Opening Doors Into Rural Communities Web Cast

What is a Community to Do?

Helping Families Help Their Children with Special Needs

Wednesday, October 17, 2001
12:00 noon (MDT)

Funding for this web conference was provided through a grant from the Maternal and Child Health Bureau to the Early Intervention Research Institute at Utah State University in Logan, Utah (Award #5-H02 MC 00047).

Richard N. Roberts, Principal Investigator; Adrienne L. Akers, Co-Principal Investigator; Diane D. Behl, Senior Research Scientist.

Viewing Today’s Web Cast

- If you are experiencing any audio or video trouble, exit out now and click on 56K or audio-only option
- Print out handouts and follow along with the presenters.
- Fill out post evaluation form, raffle of prizes will be held.
- Join us in the chat room after the broadcast.

For more information about the Opening Doors project or the Early Intervention Research Institute (EIRI), visit the EIRI web site at www.eiri.usu.edu or call us at 1-800-887-1699.
**Agenda**

**Opening Doors Web Conference**

**What’s a Community to Do?**

**Helping Families Help Their Children with Special Needs**

*October 17, 2001*

12:00 p.m. – 1:30 p.m. MDT

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Goal of the Opening Doors into Rural Communities (ODRC) Project
To develop a community model for supporting interagency groups that are working to organize services so that families can use them more easily.

ODRC Communities
- Lewiston, Idaho
- Jefferson County, Missouri
- Augusta, Maine
- Pocatello, Idaho

For Each Community, the ODRC Project Provided
- Technical assistance to help develop an action plan for improving service integration
- An evaluation model to examine and improve interagency collaboration
- $15,000 of seed money to help further each community’s service integration efforts

The Parents’ Perspective
Debbie Edmondson, Parent from Pocatello, Idaho

What Parents Need from Physicians and Service Providers
- Help me find the information I need to understand my child’s condition. My child’s condition is not temporary. I’ll be learning about it for a lifetime.
- Do not withhold or omit any information concerning the severity or extent of my child’s condition. Do not hesitate to use medical terms when necessary.
- Help me understand the range of possibilities. Tell me the worst and best possible prognosis.
- Accept that my child’s health care needs are only a part of my family’s priorities and that sometimes my family’s needs and concerns may take precedence.
- Recognize my denial, anger, and healthy and natural response to grief.
- Acknowledge that I am a competent partner in my child’s health care.
- Value that I’m the expert on my child.
- Acknowledge my sense of urgency by responding quickly to requests for medial information, referrals, etc. so that appropriate services can begin or continue.
Why Integrating Services Is Important
Merle McPherson, M.D. Director, and Diana Denboba
Federal Division of Services for Children with Special Health Needs (DSCSHN)

The Federal Division of Services for Children with Special Health Needs (DSCSHN) is a division of the Maternal and Child Health Bureau within the Health Resources and Services Administration and is located in Rockville, Maryland. DSCSHN has two branches—Integrated Services Branch and the Genetics Services Branch. The Division plays a national leadership role in the development of community-based systems of services for children with special health care needs. This focus is derived from a statutory requirement under the OMBRA ’89 amendments to Title V of the Social Security Act, which states that Title V is “...to facilitate the development of community-based systems of services for such children and their families.”

DSCSHN developed a 10-year Action Plan as part of Healthy People 2010 to achieve community-based service systems for children and youth with special health care needs and their families. DSCSHN promotes the following six outcomes for children with special health needs and their families:

Six Performance Outcomes for Children with Special Health Needs

1. All children with special health care needs will receive coordinated ongoing comprehensive care within a medical home.

2. Families of children with special health care needs will have adequate private and/or public insurance to pay for the services they need.

3. All children will be screened early and continuously for special health care needs.

4. Families of CSHCN will partner in decision making at all levels and will be satisfied with the services they receive.

5. Community-based service systems will be organized in ways that families can use them easily.

6. All youth with SHCN will receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
Service Integration Strategies Recommended by DSCSHN

1. Common eligibility/application process
2. Coordination of early intervention & the medical home
3. Shared information & data systems
4. Blended or braided funding
5. A service coordinator with whom the family communicates
6. Evaluation of DSCSHN six performance outcomes

Two New Statewide Integrated Service Grants

2. Opening Utah’s Doors – Utah State University

Communities Can! celebrates communities throughout the U.S. that have demonstrated an exemplary level of community service integration for children with special health care needs and their families. Communities Can! is affiliated with the Georgetown Child Development Center.

