children’s Assistance Center, Family Support Network, WCHS Family Advisory Council, DHHS Office of Minority Health and other organizations to support cultural diversity training and other means of assuring that families receive family centered, accessible, inclusive and culturally sensitive services on an ongoing basis. Partners Listed above</p> <p>7.1.2.5. Convene a C&Y cultural competence work</p>	<p>by:</p> <ul style="list-style-type: none"> • % of Children with Special Health Care Needs that receive family-centered care: Doctors usually or always: <ul style="list-style-type: none"> - spend enough time; - listen carefully; - are sensitive to values and customs; - provide needed information; - make the family feel like a partner. <p>Baseline Data: 71.0% Calendar Year: 2001 Data Source: SLAITS Survey</p>	

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	<p>group by the end of CY 2006 to be responsible for the following:</p> <ul style="list-style-type: none"> • Determine the racially/ethnically/culturally and linguistically diverse groups served by the Children’s Special Health Care Needs Program by the end of FY 05-06. • Identify and begin collaboration with consumers, community-based organizations and informal networks of support to identify benchmarks/standards and develop new approaches for delivering family-centered care in a culturally and linguistically appropriate manner during FY 05-06. • Conduct an organizational cultural competence self-assessment by middle of FY 05-06 in conjunction with other Units of the Children and Youth Branch. • Conduct an assessment of current Child and Youth direct service practices regarding cultural competence, and identify ways to share effective strategies and enhance efforts during FY 05-06. • Develop a mission statement for the Children’s Special Health Care Needs Program that commits to cultural competence, being family centered, access and inclusion as integral components of all of its activities by the middle of FY 05-06. • Use the cultural self-assessment report and population demographics to develop a long-term plan for Children with Special Health Care Needs with measurable goals and objectives, strategies, staff development needs and fiscal resources by the end of FY 05-06. <p>Partners: NCCC; MCHB; CDL; Families</p> <p>7.1.3.1. Continue ongoing collaboration with the AAP/NC Pediatric Society, the AAFP/NC Academy of Family Physicians, the NC Medical Home Team to develop an annual work plan to</p>	<p>7.1.3. By 2007, 60% of children with special health care needs will receive coordinated ongoing comprehensive care within a medical home, as measured by:</p>	

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	<p>expand Medical Homes for Children with Special Needs in practice settings. Partners Listed Above</p> <p>7.1.3.2. Examine current NC initiatives, including those within pediatric practices, which are models for Medical Home for Children with Special Health Care Needs by the middle of FY 05-06. NCPS; Community Care</p> <p>7.1.3.3. Identify strategies and enhance linkages within Community Transition Coordinator, Child Service Coordination Program, Children’s Developmental Services Agencies, Healthy Child Care, School Health Programs, WIC and Immunization programs that allow each initiative to better operationalize the Medical Home Concept by the end of FY 05-06. Partners Listed Above</p> <p>7.1.3.4. Collaborate with stakeholders to develop grant proposals and evaluate funding mechanisms for further development of Medical Home concept for Children with Special Health Care Needs during FY 05-06 and FY 05-06. Partners: MCHB; Duke Endowment; Kate B; CC; NCPS; Rural Health</p> <p>7.1.3.5. Identify and examine barriers to implementation of Medical Home concept for Children with Special Health Care Needs and develop a more detailed policy and programmatic agenda during FY 05-06. Partners: MCHB; Duke Endowment; Kate B; CC; NCPS;Rural Health</p> <p>7.1.3.6. Evaluate the feasibility of reallocating resources to develop demonstration projects for Medical Homes for Children with Special Health Care Needs by the end of FY 05-06. Partners: MCHB; Duke Endowment; Kate B; CC; NCPS;Rural Health</p>	<ul style="list-style-type: none"> • % of CSHCN with a regular source of primary medical care • % of CSHCN whose regular source of primary medical care communicates in a way that is clear and understandable to the family. • % of parents whose regular source of primary medical care identifies, discusses, and addresses the comprehensive needs of their child and family. • % of CSHCN whose regular source of primary medical care coordinates age-appropriate well-child checks, including: vision, hearing, developmental, behavioral/mental health, oral health, newborn screening, immunizations and provides care coordination. • % of parents of CSHCN who receive referrals and assistance from their regular source of primary medical care in accessing needs/desired services. <p>Baseline Data: 55.6% Calendar Year: 2001 Data Source: SLAITS Survey</p>	

