



How Local MCAH Programs Reach CYSHCN

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ISSUE BRIEF

The Maternal, Child and Adolescent Health (MCAH) Division is in the midst of a year of learning to better understand how to reach and serve Children and Youth with Special Health Care Needs (CYSHCN) in California. This learning phase was catalyzed by new guidance and priorities from our federal funder, the Maternal and Child Health Bureau, which oversees and administers the Title V Block Grant Program. Activities thus far have included stakeholder meetings, presentations, informational interviews with key partners and building knowledge on a variety of topics under the umbrella of CYSHCN.

METHODS

From the beginning, we understood that local MCAH programs would be an essential source of information in our learning process. In September 2018, the MCAH Division conducted key informant interviews with 11 county MCAH programs. The purpose of these interviews was to learn how local MCAH programs reach CYSHCN and interact with other CYSHCN-serving systems, as well as to understand and identify strengths, needs and gaps in services.

All local MCAH programs were invited to participate. In addition, we contacted selected

counties individually to ensure diversity in county size and geography, as well as representation of unique systems for serving CYSHCN. Eleven local MCAH programs agreed to participate in a one-hour phone interview. Local MCAH program staff interviewed included MCAH Directors, Coordinators and Medical Directors. We asked a number of open-ended questions about the structure of local MCAH programs in relation to the county California Children's Services (CCS) program and other systems serving CYSHCN, communication between systems, perceptions about overall strengths and needs, and stakeholder priorities. The combined population of children and youth ages 0-21 in the 11 counties interviewed covers over half (53%) of the overall population of the same age in the state¹.

FINDINGS

One key takeaway from the interviews is the sheer diversity in county-level structure, staffing, resources, coordination, CYSHCN-serving programs and systems, strengths, and challenges. This underscores the need for a partnered, collaborative approach between local and state MCAH to improve services for CYSHCN in a way that makes sense for each individual county. Key findings are highlighted on the next page.



¹California Department of Finance. Demographic Research Unit. 2018. State and county population projections 2010-2060 [P-3: State and County Projections Dataset]. Sacramento: California Department of Finance. January 2018.

Key Findings



We would like to thank the following local MCAH programs for generously contributing their time and sharing their experiences with us:

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- Anna Sutton, Yolo

- As expected, structures and communication between local MCAH and CCS differ greatly by county.
- Smaller (less populous) counties tended to report more ease of communication, because programs are often co-located and staff overlap between programs or come into contact more frequently.
- Public health nursing and home visiting programs were by far the most frequently mentioned venue for reaching and serving CYSHCN. While nearly all of the home visiting programs mentioned included routine developmental screening, the specific screening tools, requirements, and practices varied by program and funding source.
- The Child Health and Disability Prevention Program (CHDP) was more often co-located or integrated with local MCAH than CCS.
- Most counties interviewed (8/11) were either a Help Me Grow affiliate or implementing a similar program, most frequently funded by First 5.
- Family engagement efforts were usually discussed as taking the form of close relationships between public health nurses and home visitors with their clients, rather than formalized family-professional partnerships. Some programs reported challenges in getting family representation on local advisory boards or stakeholder groups.
- When asked to assess which topics out of a list of CYSHCN-related topic areas (including medical home, transition to adult health care, family engagement, and others) are a natural fit for local MCAH to address with regard to CYSHCN, interviewees frequently responded that “everything is MCAH.” In other words, most areas could be a natural fit because MCAH touches so many different systems and services. That said, some areas were perceived as outside of the scope of local MCAH services due to county size and structure, available resources, and which county-level programs focus on each area.
- Access to a primary care provider and/or a comprehensive medical home was frequently perceived as a very natural fit with the current goals and activities of local MCAH.
- Overall, counties reported very diverse needs around CYSHCN. A few of the key areas mentioned include: lack of capacity to expand activities, a need for training on best practices, the need for better county-level data, and improved state-level guidance to understand Title V expectations and the local MCAH Scope of Work.
- Workforce development is a key issue, particularly availability/compensation for public health nurses, pediatric specialists including occupational therapists and dentists, and mental health providers.
- An area of strength that came up across interviews was county-level engagement and investment in promoting trauma-informed care and addressing adverse childhood experiences (ACEs).

Next Steps: MCAH will utilize the information collected from these interviews to inform the Title V Needs Assessment process and inform our overall efforts to align CYSHCN services with local needs and federal priorities. Local MCAH programs will continue to be essential partners in improving the statewide network of systems that serve CYSHCN.