



The Best Beginning

Partnerships Between Primary Health Care
and Mental Health and Substance Abuse
Services for Young Children and Their Families

WRITTEN BY

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Background

Project Purpose In the past decade, interest and activities in the interface between primary health care and mental health and substance abuse services have increased markedly among the many stakeholders who care about positive outcomes for young children’s mental health and well-being. Building on that increased interest, this document was developed as a resource to give health care providers and policy makers at all levels an overview of a range of innovative efforts across the country where health care providers have attempted to treat families as a whole, provide care in the context of a medical home, identify mental health and substance abuse disorders earlier, and make successful referrals and linkages to community-based mental health and substance abuse services and supports.

Primary health care providers represent a significant and natural point of contact for young children and their families. Being able to intervene early with caregivers of infants and toddlers through primary health care can promote children’s mental health and well-being, prevent or delay later negative outcomes, promote protective factors and decrease risk factors associated with negative child outcomes, and may prevent the need for intensive and expensive care at a later age.

This document includes a relevant literature section, eight case studies of primary care sites using innovative approaches to serve pregnant women and/or families with children birth to three years old, a synthesis of these approaches, lessons learned, and strategies to assist others in replicating these approaches. Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services, this project is an outgrowth of SAMHSA’s intra-agency Children and Families Matrix Workgroup.

Selection Criteria for Sites

This project sought to identify pediatric settings that had successfully incorporated at least some of the following innovative approaches into their ongoing delivery of primary care:

- **Creating a medical home:** The American Academy of Pediatrics (AAP) first put forth the notion of the medical home in 1992 and has since updated its definition to include an entity that provides care that is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective” (American Academy of Pediatrics [AAP], 2002, p. 184). In a true medical home, the physician engages in a relationship based on mutual trust and shared responsibility with the family.
- **Providing comprehensive mental health, substance abuse and developmental screening:** AAP defines screening as a “brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment” (American Academy of Pediatrics [AAP], 2001, p. 192). Screening is voluntary and conducted with parental consent. Early identification of caregiver mental health and substance abuse concerns need to be addressed too, since their mental health and well being significantly affects that of their young children.
- **Providing facilitated referrals:** A facilitated referral is defined as a trusting and ongoing relationship among a member of a primary care clinical team, the family, and the community for the purpose of successfully referring a patient to community-based services and supports (Hanson, Deere, Lee, Lewin & Seval, 2001). This is similar to the function of the physician described in the AAP’s definition of the medical home. It is differentiated from such traditional linkage referrals as simply giving a family a list of names.
- **Providing family-centered care:** The Institute for Family-Centered Care identifies the guiding principles of family-centered care as recognizing the vital role of families in insuring the health of all family members; adopting a strengths-based approach to care; recognizing the importance of emotional, social, and developmental support in health care; working with families in decision making and empowering families; involving patients and families as experts to improve quality of services; and facilitating peer to peer support (National Institute for Family-Centered Care, n.d.).

- **Demonstrating cultural and linguistic competence:** Cultural and linguistic competence is an approach to delivering primary care services grounded in the assumption that services are more effective when they are provided within the most relevant and meaningful cultural context for the people being served. The term *cultural competence* refers to sets of guiding principles intended to increase the capacity of primary care providers to meet the needs of diverse communities, including racial and ethnic minorities. These principles include value, acceptance, and respect for diversity; capacity, commitment, and systems in place for cultural self-assessment; consciousness of the dynamics inherent when cultures interact; continuous expansion of institutionalized cultural knowledge; and service delivery models, modes, and adaptations to accommodate diversity. (Modified from Cross, Bazron, Dennis, & Isaacs, 1989). In addition, linguistic competence represents the capacity of the agency or practice and its personnel to effectively communicate with persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities (Modified from Goode & Jones, 2002).

Setting the Stage: National Efforts to Integrate Behavioral Health and Primary Care

There have been a number of national initiatives that have sought to change the way mental health and substance abuse (also referred to as behavioral health) services are delivered to young children and their families. Each initiative has addressed the gap in comprehensive services available in primary care settings from a different vantage point. Some have been funded with federal funds, others through foundations.

- **Starting Early Starting Smart (SESS)** was funded through a unique public-private collaboration between SAMHSA and the Casey Family Programs. In 1997, this initiative began with a 12-site, four-year national study, which sought to demonstrate the efficacy of integrating behavioral health services into settings where young children and their families access other services and supports. Five of the sites were primary health care practices, and seven were early childhood programs. Serving women and children through age 7, each site provided a comprehensive array of behavioral health screening (for the mothers and their children) and facilitated referrals to assessment and treatment services within a relationship-based framework (i.e., SESS staff

created ongoing, supportive relationships with families based on trust and mutual respect, and these relationships served as a foundation for all services and supports). A rigorous research component documented the differences in a range of outcomes for young children and their families.

- **Early Head Start (EHS)**, funded by the U.S. Department of Health and Human Services, Administration for Children and Families, was added to the Head Start portfolio in 1994 to focus on providing comprehensive services to low-income, pregnant women and young children through age two. Services are focused on enhancing the infant's/toddler's development and include the establishment of a medical home for ongoing health care for the child; ongoing developmental screenings; comprehensive pre-/post-natal services for mothers, especially help with post-partum depression; and referrals to community providers who have established relationships with the EHS program locally. When Congress established the EHS program, it also funded a rigorous, large-scale, random-assignment evaluation to examine a broad range of family and child outcomes. The evaluation was conducted in 17 sites by local university-based researchers, with the cross-site work conducted by Mathematica Policy Research, Inc., and Columbia University's National Center for Children and Families.
- **Healthy Steps for Young Children** was launched in 1994 as a national demonstration project by the Commonwealth Fund. It was later continued by the Robert Wood Johnson Foundation and a group of over 100 funding partners. The project was designed to determine the efficacy of embedding a developmental specialist into pediatricians' offices as a strategy to improve access to high quality preventive, developmental services. The addition of Healthy Steps specialists (usually a nurse, nurse practitioner, early childhood educator, or social worker with child development expertise) meant that a broad range of families' concerns could be addressed during a primary care visit. Healthy Steps for Young Children sites provided ongoing developmental screenings for children, parent support and education (in particular, help for mothers who were depressed), and targeted referrals to community resources. The three-year National Evaluation was published in 2002, and the national initiative now provides guidance for expansion of this model in pediatric and primary care practices across the country.

- **Assuring Better Child Health and Development (ABCD)** is an initiative launched by the Commonwealth Fund in 1999 to improve access to preventive and developmental services for low-income children. This project funded systems-change efforts in four states (North Carolina, Utah, Vermont, and Washington), all of which were led by the state Medicaid offices. An evaluation identified three outcomes: A broader array of health and developmental services available through changes to billing and reimbursement policies, strengthened screening, surveillance and assessment services for young children, and improvements in care coordination. These successes led to the ABCD II initiative that Commonwealth is currently funding in five states: California, Illinois, Iowa, Minnesota, and Utah.
- **Medical Home:** Work on the development of the medical home construct has benefited from the leadership of AAP and has been supported by the federal Health Resources and Services Administration (HRSA) within the U.S. Department of Health and Human Services as part of their efforts to improve access to services for children with special health care needs under Title V of the Social Security Act. This initiative focuses attention on the need for an ongoing source of primary care for children that is “accessible, continuous, comprehensive, coordinated, compassionate, and culturally effective” (AAP, 2002; p. 184). HRSA has funded a series of medical home grants designed to promote the adoption of best practices as well as to evaluate the effectiveness of this approach in improving quality and outcomes.
- **Bright Futures Mental Health** is a set of anticipatory guidance materials developed by a multidisciplinary panel of experts, under the direction of Dr. Michael Jellinek, with funding provided by HRSA. Released in 2002, the Bright Futures Mental Health materials contain in-depth guidelines for addressing mental health within a developmental context, facilitating the incorporation of a variety of screening tools and educational materials into primary care practices. HRSA has also made grant funds available to study the impact of the Bright Futures Mental Health initiative. Currently, AAP is working to incorporate additional mental health and substance abuse screening tools into a tool kit accompanying a revised version of the Bright Futures Guidelines.

These efforts represent examples of national initiatives that have sought to integrate screening for children’s developmental issues, as well as screening and services for adult mental health and substance abuse issues, with an array of behavioral health services and supports. Many of these projects have had a research or evaluation component that has allowed data to be gathered on the effectiveness of these strategies. None of these initiatives has been universally accepted and implemented, leaving instead a patchwork of innovations, lessons learned, and a set of ongoing challenges that the pediatric community must sort through in trying to meet the behavioral health needs of young children and their families.

**Why it Matters:
Prevalence Rates
of Mental
Health and
Substance Abuse
Disorders and
Impacts on
Children and
Families**

Adult Mental Health. According to data from the U.S. National Comorbidity Survey Replication, in a given year, approximately 26 percent of the adult population meets the criteria for some form of mental disorder (Kessler, Chiu, Demler, and Walters, 2005). Focusing specifically on depression, rates of depression among mothers of young children are high, with different studies finding rates anywhere from 12 to 50 percent, depending on the measures used (Gurian, 2003). This risk appears to be exacerbated for mothers of young children living in poverty (Pettersen and Albers, 2001). In comparison, approximately 7 percent of the general adult population is affected by major depressive disorder at any given time (Kessler et al., 2005).

The effect of maternal depression, not only on the women themselves but also on their infants and young children, has been well documented. Less data have been collected on the impact of depression in fathers. As young as two months of age, infants of depressed mothers can show difficulties in engaging in social interactions as well as in their ability to regulate their states (i.e., calm themselves when upset) (Weinberg and Tronick, 1998). As children grow, having a depressed mother puts them at increased risk for both internalizing (e.g., depression) and externalizing (e.g., acting out in classrooms) symptoms, as well as behavior problems in general (for a review, see Rosman and Yoshikawa, 2001). Maternal depression may also affect very specific parenting practices. Mothers reporting a high level of depressive symptoms are significantly less likely to engage in prevention practices such as car seat use and covering electrical plugs (McLennan and Kotelchuck, 2000). Another study found that both mothers and

fathers who experienced more depressive symptoms were less likely to maintain daily nap, meal, and bedtime routines or to read to their child daily, all of which are activities that contribute to improved health, development, and school readiness (Young, Davis, Schoen, and Parker, 1998).

Substance Abuse. According to data from the National Survey on Drug Use and Health (2005), an estimated 22.5 million persons aged 12 or older in 2004 were classified with substance dependence or abuse in the past year (9.4 percent of the total population). Specifically, the rate of substance dependence or abuse¹ was 8.8 percent for youths aged 12 to 17, 21.2 percent for persons aged 18 to 25, and 7.3 percent for persons aged 26 or older. Further, there were 4.6 million adults with both serious psychological distress and a co-occurring substance use disorder in 2004. In their review of the literature, Werner, Joffe, and Graham (1999) cite studies that demonstrate the “wide range of important morbidity experienced by the children of substance-abusing families” (p. 1099). Children whose mothers abuse substances while pregnant are more likely to experience birth defects and developmental delays, and, as they grow, they are more likely to experience emotional disorders, anxiety, and conduct disorders, as well as school problems. Children of women who abuse alcohol have also been found to be at increased risk of experiencing unintentional injuries, and this risk increases for children who have two parents with alcohol problems. These children are also at increased risk of physical and sexual abuse. It is clear that parental mental health and substance abuse places children at higher risk for a broad range of compromised developmental outcomes (Werner et al., 1999).

Child Behavioral and Emotional Disorders. Finally, millions of children themselves experience behavioral and emotional problems, with early childhood being a critical time for onset of these problems. Estimates of national prevalence rates of young children

¹ Respondents are classified as dependent on or abusing specific substances based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV) (American Psychiatric Association [APA], 1994). The questions on dependence ask about health and emotional problems associated with substance use, unsuccessful attempts to cut down on use, tolerance, withdrawal, and other symptoms related to substance use. The questions on abuse ask about problems at work, home, and school; problems with family or friends; physical danger; and trouble with the law due to substance use.

with psychosocial problems are between 10 percent and 21 percent, while rates specifically for externalizing problems can be as high as 25 percent (Powell, Fixsen, and Dunlap, 2003). In infants and toddlers, these problems can manifest themselves as an inability to regulate emotions and form secure attachments (e.g., strong, enduring affective bonds with caregivers), while in preschoolers, they often manifest themselves as challenging behaviors such as being disruptive in child care or school settings. While many children go undiagnosed and untreated, in 1997 there were, nonetheless, almost 120,000 preschoolers (1 out of 200) between the ages of birth and six who received mental health services (New Freedom Commission on Mental Health, 2003).

Why Focus on Infants and Toddlers?

New findings in neuroscience, child development, developmental stress research, and infant psychiatry have established that rapid brain development during the prenatal period and from birth to age three lays a critical foundation for healthy subsequent development. Essential capabilities related to cognition, language acquisition, emotional regulation, and interpersonal relatedness are developed through a continuous interplay of biology and experience (Shonkoff and Phillips, 2000). Early experiences, including the quality of relationships with parents and/or primary caregivers (e.g., grandparents, foster parents, other relatives, etc.), play a prominent role in providing positive experiences for healthy development. Equally important is that children's development is significantly tied to the health and well-being of their parents. Research indicates that millions of parents are affected by a mental health and/or substance abuse disorder, which may compromise their ability to provide for their child's physical and emotional well-being. Sixty-eight percent of women and 55 percent of men who experience a mental illness during their lifetime are parents (Nicholson, et al, 2001). And in 2001 more than 6 million children lived with at least one parent who abused or was dependent on alcohol or an illicit drug during the past year; approximately 10 percent of children involved in this study were aged five or younger (SAMHSA, 2004). Children who have a parent with a mental illness and/or substance abuse disorder are at greater risk for the development of psychosocial problems, including developing later substance abuse and/or mental health problems of their own.

Why Screen: The Need for an Intergenerational Approach to Screening in the Primary Care Setting

Primary health care providers represent a significant point of contact for young children in the first few years of life. They see families on a frequent basis and are in a key position to intervene early by screening the family as a whole, as appropriate, when identifying mental health and substance abuse problems in parents/caregivers *and* when conducting behavioral/emotional screens of infants and toddlers. The most basic argument for more comprehensive developmental screening is that it can lead to early identification of social-emotional and biological problems. That identification could lead to a referral for preventive or treatment interventions by behavioral health and medical specialists. The American Academy of Pediatrics defines screening as a “brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment” (AAP, 2001, p. 192). The SAMHSA statement on screening and early detection highlights several principles that communities and providers should adhere to in implementing screening programs. These include:

- “do no harm;”
- screening must be voluntary, with parental consent (in the case of children);
- screening instruments must be valid and reliable, and the person administering them must be qualified and trained;
- screening must be done in a culturally competent manner;
- screening should never be used to make a diagnosis, but should, instead, be followed by in-depth assessment; and,
- confidentiality must always be ensured (Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2005).

Screening is a tool for identifying individuals who show certain indicators of a specific condition (e.g., developmental delay, mental health disorder, or substance abuse problem) and who need further evaluation. This is differentiated from assessment, which is conducted in order to determine a diagnosis and treatment plan. For example, developmental screening can be a tool for a primary care provider to move beyond the child’s physical health and to open a door for more thorough evaluation, if warranted. This is especially important for infants and toddlers, as early identification leads to earlier intervention and treatment.