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	<p>7.1.4.1. Include screening questions regarding disability in the Youth Risk Behavior Survey on an ongoing basis to establish a surveillance mechanism for identifying and monitoring health risks and disparities among youth with SHCNs by the end of FY 05-06. (CI 8 and 9) Partners: State Center; Data Committee</p> <p>7.1.4.2. Establish mechanisms to increase the visibility of CSHNC/disparity data (including the release of Health and Disability in NC 2003) by the end of FY 05-06. Comm Partners Grant; Family Adv Comm.; FHRLine; State Center</p> <p>7.1.4.3. Assess programmatic and environmental strengths and challenges for health promotion, risk reduction and mental/behavioral health services/opportunities for Children and Youth with Special Health Care Needs by the end of FY 05-06. This should be done in conjunction with the Early Childhood Systems Planning Grant Task Force, the School Health Unit, the Health and Wellness Unit and the Physical Activity and Nutrition Branch. Partners Listed Above</p> <p>7.1.4.4. Continue to provide staff support from NCODH and expand resources from the Specialized Services Unit on an ongoing basis to health promotion initiatives that target the general and special needs population of children, adolescents and adults to ensure inclusion. Partners: CDC; UNC-CH</p> <p>7.1.4.5. Increase the involvement of CSHCN, adults with disabilities and families in the planning, implementation and evaluation of health promotion initiatives at the state and community levels on an ongoing basis. Partners: VR; DA; Families; Adv Comm; DSS; DMH</p>	<p>7.1.4. By 2007, children and youth with special health care needs and their families will receive health promotion and risk reduction services consistent with the general population of children and youth. Baseline Data: Calendar Year: Data Source: (Developmental)</p>	

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	<p>7.1.4.6. Consultation, technical assistance and training or information regarding training opportunities related to Children and Youth with Special Health Care Needs will be provided to staff in local health departments and school-based health centers in conjunction with the School Health Unit on an ongoing basis. Partners Internal –School Health Matrix; DPI</p> <p>7.1.4.7. Promote the development of programmatic, educational and promotional materials that include CSHCN/YSHCN and are available in alternate formats including readability levels, on an ongoing basis. NCHSF; Families</p> <p>7.1.4.8. Assess the Child Service Coordination Program to determine strategies for providing health promotion and risk reduction information to enrolled families by the end of FY 05-06. Partners: HD; DMA</p> <p>7.1.4.9. Partner with disability organizations in outreach, marketing and community education initiatives around health promotion issues on an ongoing basis. Partners: Comprehensive List with SSU Mngr.</p> <p>7.1.4.10. Partner with the NC Council on Developmental Disabilities and the North Carolina Office on Developmental Disabilities on initiatives related to health promotion and access to primary health care for CSHCN and YSHCN on an ongoing basis. Partners Listed</p> <p>7.1.4.11. Child Health Speech Language consultants will collaborate with community resources to screen children as part of special health promotion events, Head Start or other community mass screening initiatives during FY</p>		

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	<p>05-06 and FY 05-06. Partners Listed Above</p> <p>7.1.4.12. Explore avenues of collaboration to the NC Special Olympics Healthy Athletes screening and health promotion activities and develop a plan of action by the middle of FY 05-06. Partners Listed Above</p> <p>7.1.4.13. Integrate information regarding health promotion, screening opportunities and risk reduction activities for persons with disabilities into conferences and training activities during FY 05-06 and FY 05-06. Partners: DHHS agencies; Private Not for Profit; Universities; Medical Schools; AHEC</p> <p>7.1.5.1/7.1.8.1. Utilize input from the Women’s and Children’s Health Section Family Advisory Council on an ongoing basis in developing policy within the Child & Youth Branch . Partners Listed Above</p> <p>7.1.5.2. WCHS Advisory Council members and other family members of Children and Youth with Special Health Care Needs participate in planning, implementation and evaluation of Branch and Section programs and initiatives on an ongoing basis. Partners Listed Above</p> <p>7.1.5.3. Provide staff support and resources to facilitate the work of the WCHS Family Advisory Council on an ongoing basis. Partners Listed Above</p> <p>7.1.5.4./7.1.2.6. Membership of the WCHS Family Advisory Council will consistently reflect a variety of diversity indicators (racial/ethnic, geographic, age of child, type of special need, etc.). Partners Listed Above</p>	<p>7.1.5. By 2007, 70% of families of children with special health care needs will partner in decision making at all levels, and will be satisfied with the services they receive, as measured by:</p> <ul style="list-style-type: none"> • % of families of CSHCN reporting satisfaction with the quality of: <ul style="list-style-type: none"> - regular source of primary care; - obtaining referrals and appointments for needed services; - coordination among primary care, specialty care and overall services. • % of parents of CSHCN who report satisfaction with their level of involvement/input in setting concerns and priorities to make decisions about their child’s care plan. • % of parents of CSHCN who report knowing the steps to take when they are not satisfied with the services their child/family receives. • # of parents of CSHCN who are supported financially for their involvement in state and local activities. • # of parents of CSHCN who report that they are effective partners in policymaking at the state and local levels. 	

