Hilopa'a Project – Goals & Activities

Hilopa'a – "to braid firmly"

Integrated Systems for Children & Youth with Special Health Care Needs in Hawai'i

Transitions

Goal #1: Establish, document and implement family-centered best practices, protocols, and standards to coordinate care between programs and agencies that serve children and youth with special health care needs (CYSHCN) in Hawai'i.

Activities:

- Develop a "One Stop/Transition Certification" Program for programs, agencies, providers and families whose framework is based upon the best practices, protocols, and standards for referral and transition for 17 programs in the Departments of Health and Human Services or their contracted providers.
- Certify 250 family and professional partners as One Stop Transition Specialists and 30 program sites as One Stop Centers.

Navigating the System Training

Goal #2: Provide families with training opportunities that provide practical insight and approaches on "Navigating the System".

Activities:

- Develop curriculum addressing the needs of families navigating the system prior to exiting the Early Intervention, IDEA Part C System of Care (0-3); and curriculum addressing the needs of families for middle school aged youth, prior to the age of 14.
- Implement a Training Plan consisting of scheduling training sessions on all islands and districts for each targeted population.

Family Resources

Goal #3: Provide families with access to information training on resources for family support and leadership development. Bring together, augment resources based upon need, and compile information into a centralized directory.

Activities:

- Convene programs and agencies currently providing family support and training to define their resources for family support and training, and enhance and or restructure current opportunities to better meet the needs of families in their communities.
- Add to the Rainbow Book Integrated Resource Directory for CYSHCN family support and training information.

Family Participation

Goal #4: Increase the level of participation of families of CYSHCN in program and policy activities.

Activities:

- Develop a resource pool of 50 parents and self advocates to be linked as trainers, family representatives and partners to programs serving CYSHCN.
- Convene a paid Youth Advisory Committee of 6-9 youths/self-advocates to develop personal leadership, self determination, and community advocacy skills.

Medical Home Residency Education Program

Goal #5: Implement a Residency Curriculum which extends teaching knowledge, skills, and attributes of Medical Home to include role of Medical Home in an integrated service system for Pediatric and Family Practice Residents.

Activities:

- Provide Medical Home curriculum and educational opportunities to 50 Pediatric and Family Physician Residents in their first year of residency.
- Validate through Family Survey and Interviews, each Resident's self-assessment of his/her "Best Practice Application" of the Medical Home, by their second year.

Medicaid & CYSHCN

Goal #6: By April 30, 2008, ensure that all CYSHCN currently in the Medicaid program continue to receive primary & specialty care, inpatient, enabling, and case management services as they transition into Medicaid Managed Care.

Activities:

- Perform program evaluation to measure health status, service access and service satisfaction performance of CYSHCN under Medicaid fee-for-service.
- Monitor provider network reporting and service delivery specifically on the Neighbor Islands as part of the health plan procurement process.

Transition to Adult Health Care

Goal #7: Implement best practices, protocols, and standards into targeted application of transitioning youth within the Medicaid Developmental Disabilities/ Mental Retardation (DD/MR) Waiver from pediatric to adult health care.

Activities:

- Implement the best practices, protocols and standards in 21 Pediatric and 8 Family Physician practices to transition a total of 100 youth to adult medicine.
- Evaluate through family and youth surveys and interviews, as well as physician self-assessment, the impact that established best practices, protocols, and standards have on the efficacy & quality of the medical transition to adulthood.

Developmental Screening and Follow-Up

Goal #8: Implement and evaluate a statewide integrated developmental screening and referral process for children served in community pediatric, family practice, and community health centers.

Activities:

- Provide 21 educational workshops for 200 physicians and staff across the state on Parents' Evaluation of Developmental Status (PEDS) developmental screening tool and on best practices, protocols and standards for the integrated referral process.
- Evaluate the screening and referral activities of a minimum of 85 practices for a period of 1-2 years after training on the PEDS and the integrated referral process.

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