The federal programs that currently require young children to be screened regularly are Medicaid and the Infants and Toddlers Programs under the Individuals with Disabilities Education Act (IDEA). The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program is Medicaid's child health program for children ages from birth through age 21. Under EPSDT, all children must receive screening services, which include a comprehensive health and developmental history. The IDEA Amendments of 1997 mandate early identification of and intervention for disabilities in children as young as possible. While IDEA focuses primarily on screening children at risk for a wide range of physical and developmental disabilities, there has not been a focus on children at risk for serious behavioral/emotional problems. In fact, only eight states currently report serving children "at-risk" under their Part C eligibility definitions (Danaher and Armijo, 2005).

Advocates for expanding screening services have noted the promise of primary health care settings as screening sites for both children and their caregivers. Halfon and his colleagues note that more than 95 percent of infants and toddlers have a regular source of health care, with this figure as high as 85 percent even for uninsured children (Halfon, Regalado, McLearn, Kuo, and Wright, 2003). While it is necessary that all young children receive appropriate health care, which includes behavioral health elements, it is not sufficient. The *context* in which the child is growing and developing is critical—including the health and well-being of the child's primary caretakers. The fact that a child's parents are present in the primary care setting, suggests a key opportunity to use a "two-generation approach" for health (Shonkoff and Phillips, 2000).

Not only are pediatric primary care providers in a unique position to reach a large number of families, but research also suggests that families want screening and they want follow-up. Kahn et al. (1999) surveyed over 550 mothers bringing young children (18 months or younger) to pediatric primary care sites. Eighty-five percent of the women said they would welcome or not mind being asked about the specific conditions addressed in the study (significant/serious illness, smoking, alcohol problems, depressive symptoms, risk for unintended pregnancy, emotional/verbal abuse, physical abuse, and self-assessed fair/poor health). Ninety percent said they would welcome or not mind an offer of help with making appointments with an adult care provider (i.e., receiving a

facilitated referral) if they were affected by one of these issues. In a focus group study of young mothers, Heneghan, Mercer, and DeLeone (2004) found that mothers were open to discussing parenting stress and depression with their child's pediatrician, provided a trusting relationship had been established first.

Not only is screening recommended for parents, but a good deal of research points to several effective screening tools that could be used to assess both adult mental health and substance abuse issues and children's emotional and behavioral disorders. Looking at adult mental health and substance abuse issues, Werner et al. (1999) recommend that screening for alcohol and other drug abuse begin with the prenatal visit and focus on how substance abuse can affect parenting and the home environment. They recommend measures such as the CAGE Questionnaire and the Alcohol Use Disorders Inventory (AUDIT). Moving to maternal depression, Olson et al. (2002) review literature that suggests that a screening that uses only two questions—"During the past month, have you often been bothered by feeling down, depressed, or hopeless? During the past month, have you often been bothered by having little interest or pleasure in doing things?"—can be just as effective as longer questionnaires.

Finally, multiple tools exist for screening young children. Levitt and Jensen (2004) provide a thorough overview of available measures, including the Pediatric Symptom Checklist, which is a parent-report instrument. While many of these measures have been designed for older children, several have versions designed for younger children. AAP, in their surveillance and screening guidelines, acknowledges that screening for behavioral and psychosocial problems in young children can be especially challenging. However, they offer a list of specific tools that doctors can employ, such as the Temperament and Atypical Behavior Scale, Child Behavior Checklist, The Carey Temperament Scales, Eyberg Child Behavior Inventory, Pediatric Symptom Checklist, and Family Psychosocial Screening (AAP, 2001).

It is also possible that something more basic than a formal questionnaire can be used as a screening tool—parental concerns. Glascoe (1997), working with a sample of over 400 children between the ages of 21 and 84 months, used the Parents' Evaluations of Developmental Status to elicit parent concerns. It is

a two-question-measure that takes less than three minutes to administer and asks parents one open-ended question about concerns, followed by questions about concerns in each developmental domain. Glascoe found that parents' concerns were highly sensitive predictors of developmental problems and that the absence of concerns was also generally associated with typical development, leading her to conclude that "...parents' concerns can be safely recommended for use as a screening tool" (p. 527).

In summary, the prevalence of mental health and substance abuse challenges in families with young children, along with the known impact of these problems on young children's development, point to the need for more pediatric and family health care providers to focus on the family as a whole and for screening [of both children and caregivers], as appropriate, for behavioral health problems. This is particularly important in pediatric settings that serve a high percentage of low-income families with young children, because rates of maternal depression, domestic violence, and substance abuse are higher in this population (Knitzer, 2000), as are rates of behavioral problems in young children (Qi and Kaiser, 2003). In order to promote the adoption of innovative approaches to integrating behavioral health into pediatric primary care settings, we sought out examples that could be synthesized and shared in this document.

Methodology for Site Selection

The federal team generated the criteria for selecting the sites to be interviewed. Specifically, interviews were to be conducted at between six and nine pediatric settings that:

- Served pregnant women and/or families with children under the age of four;
- Integrated screening for adult mental health and substance abuse issues into their primary care practice;
- Integrated developmental screening for children into their routine primary care practice;
- Implemented a medical home model; and,
- Provided facilitated referrals in the context of ongoing relationships with the family and community-based providers.

An Expert Workgroup was established as part of this project. Members convened to provide guidance on the selection of sites and the development of the interview protocol. A national call for nominations was initiated in the spring 2005 through two primary strategies: contacts with national experts in integrating behavioral health into pediatric care and emails on relevant list-serves (e.g., the State Early Childhood Comprehensive Services grantees; Early Head Start technical assistance). Sites were asked to provide a brief description of how they had addressed each of the selection criteria. Fifteen sites submitted complete applications and often included additional documentation. The federal team in collaboration with the research team at Georgetown University reviewed these applications and made the final site selections. An effort was made to have a mix of rural and urban sites, as well as

sites that served different populations (e.g., children enrolled in Medicaid; families from varied ethnic/racial groups). Eight sites were selected for in-depth interviews.

The authors gathered interview data both on-site and through telephone interviews. On-site visits were made to four sites: Beaufort, South Carolina; Los Angeles, California; Seattle, Washington; and Washington, D.C. Data were collected at the four remaining sites through telephone interviews with multiple informants. For each site, a variety of respondents was interviewed, including: lead pediatricians, family members, mental health and substance abuse providers, and front-line pediatric staff. Interview data was then synthesized into case studies.

Case Studies

The Case Studies section provides basic information about each of the eight sites, including an overview; history and mission; demographic information about the area where the site is located and the population served; information about staff composition, as well as the strategies employed for staff development; and information about financing for services rendered. A synthesis of the strategies each site used to address the core constructs addressed in this study (i.e., medical home, family-centered care, comprehensive screening, facilitated referrals, mental health and substance abuse services, and cultural and linguistic competence) is presented in subsequent sections (beginning on page 45).

Beaufort Pediatrics

Beaufort, SC

BEAUFORT PEDIATRICS (AT-A-GLANCE)		
Site Description	Staffing/Staff Development	Financing
<p>Large, rural pediatric practice committed to “improving preventive and developmental services to patients under the age of 5...”</p> <hr/> <p>15,000 patients 60 % Medicaid 50 % African-American, 45 % Caucasian, 5 % Latino</p>	<p>7 Physicians 1 Nurse practitioner 20 Additional staff 2 Social workers</p> <hr/> <p>Evening staff meetings Lunchtime trainings Plan, Do, Study, Act cycle tool to affect change</p>	<p>Medicaid (60 %) Self-pay (20 %) Private insurance (20 %)</p> <p>Bill 96110 code to pay for screening services</p>

History and Mission: Located directly across from the hospital on a quiet road a few blocks from downtown Beaufort, Beaufort Pediatrics is at first glance a low-key, small-town doctors’ office. Following the Bright Futures model, the practice’s goal is to “improve preventive and developmental services to patients under the age of five, so that our patients are healthy and safe, capable of sustained attention and life-long learning, able to participate in productive interpersonal relationships, and appropriately moderate

Beaufort Pediatrics
Continued

their emotions.” Another goal is to ensure that parents and the community emotionally nurture all children. To reach this goal, Beaufort Pediatrics is working towards a greater awareness of and attention to the needs of the whole family, as well as the emotional, social, and educational needs of children. There are color-coded charts taped to the wall in the nurses’ stations to remind nurses and doctors which screening tools to use for children and families of various ages. The corresponding color-coded tools themselves lie on the counter. Another memo reminds the doctors of the billing codes for various screenings. The number of screens each doctor completes weekly is tracked through insurance documentation.

Setting and Population Served: A relatively large percentage of the population that Beaufort Pediatrics serves is comprised of both minority and low-income families. Sixty percent of their patients receive Medicaid. However, they also see children from very wealthy families, as Beaufort County includes Hilton Head and its sprawling suburbs. There are currently approximately 15,000 charts at Beaufort Pediatrics. Their patients are 50 percent African-American, 45 percent Caucasian, and 5 percent Latino. Beaufort Pediatrics is the third largest pediatric practice in South Carolina.

Staffing and Staff Development: Seven doctors, one nurse practitioner, and 20 additional staff work at Beaufort Pediatrics. They also have two social workers on-site, one of whom works full-time and was originally co-located at the practice as part of a Maternal Child Health Bureau medical home grant. Her job is to monitor and coordinate services for all of the children receiving Title V benefits. The second social worker is in the office 10 to 15 hours a week to see children and families that the doctors refer for mental health services. During the week, the practice is open from 7:00 A.M. to 7:00 P.M. While appointments are preferred, walk-ins are accommodated. When parents call, they can request the specific doctor they would like to see. One of the receptionists speaks Spanish, which has led to a significant increase in Spanish-speaking patients.

Staff development can be difficult to schedule, since doctors stagger their hours to ensure coverage from 7:00 A.M. to 7:00 P.M. Meetings among the doctors are now typically held in the evening; receptionists have recently begun trying to schedule evening meetings as well. They have settled on sporadic lunchtime trainings (lunch is provided), along with weekly Tuesday morning meetings. These meetings usually focus on Plan, Do, Study, Act (PDSA) cycles, a tool being used to effect quick, small-scale change in clinical practices (Plsek, 1999). Once a problem is identified, PDSA calls for planning a specific adaptation, implementing it, studying the effects, and then acting on what is learned to launch a new cycle. At these meetings, everyone is assigned a specific task for the next cycle, and this functions to increase both involvement and ownership.

Financing: Beaufort Pediatrics has two full-time staff members devoted to billing, one for Medicaid and one for private insurance. Approximately 20 percent of their total revenue comes from patients who self-pay, and 20 percent comes from private insurance; the remainder is Medicaid revenue. One key innovation that Beaufort Pediatrics has discovered is that it is possible to bill for administering developmental and behavioral health screenings. The 96110 billing code can be used for four children's developmental and behavioral screenings used in the practice. The practice receives \$24 for each screening tool administered. The practice is using billing data to determine which doctors are conducting (and billing for) screenings, and then using that data to promote widespread adoption of screening throughout the practice via PDSA cycles. For the future, Beaufort Pediatric's strategic plan calls for hiring a PEP (Medicaid's Physicians Enhanced Program) compliance officer to ensure that patients' referrals are properly tracked and to encourage patients to make new appointments if they fail to keep an initial appointment.

Foster Care Pediatrics
Rochester, NY

FOSTER CARE PEDIATRICS (AT-A-GLANCE)		
Site Description	Staffing/Staff Development	Financing
<p>Small, suburban primary care pediatric office based in the health department to provide high quality primary care and case management services to children in foster care.</p> <hr/> <p>670 children in foster care and their foster/birth parents 45% African-American 30% Caucasian 15% Latino 10% mixed ethnicity or ethnicity unknown</p>	<p>2 Physicians 3 Nurse practitioners .5 FTE Social worker 5.5 FTE Nurses 1 Health-aide 2 Clerks</p> <hr/> <p>Weekly clinical meetings for review and consultation Didactic trainings twice a month Consultation by partner mental health agency Annual retreat for staff Staff development opportunities in local community</p>	<p>Medicaid fee-for-service (100%)—including case management services</p>

History and Mission: Foster Care Pediatrics started in 1986 when Dr. Moira Szilagyi, then a medical resident, began to identify the need for “good, comprehensive medical care” for children in foster care in Monroe County, New York. Dr. Szilagyi began working with the deputy director of social services to start a task force to investigate issues related to health care for children in foster care. They discovered that 400 of the children in foster care had no doctor identified, and several hundred had not seen a doctor for their entire length of time in care (which was the norm for children in foster care nationally at that time). They determined that the most efficient and affordable model for improving services for these children would be serving them on-site, and the Monroe County Department of Health agreed. Two months after the practice got underway, a local pediatrician who had served on the initial task force became the director of the Monroe County Department of Health. He has been a staunch supporter of the practice’s philosophy. Foster Care Pediatrics’ mission is to provide high quality primary care and case management services to children in foster care. While providing medical care only to children, staff at Foster Care Pediatrics also considers their clients to include foster parents, casework staff, birth parents, attorneys, guardians, and other health care agencies that serve the children.

Setting and Population Served: While the patient load at Foster Care Pediatrics has ranged from 640 to 900 children, they currently serve 670 children. Approximately 45 percent of their patients are African-American, 30 percent White and 15 percent Latino. Thirty-five percent are under the age of five.

Staffing and Staff Development: Dr. Szilagyi runs the practice and works approximately 30 hours a week. The rest of the staff includes another physician, (whose time is donated by the University of Rochester) who works four hours a week; three nurse practitioners (one, four days a week, one for two days a week, and one on a per-diem basis); a half-time social worker on-site who primarily works on making facilitated mental health referrals, coordinating mental health programs, and supporting foster parents; five nurses (four public health nurses and one LPN); one health aide for hearing, vision, and clerical work, including entering immunizations in the county registry for foster children; two full-time clerks; and a volunteer, one to two days a week, who maintains the bulletin boards. Many nurses are on staff because of the large amount of case management responsibilities. According to a recent time flow study, staff members spend approximately half of their total time on primary care and half on case management.

Staff training at Foster Care Pediatrics is mainly conducted during weekly meetings. One nurse in the practice is responsible for quality assurance to ensure that charts are properly documented and up-to-date. This job is particularly critical, since charts may be requested by a court at any time. She audits ten charts per week and then reports back to the staff at weekly meetings. Typically, two staff meetings per month are didactic sessions on a current topic. There is also a full-day team-building retreat once a year, where they address such issues as how to combat compassion fatigue. In general, training is more informal than formal, although staff is encouraged to participate in any free training that is available.

Financing: The care coordination component of Foster Care Pediatrics used to be funded out of county general health dollars. Two years ago, a financial crisis resulted in Foster Care Pediatrics being cut out of the budget completely. The local Medicaid managed care (Monroe Plan), Rochester Safe Start (a program committed to preventing and reducing the harmful effects of

exposure to violence on young children), and the Department of Pediatrics at the University of Rochester agreed to pay for services for the year. According to Dr. Szilagy, this sent a strong message to the local political powers about how the community valued Foster Care Pediatrics. Furthermore, foster parents and case workers testified before the legislature on the practice’s behalf, so that the following year they again had their own budget line. Primary care services are all billed to Medicaid. They are exclusively fee-for-service, as the practice has waived out of Medicaid managed care. They are not set up to bill private insurance.