2010 Express Summit
December 12-13, 2001
Hilton Washington
Washington DC


All Aboard the 2010 Express: A 10-Year Plan to Achieve Community-Based Service Systems for Children and Youth with Special Health Care Needs & Their Families.

2010 Express Summit Goals

- Publicly release the 10-year action plan to achieve community-based service systems for children and youth with special health needs and their families
- Build national understanding and enthusiasm for the 2010 Express Action Plan.
- Mobilize committed participants to promise to undertake specific activities to make the plan a reality in their states and communities

2010 Summit Participants include:

- Youth and family leaders
- Physicians, nurses, and other health providers
- Federal and State agencies
- Social service, mental health, educational and vocational rehab agencies, and providers
- Medicaid, insurers, foundations, and other public and private players
- Other individuals and organizations committed to services for CSHN and their families
Service Integration is defined as the process by which two or more agencies, together with families, establish linkages for the purposes of increasing the efficiency of the service system and improving outcomes for children and families.

Why Service Integration is Needed

Definition of PAR

Participatory Action Research (PAR) is an approach that encourages researchers and those who will benefit from the research (families, providers, policymakers) to work together as full partners in all phases of the research.

Traditional Model of Research and Evaluation

- Audit and review process
- Outside or external evaluation team
- Local agency staff has little chance to provide input on information is collected or how data will be used.
- Evaluators analyze information and present it back in the form of a final report.

Evaluation is something you should do to yourself ! !
Participatory Action Model (PAR) of Research/Evaluation

How are PAR teams involved in research?

The PAR team as a whole:
- Determines the research questions
- Designs research project, including evaluation tools
- Carries out the research activities
- Analyzes and interprets the data
- Shares results in meaningful ways to stakeholders

PAR efforts help to ensure that the results
- Are meaningful
- Will make a difference in the lives of key stakeholders, particularly children and families
Lewiston Agencies Responsible for Child-Find
- Part C Early Intervention
- Head Start
- Part B Preschool

Purpose of Initial Child-Find Meetings…
- To look at new referrals from various sources for children ages 3 to 5
- To decide which agency would conduct an evaluation to avoid duplication

Lewiston Community Partners…

What we learned in our initial interagency meetings
- The importance of communicating with state and regional offices
- The kind of support that state and regional programs can offer
- State agencies may be willing to support one-time events (luncheons, dinners)
- State agencies may provide money for a skilled facilitator who understands the politics and culture of your state
Lewiston’s 1995 Early Childhood Priorities
1. Compile a list of community agencies
2. List the types of services each agency provides
3. Examine agency budgets, regulations, and job responsibilities

Community Alliance for Young Children (CAYC)
• Hold monthly interagency meetings
• Review screening results
• Exchange relevant information
• Discuss broader service integration issues


CAYC Screening Clinic Partners
• St. Josephs Regional Medical Center
• Lewiston School District
• Head Start
• Health Department
• Part C Program

Developmental Skill Areas Screened During the CAYC Screening Clinics:
• Communication Skills
• Motor Skills
• Cognitive Skills
• Adaptive Skills
• Behavioral/Mental Health

Key Ingredients for Creating Community Councils
• Develop an interagency mission statement
• Keep an open door and encourage new members
• Elect or appoint a chairperson
• Create multiple ways for members to be involved
• Grow with the changing needs to your community

Focusing on Infant and Early Childhood Mental Health
Marian Schultz, M.S.W., Private Practice

Lewiston’s Opening Doors Focus: Coordination of Early Mental Health Services

New Community Challenge--Families needed services for children with behavioral or mental health concerns.
Challenges Related to Behavioral and Mental Health Needs
• Children may not be eligible for Part C or Part B services
• Intensive services were lacking
• No process to ensure follow-up on referrals

Lewiston’s Behavioral and Mental Health Needs

Challenge #1: No mental health providers on council  
Solution: Invited public and private providers
Challenge #2: Family voices needed  
Solution: Involve families of older children with mental health needs

Challenges for Mental Health Subcommittee
• Parents and professionals needed to develop a definition of “mental health”
• Infant or early childhood mental health implied one-to-one psychotherapy, to others it meant prevention of behavior problems

The CAYC Definition of Infant and Early Childhood Mental Health
• Promotion/education about infant and early childhood mental health promotion and education for all children and families
• Prevention for children and families at risk
• Intervention for those who have a specific condition or diagnosis

Fiction or Fact???
• Misconception: A severe shortage of local resources and therapists to serve children birth to 5 years with mental health needs
• Reality: More mental health providers and services than we thought

Private Service Providers Add Valuable Input to Community Councils
• Private providers bring a unique perspective to interagency councils.
• Volunteering is an important ethic for all providers.
• Be sensitive to time commitments.