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	<p>7.1.5.5. Conduct an assessment of how state CSHCN programs are engaging parents as partners and report findings to the WCH Section Family Advisory Council by the end of FY 05-06. Explore linkages to the EI Branch efforts on family involvement data as part of this assessment. Partners: Family Recipients; CDL; EI</p> <p>7.1.5.6. Ensure annual attendance of parent representatives at the Association of Maternal and Child Health Program/Conference. Partners: FAC; Internal</p> <p>7.1.5.7. Provide staff support and resources to assist families, providers and agencies with advocacy support and information for delivery of timely and appropriate services related to therapy, durable medical equipment and assistive technology through FY 05-06. Internal</p> <p>7.1.5.8. Develop and strengthen linkages to the Family Support Network, Family Voices, and Exceptional Children’s Assistance Center as well as other family support and advocacy groups during FY 05-06 and FY 05-06. Partners Listed Above</p> <p>7.1.5.9. Identify the information given and strategies used in each of the MCH sponsored Information and Referral lines to provide support to families of CSHCN in order to strengthen linkages and to promote consistently available information across the Birth-21 age range by the end of FY 05-06. Partners: Families; Local Resource Updates; Agency Updates</p> <p>7.1.6.1. Collaborate with the Access to Care Unit to evaluate the number of children with special health care needs who have inadequate or no insurance coverage during FY 05-06 and FY 07-</p>	<p>Baseline Data: 65.3% Calendar Year: 2001 Data Source: SLAITS Survey</p> <p>7.1.6. By 2007, 59% of all families of children with special health care needs have adequate private and/or public insurance to pay for the services they need, as measured by:</p> <ul style="list-style-type: none"> • % of CSHCN with public and/or private insurance. • % of CSHCN with no gaps in coverage during the prior year. • % of CSHCN with insurance that usually or always covers needed services, including: mental health, dental care, age- 	

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	<p>06. Utilize the information found in the January 2003 study from the Sheps Center titled: A Cross-Insurance Comparison of NC Children with Special Health Care Needs. Partners: Internal; IOM</p> <p>7.1.6.2. Assure integration of CSHCN coverage into insurance studies undertaken by the State Center on Health Statistics during FY 05-06. Partners: State Center</p> <p>7.1.6.3. Collaborate with the NC ICC on the promotion of insurance legislation for children in early intervention during FY 05-06. Partners: EI; ICC</p> <p>7.1.6.3. Collaborate annually with consumers, community-based organizations and other stakeholders, including the Commission on Children with Special Health Care Needs and the WCHS Family Advisory Council, to identify and advocate for 3rd party coverage of services required for CSHCN, as well as provide support for reasonable fees and reimbursement policies for services already covered. Partners Listed Above</p> <p>7.1.6.4. Continue clinical and programmatic review of requests for CSHS/POMC Program, metabolic requests, the Health Choice Special Needs Program, and the Assistive Technology funds during FY 05-06 and FY 05-06. Partners: Internal</p> <p>7.1.6.5. Collaborate with the Access to Care Unit and the Commission for CSHCN to assess the needs of Youth with Special Health Care Needs age 18 and older for ongoing health care coverage by the end of FY 05-06. Partners Listed Above</p>	<p>appropriate well-child checks, durable medical equipment, ancillary services, non-durable medical supplies, care coordination, prescriptions, specialty care, related therapies (e.g., PT, OT, speech/language, audiology), in-home nursing.</p> <ul style="list-style-type: none"> • Amount of out-of-pocket costs paid by families of CSHCN, including costs of: mental health, dental care, age-appropriate well-child checks, durable medical equipment, ancillary services, non-durable medical supplies, care coordination, prescriptions, specialty care, related therapies (e.g., PT, OT, speech/language, audiology), in-home nursing, home modifications, car/van modifications, are always or usually reasonable. • % of CSHCN whose insurance usually or always permits child to see needed providers. <p>Baseline Data: 57.3% Calendar Year: 2001 Data Source: SLAITS Survey</p> <p>7.1.7. By 2007, ___% of all children will be screened early and continuously for special health care needs, as measured by:</p> <ul style="list-style-type: none"> • % of infants whose mothers began prenatal screening in the first trimester of pregnancy (e.g., substance abuse, genetics). • % of infants and families being monitored 	