Guilford Child Health, Inc.
Greensboro, NC

GUILFORD CHILD HEALTH (AT-A-GLANCE)		
Site Description	Staffing/Staff Development	Financing
Large, urban multi-site practice serving children and adolescents and their families who live at, or below, 200 percent of the Federal Poverty Line.	15 Physicians and 5 Nurse practitioners 1 Finance Director 2 each, Certified Medicaid coders and data entry staff	Medicaid Health Choice (NC’s CHIP program) County funds
30,000 patients 45% African-American 35% Latino 15% Caucasian 5% refugee/immigrant (including Vietnamese, Laotian, Montagnard, Ethiopian, and Somalian)	Written “protocols” to prepare and guide staff Monthly staff meetings Lunchtime trainings	Bill 96110 code from Medicaid to pay for screening services

History and Mission: Guilford Child Health, Inc. (GCH), is a private, nonprofit medical practice responsible for serving children and adolescents in Guilford County, North Carolina, whose families live at or below 200 percent of the federal poverty line. GCH incorporates into its mission two primary goals: to serve the whole child, recognizing relationships in the family, school, and community; and to provide a medical home for the children and adolescents they serve. Because of GCH’s commitment to cutting edge, best practice for children and families, GCH, led by Dr. Marian Earls, has become a leader in the state, encouraging other primary care providers to incorporate screening into their practices. One of the principal ways this has occurred is through GCH’s

participation with the Medicaid Community Care Network (Partnership for Health Management, or P4HM), a private, nonprofit funded through Medicaid to increase patients' access to care, as well as cost containment. Through P4HM, GCH has worked towards improving developmental screening and case management for all children. They are also currently participating, with P4HM, in a Mental Health/PCP Integration Initiative, designed to improve mental health services in the county.

Setting and Population Served: GCH currently sees approximately 30,000 patients, with the largest percentage being African-American (45 percent), followed by Latino (35 percent), Caucasian (15 percent), and a group of refugee/immigrants from many countries (5 percent). Because Greensboro is a refugee resettlement area, approximately 30 percent of the patients don't speak English or Spanish (and represent multiple ethnicities, including Bosnian, Vietnamese, Hmong, and African).

They operate two large sites and one small site, with 15 physicians and five nurse practitioners spread across those three sites. They are open from 8:30 A.M. to 5:30 P.M. Monday through Friday, as well as Saturday mornings.

Staffing and Staff Development: With 15 doctors, GCH has long functioned by consensus, with doctors agreeing upon protocols for practice-wide implementation. This means that the providers are used to the fact that they are not 15 people practicing 15 different ways. Protocols typically develop because one or two physicians have an interest and will take the initiative to change the way something is done. Staff at each site meets one Wednesday a month, when they close the practice for the morning. They report that this amount of time is never adequate, especially if they are going to be training provider staff on a new protocol. In those cases, whoever is presenting the training will do a formal presentation at each of the three sites during lunches. On a more individualized basis, the teams that take care of children with chronic health care needs try to meet together after each team-directed care clinic to discuss the children they have just seen. The social workers meet weekly as well.

*Guilford Child
Health, Inc. Continued*

Financing: GCH is mandated to care for all children in the county at or below 200 percent of the federal poverty line. Approximately 86 percent of their patients receive Medicaid, 6 percent have Health Choice (the North Carolina Children’s Health Insurance Program, or CHIP²), and the rest is a growing population of uninsured children, made up almost entirely of undocumented immigrants. They are not allowed to close the practice to new patients, and currently they use county funds, approved by the county commissioners, to pay for the child health clinic to supplement what Medicaid doesn’t cover and to allow them to care for uninsured patients. As with other private practices, they will bill when they administer developmental assessments (code 96110). They cannot do this with screenings administered as part of regular check-ups, because in North Carolina payment is bundled for all aspects of the well-child visit provided as part of Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program³. However, if a social worker administers a secondary screen or assessment, it can be billed using a therapy code. For example, if a child has an at-risk score on the Ages and Stages Questionnaires in the Personal-Social domain or if the parent or caregiver has a concern in that area or there are risk factors such as maternal depression, domestic violence, or substance abuse issues, then the Ages and Stages Questionnaires Social-Emotional is administered. GCH has on staff a finance director, an accountant, two certified coders, and two people doing charge entries. GCH is the recipient of a Health Resources and Services Administration (HRSA) grant for development of a community web-based system for the community care network of which they are part (this includes multiple practices and agencies, not just GCH).

² CHIP is a federal program designed to provide funding to states to deliver health insurance to children in families with incomes too high to qualify for Medicaid but too low to afford private health insurance.

³ EPSDT is Medicaid’s child health program for children ages 0-21. Under EPSDT, all children must receive screening services, which include a comprehensive health and developmental history.

Hagan and Rinehart Pediatricians

Burlington, VT

HAGAN & RINEHART (AT-A-GLANCE)		
Site Description	Staffing/Staff Development	Financing
<p>Large, suburban pediatric practice committed to providing comprehensive and compassionate care for children and families that is family-centered, culturally competent, and readily accessible.</p> <hr/> <p>3,000 patients Majority Caucasian Small influx of Bosnian and Russian immigrants 20% with special health care needs</p>	<p>2 Pediatricians 2 Nurse practitioners 16 Staff (part-time nursing and administrative)</p> <hr/> <p>Monthly staff meetings Bi-weekly Medical Home Updates, care conferences to discuss special needs for care Annual conferences on family-centered care and parent-to-parent training</p>	<p>Private insurance (70%) Medicaid (20%) Self-pay (10%)</p>

History and Mission: In 1991, Dr. Joe Hagan left a larger practice to start a small pediatric practice with one office manager and one nurse. The practice expanded with the addition of another pediatrician Dr. Jill Rinehart in 1999 to form Hagan and Rinehart Pediatricians. The pediatricians, nurse practitioners, nurses and staff of Hagan and Rinehart Pediatricians, PLLC, are committed to comprehensive and compassionate care for their patients and families. They feel this will be achieved with care that is family-centered, culturally competent, and readily accessible to the families of the Burlington community.

The practice is committed to the medical home model. Dr. Rinehart was on the American Academy of Pediatrics' original Medical Home Committee and helped write the original policy statement in support of medical homes. Their practice addresses the standard AAP definition directly, providing care coordinators and "24/7" accessibility for their patients and their families.

Hagan and Rinehart have also developed a unique relationship with the Lund Family Center, a residential substance abuse treatment program for women and young children, located "just up the hill" from the practice. Many women come to Lund pregnant, and it may be the first time they are receiving prenatal care. Their children up to age five can be served residentially at Lund with their mothers. Since there is a pediatrician on-site at Lund only every other week, Drs. Hagan and Rinehart become many of the children's primary care providers. This relationship is

*Hagan and Rinehart
Pediatricians Continued*

long-standing, and so the nursing staff at Lund coordinates with the staff at Hagan and Rinehart to determine what services a child needs and what basic information the Lund mothers need to know before they call a doctor. The staff at Lund truly views Drs. Hagan and Rinehart as an extension of their team. When issues arise at Lund such as the recent case of a residential toddler who was sexually abused and having multiple acting-out issues, staff at Lund will often invite one of the pediatricians to meet with the residential mothers to discuss appropriate behavior as well as strategies for supporting the mother and child dyad.

Setting and Population Served: The practice currently has approximately 3,000 patients; the vast majority is Caucasian and a small percentage are immigrants from Bosnia and Russia. Approximately 20 percent of the patients have been identified with some form of special health care needs.

Staffing and Staff Development: Hagan and Rinehart now has a total of 16 staff members, including the two doctors and two nurse practitioners. They are open from 8:30 A.M. to 5:00 P.M., Monday through Friday, with one of the two doctors on call every night, in keeping with a medical home model. While there are no well visits scheduled for weekends, the doctors will see sick patients in the office on weekends.

Staff development is conducted during monthly staff meetings, as well as through care conferences on Monday and Wednesday. At the monthly meetings, there is always a medical home update to talk about children with special health care needs that are new to the practice. The care conferences are designed for families with children with special needs who are served by multiple providers, and they function as occasions for updates and problem solving. Family members and providers attend the care conferences. Staff members also attend annual family-centered care and parent-to-parent conferences.

Financing: The majority of the patients at the practice pay with private insurance, with less than 20 percent on Medicaid and approximately 10 percent pay-as-you-go.

Healthy Steps Fresno, CA

HEALTHY STEPS FRESNO (AT-A-GLANCE)		
Site Description	Staffing/Staff Development	Financing
<p>Large, urban hospital medical center draws from surrounding suburban and rural areas “to provide the best clinical services” and train pediatric residents, using Healthy Steps program to support training and provide developmental services.</p> <hr/> <p>9,000 patient capacity at Children’s Health Center 220 client capacity for Healthy Steps program 97% Medicaid or no insurance 80% Latino (50% monolingual Spanish)</p>	<p>1 Mental health professional 1 Child development specialist 30 Pediatric residents in training</p> <hr/> <p>Pediatric Residency Training Program: Weekly didactic training Daily experiential activities including home visits, tandem visits with pediatric resident and Healthy Steps specialist, and individual coaching and consultation</p>	<p>Medical Center Services: Medicaid (97%) Self pay (very few) California Children’s Services for indigent families</p> <p>Healthy Steps Services: First 5 Fresno Grant, Children & Families Commission of Fresno County</p>

History and Mission: Healthy Steps in Fresno, California, is based in the Children’s Health Center at University Medical Center, which is affiliated with the University of California San Francisco (UCSF) School of Medicine Fresno Pediatric Residency Training Program. Residents are post-graduate doctors learning the specialty of pediatrics. Fresno Healthy Steps is in its third year of operation as a replication site for the national Healthy Steps for Young Children program, which was originally designed to address gaps in developmental and behavioral care for children ages birth to three. The results of the three-year national study by the Commonwealth Fund inspired and guided the implementation of the program within the Fresno Pediatric Residency Training. The intent of the Fresno model is to deliver high quality care to families and children and at the same time train pediatric residents in a behavioral and developmental approach to early childhood health care. The Healthy Steps specialist provides direct services by working with the pediatric resident during well-child care visits, making home visits, completing developmental assessments, providing telephone support, offering written materials aimed at prevention and promotion to families, offering parent groups, linking families to community resources, and implementing Reach Out and Read. The Healthy Steps specialist has expertise in prenatal care, child development, parenting, and prevention and provides didactic and experiential training to the pediatric residents.

*Healthy Steps
Continued*

Setting and Population Served: Healthy Steps in Fresno is part of the Children’s Health Center at the University Medical Center. The Children’s Health Center serves approximately 9,000 patients per year from the city of Fresno, the city’s suburbs, and the surrounding county, which is rural and agricultural. The community includes a large number of Latino and Mexican Spanish-speaking families. Healthy Steps currently serves about 150 first-time mothers and families, prenatally and until the children reach four years old. The program expects to reach its total capacity of 220 in spring 2006. The guidelines for enrollment in Healthy Steps are:

- Families who have or plan to have pediatric care at the Children’s Health Center;
- Priority to babies born to first-time mothers and/or first-time fathers;
- Enrollment on or after 35-weeks gestation; and/or
- Enrollment at the newborn exam or after, as space allows.

Referrals to the program are received through three program partners: Comprehensive Perinatal Services Program, the Fresno Community Hospital labor and delivery service, and newborn exams at the Children’s Health Center.

Staffing and Staff Development: The program is staffed by a clinical social worker who is the Coordinator of Developmental and Behavioral Pediatrics with UCSF Fresno Pediatric Residency Program and Co-primary Investigator of the Healthy Steps grant; the Healthy Steps specialist with the Children’s Health Center, University Medical Center; and an evaluator. The Healthy Steps specialist and the pediatric residents deliver the majority of the services. Roughly 30 residents participate in the three-year Residency Training Program. Residents operate in Continuity Teams, which include seven or eight residents, a nurse practitioner, and an attending faculty in charge. Residents are assigned a panel of patients, and each resident has between eight and ten Healthy Steps patients/families that they follow as part of that program. Residents act as a child’s primary pediatric care provider for the duration of their training.

Within the larger scope of the pediatric residency program, training for pediatric residents includes didactic and hands-on training under the guidance of the Healthy Steps specialist. Specifically, one morning a week is dedicated to lectures on child development,

videos, and observations of children at the Huggins Child Development Center in the Department of Education at Fresno State University. Residents also accompany the Healthy Steps specialist on prenatal home visits and operate as a team for all well-child care visits.

Financing: Healthy Steps is grant funded through First 5 Fresno, the early childhood health, education, and support services initiative within the Children and Families Commission of Fresno County, California (<http://www.first5fresno.org/contactus.htm>). The program is entering its third year of operation. The total grant funding is \$151,163 per year for a total of three years. None of the Healthy Steps services is currently billed to any insurance plan.

High Point Medical and Dental Clinic *Seattle, WA*

HIGH POINT MEDICAL AND DENTAL CLINIC (AT-A-GLANCE)		
Site Description	Staffing/Staff Development	Financing
<p>Large, urban family practice community health clinic dedicated to “partnership with families” and “100 percent access and 0 percent disparities.”</p> <hr/> <p>8,000 patient capacity 78% Below poverty line 30% Caucasian 21% African American 2% Am. Indian/Alaska Native 21% Asian/Pacific Islander 17% Latino 9% Other</p>	<p>7 Family practice teams: physician or physician’s assistant; nurse, and medical assistant 6 Dentists 8 Dental hygienists 1 Behavioral health specialist 2 Behavioral health interns 1 Chemical dependency provider (on-call) 1 Health educator 1 Social worker 1 Midwife (with 5 additional on-call) 3 WIC program staff 1 Referral coordinator 1 Health service’s coordinator 3 Interpreters 1 Program manager Other administrative staff</p> <hr/> <p>Existing meetings for training as needed Consultation and coaching Balint Group, peer support and case consultation for physicians Learning conversation, personnel review</p>	<p>Medicaid Community Health Plan (Healthy Options, CHIP, and Basic Health Plan) State DHSA, Alcohol, Drug Treatment Services Act funds Self-pay, sliding scale Foundation funds (supplement unreimbursed health care) Kids Get Care, Community Access Program Grant (HRSA) Public Housing Primary Care Grant (HRSA)</p>

*High Point Medical
and Dental Clinic
Continued*

History and Mission: High Point Medical and Dental Clinic is a community health clinic and part of a network of Puget Sound Neighborhood Health Centers (PSNHC), a private, nonprofit organization providing health services in central and west Seattle, Washington. This network includes three school-based Teen Health Centers, two Wellness Centers, and seven community clinics, including High Point. The mission of PSNHC is to provide community-based medical and dental health care services to people of all ages and ethnic backgrounds throughout Seattle and King County. At High Point Medical and Dental Clinic, individuals and families are perceived as partners and part of the health care team, with services guided by the goal of “100% access and 0% disparities.” High Point provides a range of primary care health services in a family practice model, including: prenatal, delivery, and midwifery services; newborn care, well-baby and well-child care; social work services; mental health and substance abuse counseling services; health education programs; pharmacy and laboratory services; and Women, Infants, and Children (WIC) services. High Point’s Dental Clinic serves children under the age of 19 and pregnant women. The adult dental care practice is limited to residents of the community or patients at High Point Medical Clinic.

Setting and Population Served: High Point Medical and Dental Clinic is located in West Seattle in a culturally and linguistically diverse community. Residents and High Point patients speak more than 30 languages, and many of them are new immigrants and young families—most of whom are low income and many of whom are indigent. The neighborhood is in transition from an urban center with old public housing high-rises to one of newly constructed mixed housing facilities. High Point Medical and Dental Clinic has recently moved to a new building with modern and welcoming features, including state-of-the-art dental facilities. High Point is next-door to the public library, which is also new, and residential buildings surround both. Public transportation is available, with a bus stop at the curb by the clinic. The clinic hours are 8:00 A.M. to 6:00 P.M. most weekdays and 9:00 A.M. to 2:00 P.M. on Saturdays, with after-hours telephone support available.

