



California's CYSHCN Activities 2017-18

June 2019

ISSUE BRIEF

Analysis of 61 Local Health Jurisdiction Efforts

INTRODUCTION

Over the past year, the Maternal, Child and Adolescent Health (MCAH) Division has expanded its efforts to understand how local MCAH programs reach and serve Children and Youth with Special Health Care Needs (CYSHCN). The MCAH CYSHCN team reviewed all 61 Local Health Jurisdiction (LHJ) 2017-18 annual reports for activities that address CYSHCN to help us understand current work and local needs.

METHODS

To grasp the breadth of efforts from 61 LHJs, the MCAH CYSHCN team developed a list of search terms representing key

activities, including developmental screening, Adverse Childhood Experiences (ACEs), medical home and others. The list of key activities was developed based on priorities that arose during key informant interviews with 11 local MCAH programs, as well as guidance from our federal funder and discussions with stakeholders and experts. To analyze the reports, the research process began with a key activities search. Key activities were organized by LHJ and activity, reviewed for themes and summarized. The themes reported on in this issue brief represent the most common activities described, as well as innovative practices in improving services for CYSHCN.



Search Terms for Key Areas of Focus



- . Case management
- . Home visiting
- . Screen, referrals, link
 - . Developmental screening
 - . Ages & Stages Questionnaires (ASQ)
 - . Ages & Stages Questionnaires: Social-Emotional (ASQ-SE)
- . Help Me Grow
- . Head Start
- . Early Head Start
- . Public Health Nursing
- . Specific screening tools: QA and QI
- . AAP guidelines
- . Medical home
- . Adverse Childhood Events/Experiences (ACEs)
- . First 5
- . Birth to Five
- . Watch Me Thrive
- . Learn the Signs
- . Act Early
- . Pediatric specialist
- . Whole Child Model
- . Shared plan of care
- . Care coordination
- . California Children's Services
- . Medical Therapy Unit/Medical Therapy Program
- . Regional Center
- . Family engagement
- . Autism
- . Asthma

ENABLING SERVICES

Case Management and Public Health Nursing

Local MCAH programs provide case management services through home visiting (including Nurse-Family Partnership and Healthy Families America), Public Health Nurses (PHNs), and other case management efforts. Case managers provide a scope of care and linkages for CYSHCN. This includes referrals to community partners such as First 5, pediatricians, regional centers, Early Start, Head Start, early intervention programs, the California Children's Services program (CCS), school districts, resource centers, and/or hospitals. Case managers help families facilitate entry into early intervention services. Case management also includes assistance with access to health insurance and a primary care provider. Local MCAH programs with coordinated case management systems reach CYSHCN effectively through tracking screening, referrals and follow-ups, thereby assuring linkage to services. Most locals use the Ages and Stages Questionnaire version 3 (ASQ-3)

and/or Ages and Stages Social-Emotional Questionnaire (ASQ-SE) developmental screening tools within the context of their case management, although this was not consistent across all LHJs. The screening form is usually provided in person to the family by a health professional unless the local county does not have the capacity; then they are mailed to the family with a stamp for return and review.

MCAH Directors, PHNs, case managers and MCAH Coordinators also have a direct impact on CYSHCN through working with other agencies to provide necessary assessments, connecting clients to resources and maintaining frequent collaboration with community partners such as Regional Centers, school-based services, pediatricians, providers, transportation services and more. These duties makes their role imperative in supporting care coordination and promoting access to a medical home. Care coordination efforts, seen throughout LHJs, are not specific to the size of the county. Reports show various ways in which local MCAH programs are

implementing care coordination. These include recommendations to providers on increasing integration of care, streamlining services and holding collaborative multidisciplinary meetings with local agencies to address gaps in services.

HELP ME GROW MODEL

Fragmented systems of care occurring in local health jurisdictions include incomplete lists of directory resources and inconsistent use of screening tools by providers. To move away from agencies working only in their domain and create a cohesive and integrated system, many counties have implemented a Help Me Grow (HMG) program, are in the discussion stage of implementing HMG or conduct HMG-type initiatives with a different model, though some do not have the resources to do so. The HMG system model is designed to help communities leverage existing resources to ensure that they identify vulnerable children, link families to community-based services and empower families to support their children's healthy development. Local health jurisdiction HMG-type programs are unique due to the scale of existing resources that vary in partnerships and services of the following components: public education plan, healthcare provider and family outreach on developmental screening, centralized call center, collaborative meetings between agencies and electronic database system.