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	<p>7.1.7.1. Support Children and Youth efforts to ensure all newborns are screened for metabolic and hearing conditions through joint planning, data systems and care coordination throughout FY 05-06 and FY 06-07. (C 10) Partners: State Lab; Birthing Hospitals; UNC-CH; EI; DIRM</p> <p>7.1.7.2. Continue to provide ongoing support to Community Transition Coordinators at the Regional Perinatal Centers to ensure that all children born in or admitted to the regional center are screened at birth or prior to discharge for risk indicators/diagnosed conditions that put them at risk for developmental delay. Partners Listed Above</p> <p>7.1.7.3. Continue to contribute to the development of new Public Health standards that support best practice in developmental screening in private and public pediatric settings during FY 05-06. (C 5) Partners: UNC-CH; DPH; HD; Private Prov.</p> <p>7.1.7.4. Contribute to the early intervention program's efforts to promote early and continuous screening and referrals by pediatric providers and consumer groups during FY 05-06 and FY 06-07. (C 11) Partners: EI</p> <p>7.1.7.3. Work with local Child Service Coordination Program providers to increase the percentage of children referred and enrolled in the Child Service coordination Program increases by 1% annually until the target of 15% of the population of children Birth to 5 is reached. Partners: HD</p> <p>7.1.7.4. Regional Child Health Nurse Consultants and the Child Service Coordination Program Manager will work with Child Service Coordination Program providers to ensure that</p>	<p>for special health care needs and developmental delays.</p> <ul style="list-style-type: none"> • % of children receiving age appropriate well-child checks including: vision, hearing, developmental, behavioral, mental health, oral, oral health, metabolic, EPSDT. • % of children receiving needed follow-up due to failed screening: vision, hearing, developmental, behavioral, mental health, oral health, metabolic. <p>Baseline Data: __%</p> <p>Calendar Year:</p> <p>Data Source: (Developmental)</p>	

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	<p>children enrolled in CSCP receive appropriate referrals based on identified needs through monitoring, technical assistance and training during FY 05-06 and FY 06-07. Partners: Internal and HD</p> <p>7.1.7.5. Provide technical assistance to the school health team and other stakeholders in planning, program development and implementation related to health and mental health services provided in schools and school based/school linked health centers that are inclusive of Children with Special Health Care Needs during FY 05-06 and FY 06-07. Partners: School Unit and Matrix</p> <p>7.1.7.6. Explore with the School Health Unit potential mechanisms for identifying CSHCN/YSHCN who receive clinical services and GAPs screening through school based-school linked health centers during FY 05-06 and FY 05-06. Partners: School Unit and Matrix</p> <p>7.1.8.1. The CSC Program Manager will work with the Family Liaison Specialist to develop a tool to measure family satisfaction with the CSC Program in conjunction with assessment of satisfaction to be used for further program planning by FY 05-06. Partners: State Center; HD; Family Advisory Council</p> <p>7.1.8.2. Structures will be developed to assure that Family Advisory Council members serve as liaisons between parents in local communities and C&Y, to be planned in conjunction with the Family Support Network during FY 05-06. Partners Listed Above</p> <p>7.1.8.3. Complete the revisions of the Children’s Special Health Services Administrative Rules by the end of FY 05-06. Partners Internal</p>	<p>7.1.8. By 2007, 83% of community-based service systems will be organized so families can use them easily, as measured by:</p> <ul style="list-style-type: none"> • % of CSHCN whose families report that services are usually or always organized for easy use. • % of parents of CSHCN who have a coordinated service plan that involves all providers and a lead service coordinator who communicates with the family. • % of parents of CSHCN who report that they are able to access comprehensive services for their child and family. • % of parents of CSHCN who have specialty care available in their region of the state. • The degree to which the state service system has an enrollment/eligibility process that links families of CSHCN and their medical home with a wide variety of public and private services and resources. • # of private/public partnerships to provide community-based, comprehensive medical services for CSHCN (e.g., data sharing, contracts, MOAs). 	