Staffing and Staff Development: High Point Medical and Dental Clinic is staffed by seven family practice teams; each team includes a physician or physician’s assistant, nurse, and medical assistant. Other staff include one full-time behavioral health specialist

(employed by Highline Mental Health Center but on-site at High Point); a midwife, health educator, and social worker for maternal support services; six dentists and eight dental hygienists; three full-time, certified medical interpreters; a program manager; a referral coordinator; a health services coordinator; and other administrative support staff. A chemical dependency provider, who is located at the Rainier Park Clinic within the PSNHC network, is available and on-call for consultation and intervention.

High Point has had a long-standing agreement with Highline Mental Health Center, a community-based behavioral health services provider. A staff member from Highline has been co-located at High Point for a number of years to provide outpatient services. In 2003, High Point applied for and received a Kids Get Care grant funded by a Health Resources and Services Administration (HRSA) Community Access Program to promote integrated health, dental, and behavioral health for children from birth to five years and their families. With additional funding from the Washington Dental Association, High Point expanded these efforts to focus on oral health and community education. The combination of these grants and carry-over funding enabled High Point to partner with Highline Mental Health Center and engage the current, full-time, on-site behavioral health specialist. For the past year, two marriage and family therapy interns have expanded these services under the supervision of the behavioral health specialist.

Staff development activities include periodic training events; regular staff meetings; physician participation in a Balint group (a facilitated, peer group learning process in which a member of the group presents a patient case situation, and then the group discusses the doctor/patient relationship); consultation and coaching; and support and/or funding for individual professional development. Although no formal staff development plan is in place, specific training related to behavioral health issues have included the King County Health Department's Kids Get Care "Red Flags" Tools training on early child development (including social and emotional aspects) and an in-house de-escalation training focused on how to calm and respond to an individual who is in crisis. The primary mode for staff development related to behavioral health issues is through consultation and coaching.

*High Point Medical
and Dental Clinic
Continued*

Financing: PSNHC is a recipient of a HRSA Public Housing Primary Care (PHPC) grant support program and services delivery. The PHPC program is a federal grant program created under the Disadvantaged Minority Health Improvement Act of 1990, reauthorized in 1996, to provide accessible comprehensive primary care and supportive services in order to improve the overall health and well-being of the public housing community and to eliminate health disparities. In addition, primary care and dental care services are billed to Medicaid and Community Health Plan coverage (Healthy Options, CHIP, and Basic Health Plan). Patient fees for self-pay patients operate on a sliding scale. Un-reimbursed medical care is supplemented by foundation funds. Patient representatives on staff are available to assist patients and families with eligibility and application for medical coverage as well as housing, transportation, and child care assistance. Medicaid changes at the state level and the need to qualify for special “coupons” have made access to coverage for mental health and substance abuse services challenging. Although historically the co-located services of the Highline Community Mental Health Center staff member, prior to this grant, billed Medicaid for services for those who qualified, behavioral health services are not billed at this time. High Point and PSNHC are developing the administrative and supervisory infrastructure to bill for behavioral health services as well as to continue to make them available to those ineligible for coverage. The Kids Get Care grant awarded in 2003 has paid for the behavioral health specialist’s services, but this funding ended in 2005. Because administration and health care providers at High Point have high value for integrated behavioral health services and its contribution to the quality of primary care services, HRSA grant funds and portions of the primary care and dental health services budgets have been dedicated to maintain the behavioral health specialist’s position as an interim funding mechanism.

Hope Street Family Center

Los Angeles, CA

HOPE STREET FAMILY CENTER (AT-A-GLANCE)		
Site Description	Staffing/Staff Development	Financing
<p>Large, urban community-based family services center affiliated with Catholic Health Care West's California Hospital Medical Center, offering multiple co-located programs, including Early Head Start (EHS)</p> <hr/> <p>Hope Street Family Center serves more than 2000 clients in all programs Early Head Start program serves 152 pregnant women and children birth to three 95% Latino</p>	<p>Early Head Start program staff include: 1 Program director 2 Mental health professionals: social services and mental health coordinator 1 Health coordinator 1 Child development and disabilities services coordinator 12 Home visitors Classroom teachers and aides Elected policy council</p> <hr/> <p>Continuous improvement focus through self-assessment, team approach, case conferences, and monthly documentation reviews Orientation training and departmental training, weekly reflective supervision and staff support</p>	<p>Hope Street Family Center funding sources: US DHHS CA DOE LA DCFS LA Prop 10 Commission, USDA, and Crystal Stairs (child care)</p> <p>Early Head Start Program: US DHHS direct award In-kind contributions</p> <p>Community Health Services Partners: Medicaid Healthy Kids Public Private Partnership County MH and EPSDT</p>

History and Mission: Hope Street Family Center was established in October 1992, following the civil unrest that destabilized central Los Angeles. It was intended to create a greater sense of community through the collaborative effort of the California Hospital Medical Center (CHMC), the University of California, Los Angeles, and the residents of central Los Angeles. Hope Street is a multi-service agency dedicated to enhancing the overall development of children, strengthening the economic self-sufficiency and stability of families, and enhancing the community's service delivery system for young children and families. Through its community partnerships, Hope Street provides a comprehensive continuum of on-site educational, medical, developmental, and social services that support children and families from birth through adulthood. The philosophy underlying these efforts is one based on mutual respect, partnership, and an understanding that the community members themselves must guide meaningful community services.

*Hope Street Family
Center Continued*

The Early Head Start Program is one part of Hope Street's comprehensive service array of co-located programs (Los Angeles County Prenatal and Early Childhood Nurse Home Visitation Project, Even Start Family Literacy, Language Enhancement Training, Pico Union Family Preservation Network, Family Childcare Network, and others). Early Head Start is a federal program for low-income expectant families and children birth to age three, focusing on early development and early intervention through early childhood education and family support. The approach is relationship-based, promoting both child and family health and development using personal interaction, trust, and relationship building over time to provide a foundation for all services and supports.

Setting and Population Served: Hope Street Family Center is located on the campus of the California Hospital Medical Center of Catholic Healthcare West in central Los Angeles. The urban setting is one of densely populated housing amidst buildings that are occupied by industrial-related business such as garment manufacturing. According to the 2000 census, the surrounding community, within a small area, is home to 351,734 people, most of whom are Latino (74 percent) and many of whom are new immigrants. There are 34,297 children under five in the community, and most of the children under age five living in poverty are Latino. Hope Street Family Center serves more than 2000 clients through its comprehensive service array. The Early Head Start program currently serves 152 pregnant women and children. One hundred and twenty are served through home-based services, and 32 are enrolled in full-day, center-based care. Ninety-five percent of families receiving Early Head Start services are recent immigrants from Mexico and Central America.

Staffing and Staff Development: Hope Street Family Center staff is employed by the California Hospital Medical Center. The Early Head Start Program has a multi-disciplinary staff of 36, including two full-time, on-site mental health professionals in the roles of Social Services coordinator and mental health coordinator; twelve professional home visitors; a nurse health coordinator; a developmental specialist and child development and disabilities coordinator; classroom teachers and aides; and other administrative and support staff. Health care provider partners located on the same campus include the University of Southern

California (USC) Family Practice Residency Program, CHMC Community Clinic, and CHMC Behavioral Health Clinic. The (USC) Family Practice Residency Program (24 residents and patient capacity of 1000 patients each) partners with Hope Street and the Early Head Start program as a formal part of the curriculum; exposing residents to a model of community based, family-centered care. These residents provide primary care to a number of families at Hope Street during their training. Likewise, the CHMC Community Clinic also serves as the medical home for Hope Street families. CHMC Behavioral Health Clinic is a new partner, opening its doors in April 2005 to offer mental health services funded by the County Department of Mental Health and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) federal matching funds to serve young children and their families. The Behavioral Health Clinic has a bilingual staff of four psychologists, two case manager social workers, and a consulting child psychiatrist, who together have the capacity to serve 100 children.

Staff development is included as part of the Early Head Start program's continuous improvement plan. A Staff Development Plan outlines how Early Head Start staff will be prepared to perform their assigned duties, meet regulatory and licensing requirements, and utilize best practices in providing quality early childhood education and family support services. The staff development plan includes orientation (including specified topics), supervision and staff support, annual performance reviews, and financial support for continuing education. Supervision and staff support include weekly reflective supervision (the practice of meeting regularly with staff members to discuss their experiences, thoughts, and feelings related to the work) for home visitors, interdisciplinary and team case conferences, and case consultation and training by health care partners. The Early Head Start staff is formal partners with USC Family Practice Residents as part of the three-year residency training, allowing exchange of expertise and experience as a learning opportunity. Additional staff development is available through in-service training and training events and conference through the Early Head Start network.

Financing: Hope Street Family Center is funded by grants and contracts from agencies that include the U.S. Department of Health and Human Services, California Department of Education, Los Angeles Department of Child and Family Services, Los Angeles

Proposition Ten Commission, U.S. Department of Agriculture, and Crystal Stairs (child care). The Early Head Start program is supported by federal funds from the U.S. Department of Health and Human Services, with a direct award of \$1,890,990, plus an indirect cost award of \$156,226, for a total grant award of \$2,047,216. In-kind contributions account for \$474,900. Health and mental health services delivered by community partners are primarily funded through Medicaid, Healthy Kids, and Public-Private Partnership (PPP), a collaborative effort between the Los Angeles County Department of Health Services and private, community-based providers who are committed to providing quality health services in a culturally and linguistically appropriate environment to low income and uninsured communities. The CHMC Community Clinic is a Federally Qualified Health Center (FQHC), approved by the government for a program to give low cost health care. Medicare pays for some health services in FQHCs that are not usually covered, like preventive care.

**Mary's Center
for Maternal
and Child Care**
Washington, D.C.

MARY'S CENTER (AT-A-GLANCE)		
Site Description	Staffing/Staff Development	Financing
<p>Large, urban community based-center established "to provide holistic, culturally appropriate services to District residents, with an emphasis on immigrant populations" through multiple co-located services, including primary medical care.</p> <hr/> <p>9, 000 clients served 86% Latino 5% Asian/Pacific Islander 4% African and Middle Eastern 3% African-American 1% Caucasian</p>	<p>Health Care Services: 4 Pediatricians 2 Internists 1 Family practitioner 2 Nurse practitioners 3 Nurse midwives 1 Dentist 1 Registered nurse</p> <p>Program Services: 58 total staff providing social services</p> <hr/> <p>Bi-monthly case reviews Monthly training during lunch or staff meetings</p>	<p>Medicaid CHIP Federally Qualified Health Center funds D.C. Department of Mental Health Federal grants Local grants Local contracts Local foundations Private grants Private donations</p>

History and Mission: The Mary's Center, located in the heart of a largely Latino section of Washington, D.C., started in 1988 in a church basement, funded by the D.C. Office of Latino Affairs. It began in response to a large influx of immigrants from El Salvador

who had come to the United States to escape civil war and who were in need of comprehensive culturally competent services. Maria Gomez, the founder and current president and CEO, originally established the Mary's Center with a staff of ten health care workers to provide prenatal services to pregnant women and home visiting services after the children were born. Additional needs were quickly identified—including pediatric services, family planning services, housing, immigration concerns, services related to domestic violence, mental health services to address depression and post-traumatic stress disorder, and case management—and so as Mary's Center has grown to fill those needs, its mission has broadened considerably. Mary's Center philosophy is to “provide holistic, culturally appropriate services to District residents, with an emphasis on immigrant populations.” This is now accomplished through a multitude of on-site services and programs, all working together towards improving access to primary medical care that addresses the needs of the entire family in a culturally sensitive manner. Mary's Center's combination of medical services, social services, and referrals, which can be accessed from multiple points-of-entry, make it a one-stop shopping setting for families.

Setting and Population Served: Mary's Center now serves a total of almost 9,000 clients: 86 percent Latino, 5 percent Asian/Pacific Islander; 4 percent African and Middle Eastern; 3 percent African-American; and 1 percent Caucasian. Staff is currently seeing an influx of Chinese, Vietnamese, and Ethiopian families. Thirty-six percent of their clients are age 18 and under. The majority of the families served by Mary's Center has an annual income of \$18,000 or less.

Staffing and Staff Development: Staff in the medical clinic includes four pediatricians, two internists, one family practitioner, two family nurse practitioners, three nurse midwives, one dentist, and one registered nurse. The medical clinic is the backbone of Mary's Center, providing medical care from prenatal visits onward. The center is open from 9:00 A.M. to 5:30 P.M. Monday through Friday, and every other Saturday from 9:00 A.M. to 5:00 P.M.. It is also currently open until 8:00 P.M. on Tuesdays, and they are working on expanding those late hours. There is also the Mama and Baby Bus, a mobile services van, which was started with a grant from the March of Dimes. The purpose of the bus was to reach pregnant women who were not yet receiving prenatal care, as

*Mary's Center for
Maternal and Child
Care Continued*

well as to provide dental care for pregnant women and children up to age five. The bus now goes into the community four days per week and now includes health promotion, as well, including HIV screening and pregnancy testing and counseling. Staff from the Mary's Center Bilingual Health Access Project also go out on the bus to help community residents apply for public benefits.

There are 58 staff members on the program side, including nine supervisors and directors. The program side of the Mary's Center also contracts with a psychiatrist and hires four extra staff in the summer for special projects such as child care in the Even Start program and a summer youth employment program.

Staff development is focused on ensuring that the services they provide truly support the entire family. A primary example is the bi-monthly case review process. The case review process recognizes that it is impossible to affect one member of the family without making an impact on others in the family. It is vital to understand the full complexity of issues that exist for the family. In case review, a staff member will identify a family case to present, and then everyone will work together to develop a *genogram* (a schematic representation of a family's medical history) with an *ecomap* (a visual representation of the family in relation to the community, showing the relationships between family members and external systems such as the school, health system, work, and spiritual community) to identify strong, weak, and fragmented linkages. Staff always start by presenting strengths and identifying what is working and what is going well, and that is followed by identifying concerns and challenges. While team review used to be conducted only by social services staff, the pediatric providers have recently started to attend as well, and staff has found that to be very helpful. In case review, mental health issues often come up, which gives staff additional mental health information and allows for impromptu mental health training. Additionally, the health promotions department presents monthly trainings on a "topic of the month." Case reviews are held during lunchtime or during a meeting time on alternate Thursday mornings.

Financing: For its primary care services, Mary's Center receives insurance reimbursement from D.C. Health Care Alliance (Medicaid for single adults) and D.C. Healthy Families (CHIP and Medicaid). It also receives payment as an FQHC. The mental

health program recently became a core service agency through the D.C. Department of Mental Health, so that those services will also now be reimbursed by Medicaid. Additional money comes from federal grants, as well as from local grants and contracts, foundations, private grants, and private donations. Mary's Center was selected by Venture Philanthropy Partners (VPP) in 2004 to be an investment partner. VPP, a philanthropic investment organization that works to help strengthen nonprofit organizations by offering major funding as well as significant management expertise, will be providing strategic assistance in developing an entire outcomes-based system that will utilize existing indicators and databases.

Innovative Approaches Used by Sites: A Synthesis

The eight sites selected for inclusion in this study vary in their approaches to integrating mental health and substance abuse services into pediatric settings. Each draws upon the unique constellation of staffing they have to meet the needs of their client populations. What follows is a synthesis of the successful strategies that the sites have used to operationalize each of the core components studied.