ADVERSE CHILDHOOD EXPERIENCES

LHJ initiatives to prevent and address childhood trauma vary on a scale including collaboration, changing provider practice and community awareness. Here is a sampling of efforts:

- **Santa Clara County** MCAH initiated the ACEs Network/Coalition and Steering Committee to discuss resources and identify projects to implement trauma informed practices.

- **Shasta County** ACE Pilot Project is a coalition of health care providers to pilot test screening, assessment, and referral to patients with ACEs. This coalition contributed to local parent cafes and an ACEs awareness campaign.
- **El Dorado County** Community Hub staff (i.e. Early Literacy Specialist, PHN, Family Engagement Specialist and Community Health Advocate) implemented a trauma-sensitive technique after ACEs training and were assessed for practice change three to six months after the completion of the training. Additionally, a trauma-informed digital library that is linked to the El Dorado ACEs connection website and access to local and national resources are available to support schools.
- **Santa Barbara County** MCAH Field Nursing Unit incorporates the NEAR@Home (Neuroscience, Epigenetics, Adverse Childhood Experiences, and Resilience) framework into home visits, which includes ACEs screening, education on protective factors, and pre- and post-test on family resilience.
- **Other locals'** current work include trainings on ACEs, meetings with key stakeholders, or strategies to increase awareness of ACEs and the need for policy change in their community.



INNOVATIVE EFFORTS

Several local programs have spearheaded innovative systems and community-level approaches to reach CYSHCN and their families. Here are the highlights:

- **Napa County** is working on universal developmental and social-emotional screening by creating a data retrieval report in the Persimmony Electronic Case Management system that tracks ASQ, medical home and referrals. The Persimmony Collaborative involves multiple counties to share data and streamline services.
- **Orange County's** Children's Health Initiative is working to improve the process of connecting families in need to resources. They manage *one-e-app*, which is a web-based system that facilitates the application process and screens families for public health and social services programs.
- **San Mateo County** has brought together an extensive network of 15 agencies in the Watch Me Grow Roundtable Medical-Community Collaborative for discussions on children with complex needs. Participants include MCAH, CCS, home visiting staff and other family health services to better the quality of care.
- **San Diego County** promoted developmental screening by attending and exhibiting at events for health professionals and families of CYSHCN. By attending the Involved Exceptional Parents Conference and exhibiting at the Marine Corps Recruit Depot, they increased awareness of services and built relationships.
- **San Francisco County** plans to decrease bullying for CYSHCN by implementing *KidPower* program with San Francisco Unified School District Special Education.

COLLABORATIVE SYSTEMS

The structure between MCAH, Children's Health and Disability Program (CHDP) and CCS is often collaborative and inclusive of other agencies that offer services for CYSHCN. Directors from different systems come together through meetings and workgroups to ensure quality improvement of processes for CYSHCN. The network extends to include other agencies that also serve CYSHCN including the following: regional centers, health plans, pediatricians and PHNs. Local MCAH programs that have a large network often have a strong internal referral system. In some LHJs, the open communication between CYSHCN-serving programs is seamless due to the MCAH Director being the CCS Medical Director, CHDP Deputy Director and/or CCS Administrator. Duplication of efforts decrease when a team-based effort occurs on a regular basis to create a plan for CYSHCN.

CONCLUSION

Local MCAH programs reach and serve CYSHCN through a variety of activities. In particular, local MCAH has the opportunity to maximize support and connections to services for CYSHCN and their families through existing case management programs such as home visiting. Another area of opportunity and need is strengthening database systems to help local programs track screening, referral, and linkages for CYSHCN. Additionally, local MCAH programs have strong relationships with their community partners and providers, and can leverage these existing connections to help the families they serve navigate complex systems. MCAH is committed to supporting local family engagement to ensure that family and community voices are heard and inform MCAH programs and public health systems.



Questions about MCAH's CYSHCN efforts?
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