CAYC Mental Health Objectives
• Broaden screening components to include behavioral/mental health
• Seek expertise from the mental health system to provide training/consultation to CAYC team
• Develop a screening coordinator position
• Increase community awareness of infant and early childhood mental health issues

CAYC Mental Health Subcommittee
• Reviewed potential screening tools
• Helped select appropriate tool
• Conducted brief training in identifying mental health concerns in young children
CAYC expanded its community interagency screening clinic with help from the Opening Doors into Rural Communities Project and the Albertsons’ Foundation.

**CAYC Coordinator’s Screening Responsibilities**
- Participate in CAYC screening by conducting behavioral and mental health screening using the Temperament and Atypical Behavioral Scale
- Conduct home visits for children needing further evaluation
- Monitor results of referrals by maintaining contact with the family

**For Children Identified as Needing Further Evaluation**
- Family completes a comprehensive psychosocial needs assessment to get a better understanding of the child and family needs.
- Family is presented with options regarding services and financial resources.
- Referrals are made to appropriate agencies.

**CAYC Coordinator’s Public Awareness Responsibilities**
- Make presentations for community agencies
- Meet with parent groups
- Design and distributes flyers
- Set up kiosks throughout the community
- Arrange for ads in local publications as well as on TV and radio

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**Continuum of Care for Children with Behavioral/Mental Health Needs and Their Families**

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Jefferson County, Missouri -- Participating with Parents

Jefferson County Early Childhood Council (JCECC)
Presenters: Andrea Wolf, Beth Diveley, Dee Atkisson, Cindy Wills

Jefferson County Early Childhood Coordinating Council serves as the local interagency coordinating council for Children birth – 8 years who have or are at risk for developing special needs.

Missouri’s Part C Early Intervention Program is called First Steps.

The JCECC Council Helped Parents to
- Feel welcome
- Recognize their own expertise
- Gain new knowledge
- Accept specific responsibilities
- Guide program development

Beth’s Words of Wisdom
“Being a member of the council, I am able to work with other parents and service providers to make positive changes that affect the services children receive in our community.”

Parents as Teachers (PAT) is a national, non-profit parent education and family support organization that targets families with infants, toddlers and preschool children. PAT’s core components consist of home visits, group meetings, developmental screenings and linkages to a network of community resources.

Parent Participation on Councils is Supported by
- Parents serving as chairs and co-chairs
- Providing child care to parents can attend meetings
- Stipends to let parents know that their time and participation is valuable

Three JCECC Projects
1. Joint referral form
2. Parent notebook
3. Toll-Free number to access screening

Purpose of the Joint Referral Form: To assist families with a quicker and easier referral process from one agency to the next.
1st Accomplishment: to develop an interagency memorandum of agreement with: the Bureau of Services for Children with Special Health Needs; Department of Mental Health; COMTREA; Jefferson County ARC; Department of Family Services; Community Action; Parents As Teachers Program; Health Department; Nurses for Newborns

Jefferson County
Early Childhood Council
Referral Form

Family Name: ________________________________________________________________
Date of Birth: ____________________ Social Security No. __________________________
Address: ___________________________________________________________________
Phone: ______________________________________________________________________
Diagnosis/Concern: ___________________________________________________________
Referring Agency: ____________________________________________________________
Phone No. ___________________________ Fax No. _______________________________

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<th>Agency referring to:</th>
<th>Fax #</th>
<th>Phone #</th>
<th>Services Requested</th>
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I authorize the above name agencies to release information about the above named person. A copy of this document is to be considered as effective as the original.

signed ________________________________ date __________________

Joint Referral Process
- Referral form is completed with family
- The form is faxed within 24 hours
- Receiving agency(ies) makes contact with family
- Paperwork trail is established

Parents As Teachers Program
- Made 40 referrals in 2000
- 50% were made to the First Steps Part C Program
The Joint Referral Form is most helpful for
- Families with complex needs
- Teen parents
- Parents who have difficulty reading
- Limited income

Purpose of Parent Notebook: To help parents organize information and records from various agencies and providers.