Medical Home

Family-Centered Care

Mental Health, Substance
Abuse and Developmental Screening

Facilitated Referrals

Mental Health and Substance Abuse Services

Cultural and Linguistic Competence

Medical Home

AT-A-GLANCE	
Site	Features and Practices Related to Medical Home
Beaufort Pediatrics	Philosophy of “it’s what a good pediatric practice should be” HRSA’s Medical Home Grant Co-located CSHCN care coordinator
Foster Care Pediatrics	Dedicated to provide on-going care for children in foster care Strength in coordinating role across service systems, including child welfare and court Intensive medical case management
Guilford Child Health, Inc.	Child sees same provider on every visit or provider-team member Team directed care approach for children with chronic illness Co-located specialists for coordinated care
Hagan and Rinehart Pediatricians	Dr. Rinehart on AAP Medical Home Committee for policy Committed to this policy and approach to care Full 24/7 access to health care services Care coordination services Medical Home Improvement Team linked to Center for Medical Home Improvement
Healthy Steps Fresno	Major health care resource in the community Strong referral linkages for continuous and regular care from prenatal and newborn services Pediatric residents serve the family for their entire three-year training experience
High Point Medical and Dental Clinic	Shared vision of integrated care (medical, dental, and behavioral health) Co-located services and one-stop-shopping for health-related care Parents and children have the same provider and see the same provider each time Monitor status of well-child checks to ensure up-to-date on medical and dental Contact “no-shows” or cancellations to provide continuous care Coordinated care and referrals to specialist services
Hope Street Family Center	Affiliated and co-located with Catholic Healthcare West’s California Hospital Medical Center Promote medical home through parent education, community partnerships, and case management support Link families to ongoing source of regular health care Monitor well-child check status and whole family health needs through health records and service plan review Offer prenatal and postnatal home visits Family practice medical resident training program partnership and community clinic linkages Co-located Nurse Family Partnership program
Mary’s Center for Maternal and Child Care	Prenatal, prevention, intervention, and prescription services available Patients see the same provider for care Family support workers provide support, care coordination, and case management

“We understand the concept of you can not treat the child without treating the parents.”

PHYSICIAN

Overview: For expectant families and young children, a medical home offers essential health care support and represents an opportunity for ensuring health and wellness by allowing for frequent observation, as well as the provision of anticipatory guidance, health education, and early intervention. For all of these sites, the notion of medical home is so much a part of how they operate that they almost take it for granted; staff at Beaufort Pediatrics called it “nothing more than what a good pediatric practice should be.” When asked to define their notion of medical home, most sites referred back to The American Academy of Pediatrics’ (AAP) statement, which defines a medical home as an entity that provides care that is: “accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective” (AAP, 2002, p. 184). Some sites such as Foster Care Pediatrics have added on to the definition to meet the needs of their specific population. Since they work exclusively with children in foster care and their families (both foster and biological), they not only have the basic features of a medical home but have also added staff who are experts in the impact of child abuse and neglect on children, as well as experts in the foster care system and its impact on children and families.

Care Coordination: The component of a medical home that could be seen most clearly across all of the sites was that of coordinated care. Almost all sites had created a role of care coordinator, in one form or another. At Foster Care Pediatrics and Hagan and Rinehart Pediatricians, nurses serve as care coordinators (at Hagan and Rinehart, it is only for patients with special needs). For children with special needs, Hagan and Rinehart have implemented a process whereby staff uses a three-point scale to rate the severity of children’s health care needs (this rating system was originally designed with parent assistance). This process ensures that more than one nurse is responsible for children with the most severe needs. In other sites such as Guilford Child Health and the High Point Clinic children and/or families are assigned to a specific team of doctors and nurses that they always see. At High Point, the Health Services Coordinator also reviews the daily schedule of patients, flagging specific follow-up or service concerns for the primary care providers. Beaufort Pediatrics draws much more explicitly from the medical home model established by the AAP, with children co-located with a special health care needs care coordinator funded by the local county health department. In

*Medical Home
Continued*

“I don’t feel like I’m a patient here, I feel like I’m part of the family.”

PARENT

Fresno, the model explicitly uses a Healthy Steps specialist to monitor a child’s and family’s progress, and a pediatric resident is assigned as the primary care provider. At several of the programs, care coordination comes from outside the medical staff. This model tends to be implemented at sites that are more fully integrated with social services. For example, Hope Street Family Center’s Early Head Start (EHS) program is required by Head Start standards to ensure that children have a medical home, are up-to-date with well-child care, and receive health record and service plan reviews for all family members. This core EHS service emphasizes the role of EHS program staff as care coordinators. Hope Street staff work closely with the University of Southern California Family Practice Residency Program and the California Hospital Medical Center (CHMC) Community Clinic, community health care partners on the same campus, which offer primary care services and serve as a medical home to many of their families. Similarly, at the Mary’s Center, family support workers from the co-located home visiting programs track families’ status, along with helping them schedule and keep appointments.

Case Review/Communication: All of these sites have instituted a mechanism for case review, to help ensure that everyone working with a particular child and/or family has the opportunity to communicate and be kept current. The Mary’s Center has a bi-monthly case review process, attended by staff from both the social service programs and the medical clinic. At these meetings, a staff member identifies a particular family, for which the staff work together to develop a genogram and an ecomap, identifying the family’s strengths, as well as concerns and challenges that they need to work together to address. At Hagan and Rinehart, during lunch on Mondays and Wednesdays, the office hosts care conferences for families with children with special needs, who have large teams. The meetings are designed specifically for updates and problem solving. For meetings for school-aged children, school staff attends as well.

“The clinic is an open place for the whole family.”

COMMUNITY
PARTNER

Continuity of Care: Sites have different ways of meeting the other goals of creating a medical home for their patients and families. Hagan and Rinehart, because it is a two-person practice, made an explicit decision to share patients to ensure continuity. Similarly, Hope Street cannot ensure that patients will see the same provider. Instead, they provide education and information to families so that they can establish a medical home and advocate for appropriate services for themselves. Hope Street also works to influence the policy and practices of their community providers so that patients receive quality medical services in the same place over time.

Types of Services Offered: Differences also stem from the fact that these sites offer a different array of services. At Guilford Child Health, many subspecialty services, (e.g., an asthma specialist, a pediatric neurologist, a developmental behavioral pediatrician, and a speech and language pathologist) are co-located. Similarly, Beaufort Pediatrics houses the local Title V Sickle Cell Clinic. At High Point and Mary’s Center, many more social services are co-located. Families are able to sign up for and receive WIC services at both facilities and can participate in such programs as the Even Start Family Literacy Program at the Mary’s Center.

Family-Centered Care

AT-A-GLANCE	
Site	Features and Practices Related to Family-Centered Care
Beaufort Pediatrics	<p>Goal to “ensure that all children are nurtured by parents and community”</p> <p>Identify strengths, assets, and needs of each family</p> <p>Link families to supports</p> <p>Offer diverse family-focused services (e.g., Reach Out and Read, clothing exchange, Pirate Toy Fund)</p>
Foster Care Pediatrics	<p>Offer support and coordination services to birth and foster families</p> <p>Co-location allows “one-stop shopping” for families who have access to other services sponsored by the health department</p> <p>Offer diverse family-focused services (e.g., Reach Out and Read)</p>
Guilford Child Health, Inc.	<p>Committed to serving the “whole child” in the context of family, school, and community</p> <p>Engages family in Ages and Stages Questionnaire and child’s care</p> <p>Offers diverse family-focused services (e.g., Reach Out and Read)</p>
Hagan and Rinehart Pediatricians	<p>Philosophical focus and continued training and education on family-centered care</p> <p>Full 24/7 access to care</p> <p>Parents involved in development of scale for rating special health care requirements</p> <p>Offer diverse family-focused services (e.g., Reach Out and Read)</p>
Healthy Steps Fresno	<p>Serve first-time parents</p> <p>Include mothers and fathers in screening, consultation, and education services</p> <p>Home visits</p> <p>Link families to community supports</p> <p>Offer diverse family-focused services (e.g., Reach Out and Read)</p>
High Point Medical and Dental Clinic	<p>Vision and mission focus on “partnership” with families</p> <p>Family practice model, parents and children have the same provider</p> <p>Midwife model and maternity support services</p> <p>Appointments for multiple family members scheduled together when possible</p> <p>Consumer satisfaction surveys</p> <p>PSNHC Board is 51percent consumer members</p>
Hope Street Family Center	<p>Whole family focus and referral plan</p> <p>Program and services are “family driven”</p> <p>Family members involved at all levels—governance, decision makers for own child, and receiving services</p> <p>Policy Council and Board membership</p> <p>Family education focused on empowerment, self-advocacy, and self-sufficiency</p> <p>Co-located diverse family-focused services (e.g., Even Start, Language Enhancement, Family Preservation)</p> <p>Community health care partners utilize a family practice model</p>
Mary’s Center for Maternal and Child Care	<p>Holistic approach to serving the entire family</p> <p>Family-focused, bi-monthly, multidisciplinary case review</p> <p>Use of genogram and ecomap to identify family strengths, concerns, and challenges</p> <p>Co-location of and communication between adult and pediatric providers</p> <p>Home visiting program for prenatal, postnatal, and family support services</p> <p>Offers diverse family focused services (e.g., Even Start Family Literacy, Teen Program, Phone a Friend, etc.)</p>

“The center provides (a supportive family approach) that helps (parents) become effective parents themselves. The center relieves...barriers to moving forward. When parents are supported, they can focus more on the kids.”

COMMUNITY
PARTNER

Overview: The context of family and the relationship between parents and child are critical to a child’s healthy development. The young child’s well-being is dependent on the well-being of his or her caregivers. Family-centered care supports the whole family by engaging parents as partners in their child’s care, recognizing their strengths and role as decision makers, and empowering them to care for and support themselves and their child. The idea of the family, rather than any one individual, as the recipient of care has become a priority for those setting goals and guidelines for the field of pediatric health care. As Zuckerman (1995) describes it, “The best way of helping children is to help their parents, and the best way of reaching parents is through their children” (p. 759).

Family-Centered Care as Part of Missions and Philosophies: Most of the programs and practices involved in this study have explicitly embraced the notion of family-centered care as part of their core philosophy and mission. Beaufort Pediatrics, in their Bright Futures aim statement, identifies one of their primary foci as “identifying strengths and resources within families.” Hope Street defines its services as “family driven,” and its website explains that “The center employs an ecological approach to service delivery that focuses on both the child and family...” High Point’s mission involves working in partnership with families, and Foster Care Pediatrics considers its clients to be not only the child in foster care, but also each child’s foster and birth families as well.

Climate Created for Families: One way that family-centered care is manifest is by making families feel welcome and comfortable when they visit a practice or a center. At High Point, they stressed that the front desk staff is friendly and engaging, speaks multiple languages, and provides multiple support services and resources. At Beaufort Pediatrics, one mother explained that she and her daughters are always made to feel welcome when they come in for visits, and that doctors take the time to talk and see what’s going on. She referred to “the extra mile they go to [in order] to make you feel good.” One of the doctor’s first questions is always, “What’s going on with you?” directed at the mom in a way that does not feel like prying.

Services Available for Family Members: Moving to a much more concrete level, many of these programs offer services and supports for multiple family members. Perhaps the clearest example of this is

*Family-Centered
Care Continued*

“When families come (to the center), they come with so many issues and so many problems. The word “hope” is what they get here and I wish it was in every community.”

PARENT

at High Point, which is a family practice model. Parents and children receive their health care from the same provider, and appointments are scheduled together whenever possible. At Mary’s Center, although there is separate medical staff for children and parents, all family members can receive medical care on-site (including men, which is a recent change), and adult and pediatric providers share office space to encourage communication and collaboration. Other programs, although not offering medical services to all family members, are co-located with programs and services that are highly valuable to families. For example, Foster Care Pediatrics placement in the health department allows for one-stop shopping for foster parents who need to drop off forms, or talk with social workers. Similarly, Hope Street and Mary’s Center are both co-located with multiple programs and services that are available to family members, depending on their needs and interests.

Information/Education/“Extras” for Families: All of the medical practices involved in this study offer services and supports for families. Beaufort Pediatrics has several wall racks full of informational handouts for families, and they have created Patient Information sheets with developmental data for every visit from the two-week visit up through the five-year visit. Beaufort Pediatrics, Hagan and Rinehart, Foster Care Pediatrics, Guilford Child Health, and Healthy Steps all participate in the Reach Out and Read Program. In many cases, doctors or nurses will also model reading aloud to children for the parents. At Foster Care Pediatrics, the list of “extras” includes the Pirate Toy Fund, which provides new toys for children; stuffed backpacks for new patients provided by the local nurse practitioner association; and quilts from a local “quilt lady” who makes unique quilts for all of the babies who come through the practice.

“I am happy about helping the program (as a parent consumer) and glad to be of help and advance the program, because it has helped me a lot.”

PARENT

Family Involvement in Program Governance: Finally, some programs and practices involve families at the decision-making and governance level. At Hope Street, parents are elected members of their Policy Council. Over half the parents are currently receiving services and the rest are former program clients. They provide input and oversight to the planning and implementation of the EHS program, including community assessment, identifying program needs, hiring of staff, budgetary review, and designing special events. These parents also relate to the Catholic Healthcare West—CHMC governing board to ensure integration of community needs and planning, including planning for health care services from community partners within the CHMC service network. At the Mary’s Center, parents serve on the Patient Advisory Board, and at Hagan and Rinehart, families are recruited to be involved with specific projects. For example, when the practice decided it needed a system to identify the severity level of their patients with special needs, parent partners were identified to help develop the rating system.

Mental Health, Substance Abuse and Developmental Screening

AT-A-GLANCE	
Site	Features and Practices Related to Mental Health, Substance Abuse and Developmental Screening
Beaufort Pediatrics	Preventive Services Prompting Sheet Prenatal Socio-Environmental Inventory (PSEI) Parent's Evaluation of Developmental Status (PEDS) Pediatric Symptoms Checklist (PSC) Connected Kids Vanderbilt Assessment Scale; Modified Checklist for Autism in Toddlers (MCHAT)
Foster Care Pediatrics	Screening by clinical and developmental interview and exam
Guilford Child Health, Inc.	Ages and Stages Questionnaire (ASQ) Follow-up ASQ-SE Pediatric Symptom Checklist (PSC) Edinburgh Postnatal Depression Scale
Hagan and Rinehart Pediatrics	Screening by clinical and developmental interview and exam Telephone contact and screening interview post-partum and again at well-child visits Parent questionnaire in waiting room
Healthy Steps Fresno	Ages and Stages Questionnaire BABES Behavior Checklist Infant Toddler Development Assessment Vanderbilt Assessment Scale; Child Depression Inventory Edinburgh Postnatal Depression Scale
High Point Medical and Dental Clinic	Screening by clinical and developmental interview and exam Health and physical assessment Health forms have behavioral health prompts King County Health Dept. "Red Flags" Tools for developmental screening Patient Health Questionnaire for depression screening
Hope Street Family Center	Registration protocol includes comprehensive social history, health information, and medical records Screening by clinical and developmental interview as well as Giselle Developmental Assessment completed within 45 days of enrollment Family assessment data collected within 90 days of enrollment Ongoing monitoring and reassessment through regular home visits, observation, Desired Results Developmental Profile, and annual Geselle Developmental Assessment Community health care partners use Well-Child Progress Notes prompts, the Staying Healthy Assessment, and the Denver Developmental (as indicated) Community mental health partners use Department of Mental Health Initial, Comprehensive, and Substance Abuse Assessment Forms and the Bayley Scales of Infant and Toddler Development (as indicated)
Mary's Center for Maternal and Child Care	Screening by clinical and developmental interview and exam Denver Developmental Center for Epidemiological Studies-Depression Scale (CESD) Substance abuse screening by clinical interview

“It’s a natural partnership (pediatrician and child development specialist)...it must be incorporated into the curriculum (and practice).

Well trained pediatricians have to understand the role of the developmental and parenting evaluation.”