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<p>Specialized Services Unit Manager (1 FTE)</p> <p>Family Liaison Specialist (1 FTE)</p> <p>Social Work Consultant (1 FTE)</p> <p>CSC Program Manager (1 FTE)</p> <p>NCODH Director (1 FTE)</p> <p>NCODH Program Manager (1 FTE)</p> <p>SSU Transition Program Manager (1 FTE)</p>	<p>7.1.8.4. Develop a marketing campaign to publicize changes in policy and promote ways to access the Children’s Special Health Care system for families and agencies by the middle of FY 06-07. Partners: NCHSF; FAC; Public Affairs; Focus Groups</p> <p>7.1.8.5. Explore the current status and projected interface of the Special Needs Helpdesk, the Family Resource Health Line and the Family Support Network to utilize resources in the most effective manner to meet the information and referral needs of families and providers by the end of FY 05-06. Partners Listed Above</p> <p>7.1.8.6. Explore options for piloting care coordination services for Children with Special Health Care Needs from age 5-21 in selected communities through an RFA process by the end of FY 06-07. Partners; FAC; DMA; NCPS; State Collaborative; Comm for CSHCN</p> <p>7.1.8.7. Evaluate the funding formula for allocating money to CSC Program services for non-Medicaid children in local health departments in conjunction with performance based contracting during FY 05-06. Partners Internal</p> <p>7.1.8.8./7.1.1.15. Continue collaboration with the AAP/NC Pediatric Society, the AAFP/NC Academy of Family Physicians, the NC Medical Home Team to develop an annual work plan to expand Medical Homes for Children for Children with Special Needs in practice settings. Partners Listed Above</p> <p>7.2.1.1/7.1.1.3. Work with the NC-ICC and its committees (e.g., Children and Families, Transition, etc.) to improve services for children 0-5 with special needs and their families on an annual</p>	<p>Baseline Data: 80.6%</p> <p>Calendar Year: 2001</p> <p>Data Source: SLAITS Survey</p> <p>7.2.1. By 2007, 30% of youth with special health care needs will receive the services and supports necessary to make transitions to adult life including adult health care, work and independence.</p> <ul style="list-style-type: none"> • % of youth with SHCN who receive guidance and support in the transition to adulthood: <ul style="list-style-type: none"> - Doctors have talked about changing needs; - The child has a plan for addressing changing needs; - Doctors have discussed the shift to adult provider. <p>Baseline Data: 21.6%</p>	<p>7.2. The percentage of children and youth with special health care needs who receive comparable services</p>

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Appendix D

Inputs	Outputs	Intermediate Outcomes	End Outcomes
<p>EI Branch CSPD Coordinator (C/TA)</p> <p>Regional Child Health Nurse Consultants (.5 of 5 FTE)</p> <p>Best Practice Nurse Consultants (C/TA)</p> <p>State PT Consultant (1 FTE)</p> <p>Regional Physical Therapy Consultants (4 FTE)</p> <p>Newborn Hearing Screening Program Manager (.5 of 1 FTE)</p> <p>Regional Speech Language Consultants (.5 of 8 FTE)</p> <p>Regional Child Audiology Consultants (.5 of 7 FTE)</p> <p>Regional Genetics</p>	<p>basis. Partners Listed Above</p> <p>7.2.1.2. Establish baseline data on transition-related factors for children 0-5, using results from the existing Family Experiences Survey by the end of FY 05-06. (C 11) Partners Internal</p> <p>7.2.1.3. Explore the need for developing a “Family Experiences”-like Survey or other assessment process to collect baseline data on transition-related factors for children and youth 5-21 by the end of FY 05-06. Partners: FAC; Comm for CSHCN; Internal</p> <p>7.2.1.4. Review the focus group report on youth and young adults with special health care needs to assess how the recommendations can be met through transition activities sponsored by SSU by the end of 2006. Partners: CDL; FPG; VR; ODH</p> <p>7.2.1.5. Synthesize the current information and the types of transition supports that are being provided (in NC and through other Title V/CSHCN Programs). Engage Child and Youth Branch staff in better defining how the different units can contribute to transition planning for Children / Youth with Special Health Care Needs by the end of FY 05-06. Partners Internal</p> <p>7.2.1.6. Explore how the Division of Public Health can support efforts of the Department of Public Instruction and the Division of Vocational Rehabilitation regarding transition for C/YSHCN during FY 05-06 and FY 05-06. Partners: DPI; VR</p> <p>7.2.1.7. Identify strategies for the Division of Public Health to support efforts of the Academy of Family Practitioners, NC Pediatric Society and the NC Medical Society regarding transition for C/YSHCN during FY 05-06 and FY 05-06.</p>	<p>Calendar Year: 2001 Data Source: SLAITS Survey</p> <p>7.2.2. By 2007, 28% of youth with SHCN will receive adequate vocational or career training to make necessary transitions to adult life. Baseline Data: 21.4% Calendar Year: 2001 Data Source: SLAITS Survey</p>	<p>across age, racial/ethnic, socio-economic, geographic and disability conditions will increase by ____% by 2010. These services include those necessary to make positive transitions across the Birth-21 year age range, to facilitate transition to all aspects of adult life, including adult health care, work and independence. Baseline data: Calendar Year: Data Source: (Developmental)</p>