Show Me, Me Notebook Development
- Sample group of parents tested the notebook
- After trial period, a survey was conducted
- Parent input was used to make improvements.
- The new larger notebook now holds more reports, business cards, envelopes, etc.

Show Me Me Notebook Sections
1. Family Information
2. Medical
3. Calendar/Appointments
4. Service Plans
5. Financial Information
6. Phone Numbers
7. Resources

Purpose of Toll-Free Number: To increase the number of health and developmental screenings and to simplify the process for families.

Parents As Teachers (PAT) Program
- Provides free screenings for infants and preschoolers
- Links parents with services and resources

Problems with Child-Find Process
- 11 school districts in Jefferson county
- Each district has its own PAT phone number.
- Long distance calls for some families

Jefferson County Opening Doors Effort
- Single toll-free number for PAT was established
- Any parent within the 11 school district area can use the number
- Parents are connected to the appropriate program
Keeping Families Engaged in Interagency Councils

1. Recruit Families Through Different Doors
   • All agencies should encourage parent participation
   • Aim for families of children of different ages, backgrounds, culture

2. Make Sure Families Know Why They Are There
   • Create a new member packet
   • Identify various activities/ways to participate
   • Make parents feel welcome

3. Value Family Member’s Time
   • Give parent stipends to encourage participation
   • Provide for child care
   • Arrange or reimburse transportation

4. Identify Different Ways Families Can Participate
   • Encourage parental viewpoint during discussions
   • Allow parents to share their talents on focused activities
   • Encourage parents to be decision makers and trainers

Benefits of Parent Participation
   • Keeps parents aware of services and resources
   • Helps parents stay connected with other parents
   • Maintains the parent perspective in council discussion and decisions
Augusta, Maine—Organizing Services in Rural Communities
Presenters: Barbara Crowley, Debbie Dunn, Joan Marson

Vickery Partners

- Kennebec Pediatrics
- WIC
- Big Brothers/Big Sisters
- Child Abuse and Neglect Council
- Child’s Health Collaborative
- Parent Resource Center
- Vickery Café
- Child Development Services (combined Part C and Part B Programs)

What is a Medical Home? The provision of medical care that is…

- Accessible
- Continuous
- Comprehensive
- Family-centered
- Coordinated
- Compassionate

A Medical Home is NOT…medical care that is provided in emergency rooms or walk-in centers where no one knows the family.

Medical Homes are critical for children with health and developmental needs.

Barbara’s Words of Wisdom…

No matter what their stage of development or whether they are located in the same building, all communities can find ways to integrate their services more effectively.
Child Development Services of Southern Kennebec

- Serves children ages birth to 5 years and families
- 17 rural towns and 10 school districts with a population base of about 50,000
- Lead agency for Part C and B is the Maine Department of Education

Vickery Guidebook Table of Contents

- The Vickery Transformation
- A Look Inside the Vickery
- Coordinating the Medical Home and Early Intervention
- Practices for Pediatric Offices
- Practices for Early Intervention Programs
- What Do Families Think?
- Integrating Services in the Community
- Future Directions for the Vickery
- References

“Taking time to develop trust and to form relationships is undoubtedly the most critical factor in the success of any service integration initiative.”

quote from the Vickery Guidebook

To order a copy of the Vickery Guidebook, call the Family Health Resource Center at 1-877-814-0410.

Augusta’s Strategies for Coordinating Early Intervention and Medical Home

1. Compatible Intake and Referral Forms
2. Screening Summary Form
3. Physician’s Prescription for Evaluation and Treatment
4. Physician’s Signature on IFSP
REFFERRAL NOTIFICATION FORM

Referring Person/Agency: __________________________ Phone: __________________________

How did you become aware of CDS:

Child's Name: __________________________ Age: __________________________

Date of Birth: __________________________ Gender: ______ Male ______ Female

Father's Name & Address: __________________________ Mother's Name & Address:

Town of Residence: __________________________ Exact Street Location: __________________________

School District to be attended (complete for 3 & 4's only):

State Ward? ______ Yes ______ No (Foster Child) Guardian:

Address: __________________________

Are you a single parent? ______ Yes ______ No
Is the other parent involved in any way with the child? ______ Yes ______ No
Comments: __________________________

Telephone: Home: ______ Work: ______ Can you be called at work? ______ Yes ______ No

Other Children in Home? (Names and ages) __________________________

☐ Medicaid ☐ Prime Care Number: __________________________

Have you applied for Maine's Child Health Insurance Expansion/Cub Care: ______ Yes ______ No