PHYSICIAN

Overview: Comprehensive screening facilitates early identification of concerns and early intervention to address those concerns for both caregivers and young children. It can also encourage and support conversations about child development, parenting, and ways to strengthen the whole family. The American Academy of Pediatrics defines screening as a “brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment” (AAP, 2001, p. 192). Along with this push towards more developmental screening for children comes the realization that pediatric primary care practices are in a unique position to screen for parental mental health and substance abuse issues as well.

Use of Developmental Screening Tools: Most of the programs and practices studied here have worked at incorporating the use of developmental screening tools into ongoing pediatric care. Five of the eight programs use nationally recognized, normed screening tools for children. For some programs, they are part of a larger program that mandates the use of a specific screening tool. For example, both Healthy Steps and Mary’s Center, with its home visiting program that is part of Healthy Families America, administer the Ages and Stages Questionnaire. At the Mary’s Center, with an almost exclusively Medicaid population, the Denver Developmental II is administered in accordance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines. Hope Street meets and exceeds federal Early Head Start protocols by administering the Gesell Developmental Assessment, initially at each child’s enrollment and then annually after that. In addition, Hope Street implements ongoing assessment using the Desired Results Developmental Profile (DRDP), an observation tool for home visitors and teachers to use with parents to monitor an individual child’s progress and plan intervention, required by California. Community health care partners for Hope Street also use screening tools such as Well-Child Progress Notes with developmental prompts for each visit and the Denver Developmental, if there is a concern. The CHMC Behavioral Health Clinic utilizes clinical interview and evaluation and the Department of Mental Health Initial, Comprehensive, and Substance Abuse Assessment Forms and process for all children and families within two weeks of their initial contact for services. If there are remaining unanswered questions about a young child’s development, clinical staff administer the Bayley Scales of Infant and Toddler Development.

*Mental Health,
Substance Abuse and
Developmental
Screening*

“The best thing about the program is that I know how my baby is growing and the things that she’s supposed to be doing at her age. Some of these things I already knew, but the things that I didn’t know, like what the baby is supposed to be doing at certain ages. It’s weird, sometimes I would think like she was too young to play. And then I tried some of the things and she actually likes to play them.”

TEEN PARENT

Protocols Created On-Site: Some of the private practices involved in the study have designed their own protocols based upon available measures. For example, Beaufort Pediatrics uses multiple screening tools, including the Beaufort Pediatrics Modified Prenatal Socio-Environmental Inventory Form (PSEI), which is a family stress index (Orr, James, and Casper, 1992), the Parents’ Evaluation of Developmental Status (PEDS), and Pediatric Symptom Checklist (PSC). They are also incorporating questions from the Connected KIDS screener, the Vanderbilt Assessment Scale for ADHD, and the Modified Checklist for Autism in Toddlers (M-CHAT) screener. To facilitate use of the screenings, they created a Preventive Services Prompting Sheet (PSPS), which the nurses place in each child’s chart to remind the doctors to administer the screenings. The PSPS is color-coded to identify which screenings should be conducted for which age. The PSPS lists the physical health screenings to be conducted simultaneously with the psychosocial and developmental screenings and indicates which of the preventive services handouts to give out at that visit. It also reminds doctors to ask about whether the family has a home visitor or case manager and if the family is involved with any other community programs such as Early Head Start or BabyNet (i.e., South Carolina’s early intervention program for infant and toddlers, or Part C).

Using the Clinical Relationship for Developmental Issues:

Programs that do not use formal screening instruments have implemented less formal ways of flagging developmental concerns. At Foster Care Pediatrics, delays are so prevalent that they find little value in using a screening tool. Sixty percent of the children they serve under age five have a delay, making them eligible for early intervention/special education services. Their staff is all very knowledgeable about child development and therefore asks foster parents specific questions about cognitive, motor, and social-emotional development. They have an unwritten rule that no one should ask a global question such as, “Do you have any concerns about your child’s development?” because much more specific, focused questions are necessary. In fact, a full 80 percent of their patients are referred for early intervention and special education evaluations. Similarly, at High Point, the staff undergoes Developmental “Red Flag” Tools training, with prompts on the health and physical forms for specific developmental issues.

“While you assess the child’s development, you also assess the parenting skills, then you intervene and assess the plan.”

PHYSICIAN

Use of Adult Mental Health Screening Tools: In the area of mental health for parents, those programs that use formal screening tools most often use them to detect depression in caregivers. The Mary’s Center screens all pregnant women using the Center for Epidemiological Studies-Depression Scale (CESD). As part of an ongoing research study, women who score above 16 on the CESD are administered a tool to determine if they currently meet DSM criteria for major depression. This two-stage process allows the Mary’s Center to identify those pregnant women at high risk for depression as well as to refer women who are currently depressed for mental health treatment services. Beaufort Pediatrics includes the two-item depression screening tool as well as questions in the PSEI that address domestic violence and/or substance abuse by partner and self. Guilford Child Health uses the Edinburgh Postnatal Depression Scale to screen for maternal depression at two- and four-month well-child visits, and some residents in the Fresno Healthy Steps program use the Edinburgh. Some but not all medical teams at High Point have implemented a chronic disease management strategy to inquire about symptoms of depression. This strategy has adults respond to three or four questions about symptoms of depression prior to their medical appointment, which will then be addressed during the visit with their primary care provider. None of the programs studied here used a standardized tool to routinely screen caregivers for substance abuse.

Using the Clinical Relationship for Adult Mental Health and Substance Abuse Issues: As with developmental concerns, some programs rely on their clinical relationship with parents to conduct less formal screening. At Hagan and Rinehart, all families with newborns receive a call within two days of being discharged from the hospital, and, during that call, nurses specifically ask about breastfeeding concerns and screen for maternal mental health. Then, at the baby’s first office visit within the first week, doctors ask about postpartum depression and discuss “baby blues”; this is part of the protocol used to document the initial visit. Those programs that reported screening for substance abuse in adults relied almost exclusively on clinical interviews or health and physical examination, rather than on a formal screening instrument, to gather this information. Mary’s Center screens women informally for substance abuse during intake. Hope Street, High Point, and the Mary’s Center all rely on clinical skills and a relationship-based model to probe for additional behavioral health issues.

*Mental Health,
Substance Abuse and
Developmental
Screening*

Choosing Parent-Completed Surveys: Most programs and practices have adopted the model of having parents fill out the screening tools while they are waiting for the doctor in the exam room. For example, Hope Street's community health care partners utilize the Staying Healthy Assessment, a parent completed survey to address psychosocial and preventive health care concerns so that health care providers can identify and prioritize issues to be addressed during well-child visits. Doctors find that having parents complete the screenings can start conversations by presenting issues that parents might not have felt comfortable introducing without prompting. Completing the screening is also an implicit consent to screening, following Substance Abuse and Mental Health Services Administration's (SAMHSA's) guidelines for screening, which call for recognizing that parents are the ultimate experts and decision-makers for their children (U.S. Department of Health and Human Services, SAMHSA, 2005).

Facilitated Referrals

AT-A-GLANCE	
Site	Features and Practices Related to Facilitated Referrals
Beaufort Pediatrics	Strong working relationships with local specialists, BabyNet (Part C Program), and medical centers for health care
Foster Care Pediatrics	Written referral provided to client/family with case management support services
Guilford Child Health, Inc.	On-site case management staff act as community liaisons and facilitate referrals Participate in the Mental Health/PCP Integration Initiative
Hagan and Rinehart Pediatricians	Care coordination services Partnership with community service providers Regular communication with patient permission
Healthy Steps Fresno	Regular contact with families—in-office, home visits, and telephone—to support referral and follow-up Resource directory used by whole pediatric practice Directory of 50 providers with managed care mental health Referrals to Westcare Comprehensive Alcohol Program
High Point Medical and Dental Clinic	Flexible schedule and easy access to Behavioral Health Specialist “Meet and Greet” opportunities with behavioral health specialist and primary care provider Behavioral health specialist makes referrals and supports client access Nurses make immediate medical referrals Full time referral coordinator makes less urgent medical referrals Chemical dependency provider makes referrals and supports client access
Hope Street Family Center	Home visitors provide assistance and case management services Accompany families to appointments providing transportation, advocacy, cultural bridging, and interpreter services when necessary Strong community partnerships and “shared responsibility” for families in the community
Mary’s Center for Maternal and Child Care	Referrals for specialized services Staff support and follow-up to patient

Overview: Facilitated referrals help families to access resources and supports that can promote health and wellness, child development, and intervention to benefit both caregivers and the very young child. The use of facilitated referrals has been identified as a key component of a true medical home. These referrals do not merely involve providing a family with the name of a community-based provider, but rather occur within the context of ongoing relationships to ensure that the referral is a good fit for the client and to ensure that the primary care provider receives information back from the referral provider. This involves relationships between

Facilitated Referrals
Continued

“Once we refer...the primary care person will check in with them. We have providers that will go out of their way (to communicate with the community provider). It’s a big challenge and everyone has to change...(from the tunnel vision that gets in the way... of (sharing information).”

BEHAVIORAL
HEALTH
SPECIALIST

the family and the primary care practitioner, as well as between the primary care practitioner and the community-based provider. This process bridges service systems, mediates cultural and linguistic differences, and supports understanding of the individual child and family. Facilitated referrals increase the likelihood of follow-up as well as improve the match between families’ needs and services provided.

Tracking Available Referrals: The programs and practices involved in this study make referrals for medical specialists and a broad range of other services such as housing assistance. At the most basic level, many of the practices have put in place mechanisms for keeping track of resources that are available in the community for their patients. For example in Fresno, Healthy Steps has a resource directory used by the whole pediatric practice that lists local social services, as well as private mental health providers who accept MediCal. Hagan and Rinehart recently completed a summary of resources in their community and put it on their computer system for all nurses to access. This is especially useful for the nurse who is working phone triage.

Community Relationships as the Basis for Referrals: Referrals also operate at varying degrees of formality. Many of these programs and practices spoke of the value of being deeply entrenched in the community so that referrals happened almost automatically. At Hope Street, twenty-six Memoranda of Understanding represent the committed and formal working relationships and purposeful collaboration among Hope Street and their community partners. Staff also spoke of strong community relationships that they have formed as a result of being seen as a reliable and capable resource by these same partners. Hagan and Rinehart staff also spoke of having strong connections to the community and having a sense of who is taking new patients at any given time. At Foster Care Pediatrics, the staff reported that “everybody knows we’re here.” As a result, their charts are voluminous—with information on each child constantly flowing in and other community resources open to referrals from them. Guilford Child Health has community liaisons keeping track of providers in the community who are currently accepting patients and who accept Medicaid.

“We are all part of the health care community and we interact all the time. I think that’s the key. We refer back and forth, are collaborative back and forth, on a wide variety of projects and stay very connected.... We all feel part of this fabric in the community and we’ve been able to weave together the relationships.”

COMMUNITY
MENTAL HEALTH
PARTNER

Feedback from Referrals: As for feedback after the referral, that also occurred with varying degrees of formality and regularity. The first step after the referral is ensuring that the patient actually made it to the referral. The programs co-located with social service programs tended to have better mechanisms in place for accomplishing this step. At Hope Street, staff will transport, translate, and advocate for clients, and at times actually accompany children and parents to appointments, when appropriate. Similarly, family support staff at Mary’s Center follow-up to ensure that clients have actually attended appointments. The next step is getting feedback from the referral providers themselves. Again, some places had formal mechanisms for achieving this. At Beaufort Pediatrics, whenever a patient is referred to a large medical center (in Charleston or Savannah), the practice receives clinic notes. Hagan and Rinehart foster relationships with community mental health providers such that they routinely share relevant information after visits (with permission from the family). At Foster Care Pediatrics, one agency routinely conducts all of their mental health intake evaluations and then provides reports to both the practice and to the individual child’s caseworker.

Building In-House Capacity: Foster Care Pediatrics’ excellent working relationship with its community mental health agency was one of the few examples of this type of collaboration. In fact, in several of the sites studied, it was the inability to make facilitated referrals to community mental health providers that led to the creation of on-site mental health services. Mary’s Center, Beaufort Pediatrics, and Guilford Child Health all specifically cited this frustration as the impetus for building in-house mental health capacity. Staff at Guilford Child Health cites the co-location of mental health providers as crucial to their ability to make facilitated referrals and follow-up after screening tools are administered.

New Directions for Facilitated Referrals: Frustration also led Guilford Child Health and their community partner Partnership for Health Management (P4HM) to participate in the pilot phase of the Mental Health/PCP Integration Initiative. As part of the pilot, participating doctors and mental health providers have agreed to complete a summary form on a specific patient to provide basic information about diagnosis, medications, major medical concerns, and other providers the patient might be seeing.

Mental Health and Substance Abuse Services

AT-A-GLANCE	
Site	Features and Practices Related to Mental Health and Substance Abuse Services
Beaufort Pediatrics	On-site licensed social worker offers services to families and children
Foster Care Pediatrics	Advocates for the mental health needs of children in foster care Local agency partnerships: Strong Child and Adolescent Psychiatry, provides mental health evaluations; an on-site therapist from Mt. Hope Family Center at University of Rochester provides services; and foster parent support group run by psychologist Peer-to-peer supports for foster parents
Guilford Child Health, Inc.	On-site mental health services providers: 4 licensed clinical social workers for short-term and crisis therapy, 1 child psychologist for longer term intervention
Hagan and Rinehart Pediatricians	Partnership with Lund Family Center residential substance abuse treatment program for women and young children Mental health consultation and intervention provided by 6 local psychiatrists
Healthy Steps Fresno	Screening and anticipatory guidance at each visit Parent education about child development: parent groups, telephone support, handouts, and newsletters Home visits with developmental focus Referrals to mental health and substance abuse providers Behavioral Health Clinic, on-site mental health consultation and services Linkages to: private MH providers, Westcare Comprehensive Alcohol Program for expectant mothers
High Point Medical and Dental Clinic	On-site behavioral health specialist, available for “meet and greet” crisis counseling, and short-term intervention On-call chemical dependency provider available for “meet and greet,” crisis counseling, and short-term intervention Partnership with Highline Community Mental Health Center Linkages to youth and family services, detox services; Swedish Hospital 28 days residential program for expectant mothers; local AA meetings
Hope Street Family Center	Relationship-based approach to service delivery Comprehensive family support model that emphasizes social and emotional prevention, promotion, and intervention through “non-traditional” mental health services On-site mental health professionals (2 FTE) who can provide clinical assessment, crisis and short-term (3-6 sessions) services Home visitors make weekly visits Referrals to community-based mental health and substance abuse services when indicated Referrals to early intervention and special education services
Mary’s Center for Maternal and Child Care	On-site mental health services, which provide intensive assessment, diagnosis, community support, and treatment to clients who are eligible (live in D.C. and have no insurance or D.C. Healthcare Alliance) Services provided by 1 Licensed professional counselor, 1 licensed graduate social worker, and family/community support workers Psychiatrist on-site for 4 hours/week

“One of the best things (about having the behavioral health specialist on-site) is they can step in and consult with me. I am more willing to deal with the behavioral health issues. I am more willing to ask about behavioral health issues, because I can do something.”

PHYSICIAN

Overview: Behavioral health services for young children and their caregivers include a wide array of mental health services for either the child or a member of his/her family, as well as substance abuse services provided to caregivers.