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Inputs	Outputs	Intermediate Outcomes	End Outcomes
<p>Consultants (.2 of 6 FTE)</p> <p>(Community Transition Coordinators) (11 Contract positions)</p> <p>C and Y Best Practices Unit Manager (C/TA)</p> <p>C and Y Health and Wellness Unit Manager (C/TA)</p> <p>C and Y Newborn Hearing and Genetics Unit Manager (C/TA)</p> <p>C and Y School Health Unit Manager (C/TA)</p> <p>C and Y Operations Unit Manager (C/TA)</p> <p>C and Y Branch Medical Consultant (.5 of 1 FTE)</p> <p>ECCS Grant Manager (1 FTE)</p> <p>School Health</p>	<p>Partners: NCPS; NCMS; AFP</p> <p>7.2.1.8. Promote increased awareness of the importance of health insurance for young adults with special health care needs above age 21 in being able to pursue employment, secondary education and independent living on an ongoing basis during FY 05-06 and FY 06-07. Partners: VR; DSS; Insurance Comm; CIL; NCPS</p> <p>7.2.1.9. Explore the accessibility, beginning with other WCH/DPH Programs such as Family Planning or Prenatal Care, for young adults with special health care needs, and make recommendations to improve policies, programs, and public education during FY 05-06 and FY 06-07. Partners: Women’s Health Branch; Private Prov.</p> <p>7.2.1.10. Provide staff support and resources to consumers, agencies, providers and community-based organizations for consultation and technical assistance about transition issues related to therapy, durable medical equipment and assistive technology during FY 05-06 and FY 06-07. Partners: Listed in Grant Application</p> <p>7.2.1.11. Regional Physical Therapy Consultants will continue participation in provision of leadership for statewide issues related to transition and therapy, durable medical equipment and assistive technology during FY 05-06 and FY 06-07. This is designed to promote greater community and vocational accessibility, better health care and increased independence in activities of daily living. Partners: Private Providers; DMA; VR; DPI</p> <p>7.2.1.12. Assess the need and approaches for establishing youth/young adult/family advisory structures for the SSU Transition Initiative by the end of FY 05-06. Partners: Listed in HRSA</p>		

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Inputs	Outputs	Intermediate Outcomes	End Outcomes
<p>Maxtrix Team (C/TA)</p> <p>(Contract staff)</p> <p>(State Center for Health Statistics Staff)</p> <p>(Local Health Department Staff -CSC, child health, mental health, school health)</p> <p>(Family Advisory Council)</p> <p>(Commission for Children with Special Health Care Needs)</p> <p>Funds for stipends and travel for Family Advisory Council members and other family participants.</p> <p>Title V MCH Block Grant</p> <p>ECCS Grant</p> <p>NCODH Cooperative</p>	<p>Transition Grant</p> <p>7.2.1.13. Conduct additional transition needs assessment activities, as appropriate, for enriching and updating the findings of previous efforts by the end of FY 05-06. Partners Internal</p> <p>7.2.1.14. Design and implement up to 3 workshops for youth on health-related transition by the middle of FY 05-06. Partners: UNC-CH; VR; DMH; DSS; EI; DCD; DPI</p> <p>7.2.1.15. Develop an integrated and complementary work plan for transition with other key SSU initiatives including but not limited to Medical Home and Family Involvement by the end of FY 05-06. Partners Internal</p>		

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Inputs	Outputs	Intermediate Outcomes	End Outcomes
<p>Agreement</p> <p>State Appropriations</p> <p>DHHS Call to Action and the NC Office on Disability and Health/C&Y plan to reduce health disparities</p> <p>(Assessing the Needs of Youth and Young Adults in NC)</p> <p>(NCDD Council Access to Primary Care Grantees)</p>			

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Inputs	Outputs	Intermediate Outcomes	End Outcomes