(If NO: Info Sent on _____________/please initial)

Insurance Company: __________________________ EPSDT: ______ Yes ______ No

Child's Doctor: __________________________ Date of Last Well Child Physical: __________________________

Child's Public Health Nurse: __________________________ WIC: ______ Yes ______ No

Overall Development Information Given By: __________________________

Presenting Concern/Diagnosed Disability:

Development Information:

Other Services: ____ Head Start ____ Day Care ____ Nursery School / Location:

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An Intermediate Educational Unit responsible for ensuring identification of children with disabilities or developmental delays who are aged birth through five.
SUMMARY OF SCREENING

CHILD’S NAME: ___________________________ PARENT(S): ___________________________
DOB: ___________ AGE: ___________________ ADDRESS: ___________________________
DATE OF SCREENING: _____________________ PHONE: _____________________________
PLACE: _________________________________ TOOL: _______________________________
SCREENER: ______________________________ REFFERAL DATE: ________________
CONCERN: ______________________________ REFERRED BY: ______________________

SCREENING RESULTS

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<td>Appropriate</td>
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<td></td>
<td>Skills</td>
<td>Difficulty</td>
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- Personal/Social parent report
- Articulation
- Expressive Language
- Receptive Language
- Fine Motor
- Gross Motor
- General Knowledge

Vision Screening Date: _____  ( ) No Concerns ( ) Rescreen ( ) Refer
Hearing Screening Date: _____ ( ) No Concerns ( ) Rescreen ( ) Refer

Dr. ___________________________ Date Sent ___________________________

PRESCRIPTION FOR EVALUATION(S) AND/OR NEEDED SERVICES

Child’s Name: ___________________________ DOB: ________________
Parents: ________________________________
Address: __________________________________
_________________________________________

Diagnosis (if known):
________________________________________

MEDICAL/HEALTH STATUS

Well Child Physical up-to-date?: ___ No ___ Yes Date: ___________________________
Immunizations up-to-date?: ___ No ___ Yes
Medical Office Procedures
Joan Marson, R.N., Nurse Manager, Kennebec Pediatrics

Medical Office Procedures for Coordinating with Early Intervention
- A reciprocal confidentiality form is signed by the parent
- All forms and reports are bundled for a child’s physician and placed in a Review Folder
- Forms requiring physician’s signature are placed in the CDS folder for easy retrieval

Kennebec Pediatrics’ Philosophy
- Discuss family concerns, priorities, and resources
- Goal is to determine what works best for the child and family

Two Key Strategies for Coordinating Early Intervention and Medical Home
1. Use a well-defined coordination process that involves all key stakeholders
2. Identify key contact people who are available at each agency

Organizing Services in Rural Communities
Barbara Crowley, M.D., Pediatrician, Kennebec Pediatrics, President, Maine Medical Health Associates

Interagency work can be challenging but the rewards are many. Organizing services so that families can use them more easily can be a goal for all communities.
Pocatello, Idaho--Value of Participatory Action Research
Children’s Special Health Program CSHP Task Force
Presenters: Sidena Bitton, Nancy Renn, Deb Edmondson, Nancy Mann, M.D., Larraine Clayton

Pocatello’s Opening Doors Focus: Coordination of early intervention and the medical home

Pocatello’s Greatest Achievement… Our CSHP Task Force is still together!!

Three CSHP Task Force Projects
1. Implementing a community wide screening clinic
2. Providing statewide inservice training on medical home
3. Establishing a training program for family practice residents on child development and special needs

Interagency Screening and Referral
Nancy Renn, RN, MS, Assistant Professor, Department of Nursing, Idaho State University

Goals of CSHP Screening Clinic
• Provide support to all families with children under the age of 5
• Identify and refer children for needed services
• Assist families in finding a medical home
• Educate the community about child development

Developmental Screening Areas…
• Speech and language skills
• Cognitive skills
• Social-emotional skills
• Gross and fine motor skills
• Vision and hearing
• Health and dental screening
Community Partners Include…
- Southeastern District Health Department
- Department of Health and Welfare
- Bannock Regional Medical Center
- Pocatello Regional Medical Center
- Idaho School for the Deaf and Blind
- Idaho State University
- Idaho Parents Unlimited

Early Childhood Screening Clinic Data (1999-2001)
- # of children screened 273
- # referred for further evaluation 99

% of Referrals to EI From Primary Care Physicians…

For more info on Medical Home: [www/aap.org/advocacy/medhome/CurriculumHome.htm](http://www/aap.org/advocacy/medhome/CurriculumHome.htm)

The one-hour Medical Home In-Service Training was developed to be conducted by a pediatrician and a parent in physician’s offices. Each presentation was followed by a discussion on how to create more supportive and helpful procedures for families and physicians. This inservice training has been presented in multiple communities in Idaho.
15-18% of American children have or are at risk for health, developmental, behavioral, or emotional disorders.