On-Site Mental Health Services: Multiple programs and practices in this study integrated on-site mental health services: Hagan and Rinehart have a child psychologist in their office three days/week; Guilford Child Health has four licensed clinical social workers on-site, as well as a child psychologist; and Beaufort Pediatrics has a mental health counselor (who is a MSW social worker) on site 13 hours a week. This practice is especially prevalent in programs that also offer social services. Mary’s Center has four mental health professionals on-site. Hope Street has two full-time, bilingual, bicultural mental health professionals on-site who supervise home visitors, support the delivery of behavioral health supports to families during home visits, provide some direct services, and link families to co-located as well as community-based programs that provide mental health services. For example, Hope Street Family Center is also home to a Family Preservation Program that includes family intervention, anger management, parenting, and domestic violence group work. Healthy Steps works collaboratively with the Medical Center’s on-site mental health therapist to address specific needs of families as they arise at the pediatric residency clinic, the Children’s Health Center. High Point has a full-time behavioral health specialist on-site. All of the sites spoke of the value of having someone on-site for questions, concerns, and immediate mental health services.

On-Site Substance Abuse Services: None of the sites had on-site staff specifically devoted to substance abuse issues in caregivers. However, at High Point there is a chemical dependency provider who is shared by Puget Sound Neighborhood Health Centers and is on-call and can be at the site within 15 minutes.

Partnerships with Substance Abuse Services Providers:

Alternatively, a number of sites have strong partnerships or close referral linkages with substance abuse services providers. Hagan and Rinehart and the Lund Family Center have created a strong relationship in which the pediatricians serve as primary care doctors and in many cases developmental specialists for mothers in the residential drug treatment program and their young children.

*Mental Health and
Substance Abuse
Services Continued*

Healthy Steps links families to the Westcare Comprehensive Alcohol Program for expectant mothers, and High Point links families to the Swedish Hospital Residential Program for expectant mothers. A number of sites describe challenges to accessing outpatient substance abuse services and shrinking intervention resources in their community, limited culturally and linguistically competent services, and multi-step coverage and eligibility processes as major concerns.

Partnerships with Mental Health Services Providers: Some sites have also built incredibly strong, lasting relationships with off-site mental health providers. Foster Care Pediatrics has forged a partnership with Strong Child and Adolescent Psychiatry, and this agency now conducts all of the intake mental health evaluations, including parenting support in the case of infants and referrals to other community providers when appropriate. Foster Care Pediatrics also has a relationship with the Mt. Hope Family Center at the University of Rochester by which Mt. Hope placed a therapist on-site at the pediatric clinic. She conducts contextual assessments, provides individual child therapy, and works with staff in community settings (e.g., day care) to better manage children's behavior. Hope Street works with the California Hospital Medical Center Behavioral Health Clinic children's mental health program across the street for ongoing intervention services, and High Point maintains its long-standing working relationship with Highline Mental Health Center within the same community.

Communication between Behavioral Health and Primary Care Providers: For all mental health services, whether on-site or off-site, communication is crucial. Many of the sites have formalized procedures for ensuring that communication occurs. At Hagan and Rinehart, the doctors meet with a psychologist and a consulting child psychiatrist for an hour every other Friday morning, discussing patients with mental health issues to identify any questions, problems, or concerns (for example, complex psychopharmacology management). At High Point, when the on-site behavioral health specialist counsels or consults with a family member or young child, formal case notes are color-coded and flagged in the chart or put in the primary care provider's box. In addition, every effort is made to communicate directly, in person, with the primary care providers. When a referral for longer term services is made to Highline Mental Health Center, the behavioral

health specialist, who is an employee of Highline, can complete paperwork to facilitate referrals to and communication with that agency. At Foster Care Pediatrics, the Mt. Hope therapist is at their weekly clinical meeting every Thursday to report on the children she is seeing. Hope Street and Healthy Steps work side-by-side with the pediatric or family practice residents, integrating mental health services and primary care through immediate consultation, communication, and exchange of information.

Support and Information Groups for Parents: A final way that these sites address mental health issues is by hosting support and/or information groups for parents. Healthy Steps in Fresno offers Topical Parent Groups monthly. At Foster Care Pediatrics, staff help match more experienced foster parents with new parents, as well as collaborate with a local psychologist who runs support groups for foster parents.

Cultural and Linguistic Competence

AT-A-GLANCE	
Site	Features and Practices Related to Cultural & Linguistic Competence
Beaufort Pediatrics	1 bilingual staff member
Foster Care Pediatrics	38% staff African-American 1 Asian physician Informal learning regarding cultural influences on parenting, health, and mental health practices
Guilford Child Health, Inc.	Bilingual staff members 1 full-time interpreter ATT language lines in all exam rooms Center for New North Carolinians provides resources to address cultural beliefs and practices related to health; provides training, and interpreter services Offers multi-lingual Reach Out and Read program
Hagan and Rinehart Pediatrics	Provider assignment accommodates patient religious and cultural values Telephone translation services available
Healthy Steps Fresno	Healthy Steps specialist, who is bilingual and bicultural, can provide translation and interpretation as well as cultural consultation and negotiation between pediatric residents and families One-third of pediatric residents are Spanish speaking Hospital has 3 full-time interpreters and others available through local agency
High Point Medical and Dental Clinic	Staffing reflects the diversity of the community Staff members speak 17 languages Full-time, certified medical interpreters Families matched with same interpreter for all visits when possible Signs, forms, booklets in multiple languages
Hope Street Family Center	Staff reflects the diversity of the community Most staff are bilingual and bicultural Staff provide cross-cultural support and act as interpreters when necessary ESL classes provided on-site Family members on Board and Policy Council represent the cultural and linguistic community
Mary's Center for Maternal and Child Care	Bilingual, bicultural staff Cultural competency training for staff and other service providers Recognition of influence of own values in providing culturally competent services Cultural Competency Committee

“Being away from home (Mexico), I must be strong. This is one of the reasons I am coming to (see the behavioral health specialist), I felt myself going down, but now I am stronger.”

PARENT

Overview: Every family, including both immigrant and native-born families, has its own cultural and linguistic background and brings its unique experience, values, and beliefs to being a family and raising young children. The family’s cultural influence on health, growth, and development; child-rearing; family relationships; and sense of community can shape the child’s and family’s health and development—including social and emotional health. Cultural factors can also impact the family’s beliefs about health and wellness, health care and behavioral health practices, and services and supports in the community. Expectant mothers, caregivers, and young children, including recent immigrants as well as those who are undocumented, may be seen frequently in prenatal and pediatric primary care. Culturally and linguistically competent health and behavioral health care services in primary care settings can help ensure access to, engagement in, and timely intervention for young children and their families. (Hepburn, 2004).

Diverse Populations Served and Mission Statements: All but one of the eight sites serve sizeable culturally and linguistically diverse populations. Six sites serve a patient population where diverse communities (African-American or Latino) represent a 45 percent or higher proportion of the patient population. Many of the communities include new immigrants. Hope Street Family Center in Los Angeles and Healthy Steps in Fresno serve an almost exclusively Latino population. High Point Medical and Dental Clinic serves a diverse population in a Seattle community where more than 30 languages are spoken. In keeping with this level of diversity, a number of the sites have incorporated their value and respect for their service community and its diversity in their founding and/or mission statements. For example, Mary’s Center in Washington, D.C., was started in 1988 in response to a large influx of immigrants from El Salvador who were in need of comprehensive culturally-competent services. The service philosophy at the Mary’s Center is “to provide holistic, culturally appropriate services to District residents, with an emphasis on immigrant populations.” At High Point, the work is guided by a motto of “100% access, 0% disparities.” These sites have a high value and regard for serving their communities and designing and adapting services to meet the needs of the culturally and linguistically diverse populations.

*Cultural and Linguistic
Competence Continued*

Being a Presence in the Community: Each of the sites serving a large diverse population has a significant presence in the community. They are known by the cultural community and viewed as an accessible resource. Hope Street Family Center and Mary's Center were built upon a community commitment to serve the Latino population and utilized community and self-assessment information to build service capacity. Other sites have utilized community information to inform and shape their capacity to serve diverse populations. Direct and ongoing family and community input in governance, design, delivery, and evaluation of services are present at Hope Street Family Center. The Mary's Center has a Cultural Competency Committee made up of staff across programs to address issues of cultural and linguistic diversity, the changing community, and building staff and program capacity. Guilford Child Health, Inc. in North Carolina utilizes resources from the local Center for New North Carolinians to incorporate ways to address different cultural beliefs about illness, medications, and treatments and build capacity through training and staff development.

Understanding Cultural Differences: Being conscious of the dynamics of difference requires self-knowledge and vigilant openness to hearing different perspectives. In providing primary care services and addressing behavioral health concerns, most of the sites have described interactions with families that challenge values, risk misunderstanding, and impact health and behavioral health care services because of cultural and linguistic diversity. From the front desk and reception area to the physician's office to labor and delivery to home visits, sites have made some adjustments to be more culturally and linguistically competent. For example, providers at High Point strive to understand cultural health practices and negotiate treatment plans to accommodate both traditional medicine and non-Western medicine. Staff uses interpreters and cultural brokers to convey health care concerns in culturally acceptable ways (such as finding a way to describe depression to an individual whose culture has no word or descriptor for this emotional state) and to encourage taking advantage of an intervention. Other sites, like Hope Street Family Center, have focused on relationship-based intervention in a community and culture—professional home visitors use visits and personal interaction to build trust over time so that families feel understood, can be self-disclosing, and accept recommendations and support to negotiate and access community services that may

“Most of us come from the experience of one or more cultures. We are all bi-lingual and bi-cultural people, and...try to mirror the communities, but we don’t live like our clients do...we are not bi-economic. We aren’t part of the culture of poverty—and we must be sensitive to that and be able to understand that. We learn (about culture and cultural differences) together—from each other and our families...who we see as partners.”

COMMUNITY
CENTER STAFF

be an “out of culture” resource. At Mary’s Center, bilingual and bicultural staff also acts as cultural brokers and helps to negotiate the dynamics of difference by facilitating interaction between providers and families by coaching providers individually or through staff development activities. A number of sites expressed continued interest in building greater cultural knowledge and becoming more comfortable with culturally diverse worldviews and perspectives on health, behavioral health, child development, and family relationships.

Staffing, Staff Development, and Governance: In those sites serving diverse communities, the continuous expansion of cultural knowledge and linguistic capacity takes a variety of forms. Three key strategies are hiring staff that reflects the community, engaging in staff development activities, and establishing formal structures that support institutional expansion of cultural competence. All sites with culturally and linguistically diverse clientele have several staff members who reflect the make-up of the community. Almost all of Hope Street Family Program’s staff members are bilingual in Spanish and English, and most are bicultural. Other sites have a number of staff members who are bilingual in a variety of languages such as Vietnamese, Cambodian, Arabic, and Urdu. High Point Medical and Dental Clinic staff speaks 17 languages across all members. Several sites—High Point Medical and Dental Clinic, Healthy Steps, and Guilford Child Health, Inc—employ full-time interpreters, including those who are certified medical interpreters, for the predominant languages of that community, and use other linguistic supports for less dominant languages such as ATT language lines in offices and/or exam rooms. Staff development activities range from formal training in cultural competence (Mary’s Center and Guilford Child Health, Inc.) to coaching or consulting with individual providers to team meetings (Healthy Steps, High Point Medical and Dental Clinic, and Hope Street Family Center) to “informal learning” (Foster Care Pediatrics). Only two sites, Mary’s Center and the Hope Street Family Center, have identified a formal, internal structure that supports institutional expansion of cultural knowledge and community response. Mary’s Center hosts a Cultural Competence Committee to address cultural and linguistic diversity issues, and Hope Street Family Center’s governing Board and Policy Council have family members in decision-making roles to guide the program’s responsiveness to community cultural and linguistic concerns.

*Cultural and Linguistic
Competence Continued*

Adapting Service Delivery: Service delivery in each site included adaptations to accommodate cultural and linguistic diversity. Some of the key strategies included home visits and relationship-based work, use of interpreters and translators, and facilitated referrals to culturally-based and linguistically appropriate support services. Hope Street Family Center's primary approach in working with families is through home visits and relationship-based work. Home visitors have bilingual and bicultural skills and a sustained, long-term relationship with the family that accommodates the opportunity to convey cultural meaning in ways and at a pace that is comfortable for the family. Facilitating referrals or accompanying families to appointments offers support and can help families negotiate unfamiliar and culturally different circumstances and services. Interpreters and translators are essential to the ability of the sites to serve their families, and their use can be adapted to best meet a family's needs. In response to patient feedback, High Point Medical and Dental Clinic tries to ensure that the family works with the same certified medical interpreter at every visit, especially behavioral health services visits. In this way, they have adapted their practices to support continuity of care and to accommodate cultural and linguistic diversity.

Challenges to Facilitated Referrals: Facilitated referrals, like those noted above in the Hope Street Family Center home visitor practices, are common across sites to some degree. Most sites offered services that can bridge between services and providers, most often trying to link families to those services that can accommodate cultural and linguistic diversity. However, a common challenge across sites is to find resources in the community that can meet these criteria, particularly in the area of mental health and substance abuse services.

What Practitioners Need to Know: Lessons Learned from the Field

Each of the eight study sites were asked to give their advice for other pediatric providers who might be interested in adding these innovative medical home, screening, and facilitated referral strategies to their settings. Respondents were asked to identify key lessons learned in overcoming challenges in integrating behavioral health services into pediatric primary care settings. Suggestions for successful implementation ranged from very broad recommendations such as “never take no for an answer” and “make incremental adjustments rather than attempting a sea change” to more specific advice about billing codes for screening. This section summarizes the key lessons learned from these eight sites.

- **Make comprehensive screening routine in primary care settings.** Respondents emphasized that in order for behavioral health and developmental screening to fit naturally into primary care settings, tools must be selected that can be easily administered and are a good fit with the cultural and literacy needs of the client populations. Staff needs to understand the value of screening in overall health care, establish procedures that support implementation, and maintain a system to integrate screening as a routine process. Effective screening procedures require staff development time to orient and prepare staff to implement screening. In addition to learning how to utilize specific screening instruments, the approach of comprehensive screening—including attention to the mental health and substance abuse needs of parents—requires a shift in mindset, seeing the emotional well-being of the caregiver as a proximal cause of child well-being and health. Although setting aside time is never easy

“The way funding happens...like a patchwork quilt. (We)...are responsible for making sure each patch stays in place, but to the families, they see the seamless blanket. And, whatever services they need, we provide ourselves or find in the community.”

CENTER
EXECUTIVE
DIRECTOR

in a busy primary care practice, many of the sites addressed this through lunch-time seminars or after-hours staff meetings. Strategies and systems related to office management as well as clinical routines that encourage screening also need to be implemented. For example, busy pediatric practices can take advantage of the time spent in the waiting room for families to complete checklists or questionnaires. Other strategies involve incentives that encourage and reinforce nurses and physicians to use the screening tools. A good example of this strategy is Beaufort Pediatrics’ practice of posting of the number of screens that different team members billed for in the last several months on the wall near the color-coded screening tools. This creates “competition” among the providers, reminding and ideally motivating them to conduct the screenings. All respondents reported that maintaining and sustaining comprehensive screening requires billing systems to be in place to recover some of the costs of providing this service.