**ODRC/ISU Family Residency Program Developed:**
- A series of lectures on child development
- Clinical demonstration of typical and atypical development
- Hands on experience in developmental clinics
- Teaching of developmental screening tools
- "A Day in the Life of a Child with Special Needs" video helps residents see the family’s life beyond the clinic

**ODRC Evaluation Tools**
1. Community Mapping
2. Service Integration Matrix
3. Community Self-Assessment
4. Parent Phone Survey
Pocatello Service Integration Matrix

Service Integration Goal: Coordination of Early Intervention with the Medical Home
Target Population: O-5 Part C Part B BITH CDES or GSHCN Definition Children and Families
Outcomes and Accountability: Referrals from local physicians to early intervention. 16% in 1999; increased to 26% in 2001.

<table>
<thead>
<tr>
<th>Partners/stakeholders</th>
<th>Intensity of Integration Continuum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Connection</td>
</tr>
<tr>
<td>Prior to task force</td>
<td></td>
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<tr>
<td>1999 - 1999 SI level</td>
<td></td>
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<tr>
<td>2001 - 2001 SI level</td>
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</tbody>
</table>

Shared goals/mission statement

Connections b/w task force and state agencies

Community/task force governance and authority

Service delivery system/model

Financing and budgeting

Information systems/data management

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Opening Doors Service Integration Matrix…
- Promotes rich discussion about key issues
- Allows for “ah-ha” experiences
- Helped set goals for relationship building at both the community and at the state level

Examples of Qualitative Items on Community Self-Assessment Survey
- Barriers to service integration
- Degree to which programs address cultural needs of families
- Degree of parent involvement in planning and decision making

ODRC Parent Phone Survey Topics
- Family Information
- Medical Home
- Insurance Coverage
- Community-Based Services
- Cultural Competence
- Family-Centeredness

Examples of Items on Community Self-Assessment Survey
- Number of children receiving services in various programs
- Number of providers available
- Availability of health care

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Creating Sustainable Interagency Councils
Diane Behl, M.Ed., Senior Researcher
Early Intervention Research Institute, Utah State University, Logan

1. Create Visibility for Your Council
- Hold meetings in visible locations, such as libraries or recreation centers
- Contact local newspapers, radio and TV stations to announce events and promote accomplishments
- Offer tangible items, such as t-shirts, refrigerator magnets, coffee mugs, medicine spoons
- Attract volunteers from local businesses, churches, and political offices

2. Investigate Sources for Funding
- Keep on the lookout for grants and other funding sources
- Give credit to funding sources by mentioning donations in newsletters, meeting minutes, etc.
- Approach regional and national foundations and benefactors
3. Nurture the Commitment of Council Members and Agencies
   - Try to be sensitive to members’ job responsibilities
   - Note members’ strengths and interests
   - Use subcommittees to “get the job(s) done”
   - Pair new members with a mentor
   - Develop council procedures for decision making and hearing all opinions

4. Translate Council Efforts Into Institutional Policies
   - Develop interagency procedures with partner agencies (e.g., through written agreements, joint training activities)
   - Explore how blended interagency funds can be used to support council activities

5. Maintain Strong Family Voices on Your Council
   - Ensure the meaningfulness of your council’s efforts through on-going family participation
   - Avoid overworking the same parent volunteers
   - Ensure parent participation through stipends, child care and transportation reimbursement
   - Establish a “family involvement” subcommittee

6. Celebrate Your Success
   - Give credit to accomplishments of council members and agencies—pat yourself on the back!!
   - Build some fun activities into meetings

“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.”

---Margaret Mead

It takes commitment and maintaining a focus on why we’re all doing this hard work --- it’s for our children, our families, and our communities.

Don’t forget to visit the chat room and complete the online evaluation. Thanks!

For more information about the Opening Doors project or the Early Intervention Research Institute (EIRI), visit the EIRI web site at www.eiri.usu.edu or call us at 1-800-887-1699.