- **Be innovative in billing.** Several sites have identified the Current Procedural Terminology (CPT) “96110” code for billing Medicaid and private insurance for child developmental screening⁴. Moving beyond innovative coding, many sites articulated concerns that much of their interaction with families is simply not billable. As managed care has shifted pediatric practices to bundled rates and shorter appointment times, many providers find that it is not possible to bill for the additional time spent addressing the behavioral health needs of parents. There is also a growing population of uninsured clients, including but not

⁴There are many resources available from both the American Academy of Pediatrics and the American Medical Association to assist providers in using the appropriate CPT codes for developmental screening and testing. As explained in the American Academy of Pediatrics *Developmental Screening/Testing Coding Fact Sheet for Primary Care Pediatricians* (<http://www.medicalhomeinfo.org/tools/Coding/Developmental%20Screening-Testing%20Coding%20Fact%20Sheet.doc>), the CPT code 96110 is used for limited developmental screening (e.g., PEDS, Ages and Stages Questionnaire), which can be performed as part of preventive services or with other evaluation and management services. These screenings are typically administered by non-physician personnel, so the reimbursement fee reflects expense of office staff and nurses, the cost of the materials, and professional liability. The CPT code 96111 is used for more extended developmental testing (e.g., Bayley Scales of Infant Development), when typically it is the physician or another trained professional who administers the testing tool. For further information, see the American Academy of Pediatrics on-line bookstore section on coding: http://www.aap.org/bst/showprod.cfm?&DID=15&CATID=133&ObjectGroup_ID=795

limited to undocumented immigrant families. Until billing options become consistent across insurers, respondents recommend that practices and programs seek out innovative ways to bill for these services and populations such as seeking additional funding through grants from federal, state, community, or philanthropic organizations that can offer more fiscal flexibility.

- **Ensure that an array of referral sources is available for children and families that screen “high” on developmental or behavioral health screens.** Practitioners acknowledged that screening is irresponsible (and potentially unethical) if there are no services available to families after an area of need has been identified. Respondents said that programs that adopt a relationship-based approach are more likely to understand the types of follow-up services and supports that meet the young child’s and family’s needs. Therefore, it is vital that designated office staff develops strong working relationships with community-based providers to facilitate linkages to responsive and specialized services. Who is taking new clients, the availability of culturally appropriate and bilingual services, hours of operation, and health insurances acceptance are all critical facts needed to ensure that families are connected with appropriate diagnostic and treatment services.
- **Implement a medical home model.** The core constructs of a medical home, when implemented, allow pediatric practices to respond to the needs of children and their families as they grow and develop. Although essential for all children and families, respondents said that the value of a medical home approach was especially apparent among subgroups of clients that present some special needs, when coordinated care can be most challenging. For example, at Foster Care Pediatrics, staff was constantly driven by the knowledge that, for children in the revolving door of foster care, decisions about when and where to move the children rarely ever took into account their medical needs. Foster Care Pediatrics strove to fill that gap, providing services to the children and their foster families. Respondents also emphasized the need for a medical home for children who have ongoing health concerns—whether chronic physical conditions or behavioral health needs. Beaufort Pediatrics co-located a children with special health care needs coordinator, and introduced support groups for parents of children with special needs to attempt to fill this gap for this subgroup of families.

“We are proud of what we are doing and believe it’s pretty effective. When I was asked what I am most proud of (in my work at the clinic), it’s the integration work of primary care and behavioral health.”

HEALTH CLINIC
PROGRAM
MANAGER

- **Whenever feasible, co-locate services.** Co-locating a variety of services and supports to families allows health care providers to more effectively attend to the variety of needs that a family may have. The experiences of the study sites reinforced the value of co-location as a strategy for increased utilization of mental health services. This was particularly true for those sites that chose to have a mental health practitioner on-site. When mental health services are available on-site, respondents reported families are more likely to take advantage of them. Respondents emphasized that not only does co-location increase the likelihood that families will access to behavioral health services, but it can also help reduce the stigma associated with receipt of mental health and substance abuse services. In settings like the Mary’s Center and Hope Street, families can access a broad array of child development, social services, and parenting supports in addition to primary health care and mental health services. The comprehensive, one-stop approach to serving young children and families offers support to the whole family.
- **Don’t forget substance abuse.** While many of these sites were successful in integrating mental health services, there was much less evidence of success in integrating substance abuse prevention and treatment into these primary care settings. Pediatric and family practitioners are beginning to gain more experience in addressing some of the more common mental health condition in parents of young children, but substance abuse prevention and treatment services have not been integrated to the same degree. Given the level of untreated mental health and substance abuse that can occur in families with young children, the integration of highly reliable, brief screening tools (such as the CAGE and AUDIT) can help providers identify those families at highest risk. There are still barriers to overcome such as the historical delivery system split between primary care and substance abuse services, discomfort of primary care providers with issues of substance abuse, and shrinking community resources for substance abuse services.
- **Move from individual-centered care to serving the family as a whole.** When this research project was initially conceived, there was interest in identifying pediatric practitioners who were serving the family as a whole. Most behavioral health care services (including mental health and substance abuse) adopt the view that services need to be targeted to the “identified patient.” In contrast, this project takes the approach that adequate

infant/toddler mental health services require that the health and well-being of young children be considered within the context of their families and other important relationships. In the interviews, many sites embraced this viewpoint of child health and development; however, implementing this philosophy within the current health care system can be daunting. What these pediatric practices have successfully accomplished is approaching service delivery from a family-centered perspective. The next step entails a systematic assessment of the range of families' strengths and risks that may have an impact on a young child's development. Accordingly, this requires changes in the way providers are initially educated and receive continuing training, as well as how services are paid for and organized. It also requires new strategies to engage fathers, grandparents, foster families, and others who are raising young children.

“How do you talk about depression, traumatization, and somatization with a culture that doesn't take advantage of resources focused on mental health?”

NURSE

- **Increase cultural awareness and cultural competence.** Nearly every facet of parenting a young child is influenced by the cultural norms and beliefs of the family, from feeding and sleep practices to strategies used to discipline children. Pediatric providers must be sensitive to the myriad of ways that a family's cultural beliefs may affect the way they are raising their child. Respondents noted that their sites faced challenges in meeting the needs of increasingly diverse populations of families raising children in communities across the United States. Some of these families have emigrated from places where there are different beliefs about health and health care (especially mental health), and these patients may be wary of routine, Western medical procedures. Others may not have health insurance or cannot communicate effectively in English with medical providers. The lack of community-based specialty providers available for immigrant families was also cited as a challenge to implementing facilitated referrals. Respondents addressed these challenges in a variety of ways, from installing ATT language lines in exam rooms to hiring bilingual and bicultural staff to consulting with local immigrant groups. Hiring staff members who reflect the culture of the populations served in the pediatric practice was another successful strategy for bridging some of these gaps in knowledge. Strong ties to the community and community resources are vital, along with a respect for families' beliefs and practices and providing ongoing staff development that supports cultural competence.

“Providers like good systems and there is evidence that this (integrating behavioral health into primary care) will make my practice and my patients better. Behavioral health was a “no-brainer”. Psychosocial and behavioral issues drive the majority of visits.”

PHYSICIAN

- **Be aware of what is happening in the macro-level policy climate.**

All of the sites, because they are community-based, are affected by changes in national policy as well as political shifts in state government. For sites serving large numbers of immigrants, federal immigration policy shifts and changes in eligibility for safety net programs (i.e., Medicaid, WIC, and food stamps) result in loss of benefits to clients and increased unmet needs. At High Point, changes in eligibility have stimulated pursuit of alternative funding (grant and foundations funds) in order to continue to serve those families who may have lost eligibility for Medicaid coverage. Several urban sites cited lack of affordable housing as a concern that affects families’ well being. Practitioners need to be aware of how these changes may have an impact on their families’ resources, needs, and priorities in order to pursue alternative resources or strategies and provide continuity of care. For example, in a shrinking economy with rising unemployment, the Reach Out and Read program in a pediatric office may become even more vital, as families cannot afford to purchase children’s books.

- **Use data to advocate for services.** Many of the sites were well versed in the recent data on the impact of early brain development on children’s later success in life. They understood the linkage between healthy bodies and mental health. Whether it is articulating the link between parental mental health and productivity or early relationships and school readiness, these pediatric providers worked with their community partners to advocate for support to families with young children. Respondents said this is especially important for program sustainability. Often, sites were able to articulate a component of their program that had strong outcome data such as the Home Visiting program at the Mary’s Center, or Hope Street’s Early Head Start program. At Fresno Healthy Steps, which is receiving state early childhood initiative grant funds and continuous support and guidance from the National Healthy Steps for Young Children initiative to implement the Healthy Steps model, funding has been set aside for collecting and reporting impact data. These data are a critical tool in obtaining ongoing, institutional support for innovations and sustainability. However, establishing and maintaining data collection systems remain a challenge.

- **Take chances and experiment with new approaches.** While many respondents cited the challenge of sustaining innovations after a grant ends, there is much to be gained by trying out new

“The provider teams are interested in innovation and doing something different. It’s a big step to say that we are doing the same thing and patients don’t have the outcomes we want to see, so let’s do something different.”

HEALTH CARE
MANAGER

“One of the challenges was that some staff people have a more collaborative mode of interacting than others and some thought that offering services wouldn’t require them to change at all.”

BEHAVIORAL
HEALTH
SPECIALIST

approaches to serving young children and their families. For example, Beaufort Pediatrics implemented group well-child visits for a three-year period in the late 1990s, using grant funds. These Well Baby Plus visits brought together a group of mothers who had children the same age to learn from each other at regular intervals. An array of community-based collaborators from the school system, social services, and health department also attended these group health supervision sessions. There were evaluation data that demonstrated that this change in delivering well-child visits resulted in a range of improved health outcomes—including higher numbers of completed well-child visits, better immunization rates, and some evidence of lower emergency room use (Rushton, Byrne, Darden, and Smith, 2002). However, this modality for delivering pediatric well-child care was not able to be sustained after the grant ended. Similar stories were shared from many of the other sites. And yet the knowledge gleaned from these innovations is now part of the community’s shared history and will certainly be drawn on in the future as different funding becomes available.

- **Be flexible.** Respondents told interviewers that implementing innovative approaches requires flexibility in all staff members who work in a pediatric or family practice, from the front-desk staff to nurses, physicians, behavioral health services providers, and the billing staff. Everyone, in their own role, must value service integration and be willing to change the way they do their jobs, in both broad parameters and in the day-to-day details. Another form of flexibility is required to sustain innovative practices through ongoing staff development. This may entail scheduling staff development meetings over lunch or in the evening. It is also important to be flexible about funding to ensure there is a diverse base of funding streams available to the primary care practice. Changes in Medicaid eligibility and reimbursement can make reliance on one source of funding impractical. Each primary care site is unique, and changes must be made that are consistent with the philosophy, infrastructure, and client population.
- **Be a leader with a vision.** In each of these sites, there was at least one person who had a vision of what success would look like for families in their care. This vision included a non-traditional view of what primary care services are and how behavioral health services should be delivered. At High Point, the Director of Puget Sound Neighborhood Health Centers and the

Director of Highline Mental Health Center discovered their common interest in integrated behavioral health services at a local training on the topic. Inspired by their shared vision, they began a collaboration that evolved to the current model of services. They were able to step out, take chances, make mistakes, but persist because of their commitment to this vision. To make sustained change over time takes patience and leadership. Each of these sites has benefited from the work of a champion of comprehensive services for young children and their families. Vision and leadership are often contagious.

Using Lessons Learned to Bring Mental Health and Substance Abuse Screening and Referral into Primary Care Settings

The lessons learned from these innovative sites provide examples that can inspire changes at both the practice and policy levels. Pediatric practitioners have the opportunity to partner with those individuals and organizations that are seeking to provide comprehensive care for young children and their families. Ongoing efforts in every state include the Early Childhood Comprehensive Systems grants funded by the federal Maternal and Child Health Bureau/Health Services and Resources Administration, the implementation of early intervention systems for infants and toddlers with disabilities under the Individuals with Disabilities Education Act, and a variety of projects and programs at the state and local level funded by the Substance Abuse and Mental Health Services Administration that are supporting systems of care for children and their families. Fundamentally, all families with young children require access to services that support healthy growth and development, offer mental health and substance abuse services, and are responsive to the changing needs of the child as he/she grows from infancy through toddlerhood and prepares to enter school. Primary care settings offer a unique window into the early life of young children and their families. They also offer an excellent opportunity for early identification and delivery of mental health, substance abuse, and developmental services that should be part of the broad array of services and supports that are available to families.

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2 Interview Protocol

Your program was selected as an example of an innovative approach to serving young children and families. We are especially interested in how you have integrated strategies to address families' behavioral health needs in a primary care context through a medical home, assessments of behavioral health (mental health and substance abuse) needs, and facilitated referrals. The questions we are going to ask you will allow us to develop case studies of different program approaches that will be available on the web.

Concrete information to receive beforehand:

Program's philosophy, primary goals, and your mission statement

Hours of operation

Staffing

Policies and procedures manual

Information mailed out to families

Any forms, brochures, materials available in other languages (list or sample actual materials)

Staff development plan

Strategic plan (if available)

Marketing materials

Photos of families, staff, the building/facilities (jpeg) (optional)

Annual report (if available)

Information on committees that work in a supportive or advisory role

1. Please give us an overall description of your program. (This may not be necessary, depending on the amount/quality of information received in advance.)
2. What array of services does your program provide to families, and what services do you refer families to? How do families find out about your services?
For families, the question will be: How did you find out about the program?
Which services/supports have you received from this program or through referrals by the program to other services? Which have been the most useful/important for your family?
3. Describe a "typical" visit from the families' perspective. Who is the first person the family speaks with? Who else do they interact with? Where do they go? How might this differ for families with special needs or disabilities? This will be asked to families too.

*Interview Protocol
Continued*

4. **We are especially interested in how you have operationalized several concepts that make your program special; specifically:**
- a. treating the “family as the unit of care”**
BE SURE TO INCLUDE: Description of families served (e.g., economic, racial, different types of families, families of children with special needs). How is family defined in your program? How are families treated as a unit?
- b. the concept of making your primary care setting a “medical home”**
BE SURE TO INCLUDE: How does the program define medical home? How does the program integrate primary care and behavioral health (e.g., co-location or close coordination or team approach)? Is a family able to see the same doctor for each visit?
- c. “comprehensive screening for behavioral health,” including mental health, substance abuse, and developmental issues**
BE SURE TO INCLUDE: Who do you screen and how? Do you ask permission to screen? What screening tools do you use? How were they selected? Who actually does the screening and when? How is the information shared with the family? How is the information analyzed to determine appropriate referrals for services?
- d. “facilitated referrals”**
BE SURE TO INCLUDE: What happens between screening and referral? How do you act upon a positive screen? How are privacy, confidentiality, and family comfort addressed? How do you know who you should be referring to and if they are competent? How do you get the family to accept the referral? Does information from the referral flow back? If so, how are issues of confidentiality addressed and how does the information from providers to whom you make a referral flow back to the pediatrician? Is it someone’s specific responsibility to follow-up on the referral? What does your program do to address real barriers to referral (internal and external)?

These constructs will also be explored with family members.

5. Describe your staff (responsibilities, racial/ethnic mix, etc.) and your practices of staff development.

BE SURE TO INCLUDE: How does your program philosophy/mission statement affect who you hire? Descriptions of staff orientation and training, cultural competence training, training on involving parents as partners, and training around confidentiality issues. Descriptions of staff qualifications and certifications.

Now we'd like you to describe your program's relationship with families.

6. Were any families involved in the development of the program and, if so, how?

7. How are families made to feel welcome and comfortable?

BE SURE TO INCLUDE: How do you address the issues of cultural and linguistic competence? What is the average length of time that families stay with the practice? Do you have a tracking function within the practice? How are you able to meet families' other needs as they arise (e.g., providing language interpretation, nurse call-in program, same day access for visits)?

8. What other kinds of support are offered as part of the program? Is there a home-visitor, social worker, psychologist, care coordinator, case manager, child development specialist—and what do they do?

BE SURE TO INCLUDE: How is care coordinated?

9. In what ways are families involved in the governance of the program? How does your program cultivate families as leaders and advocates?

Include prompts like: serve as members of the Board of Directors, fundraising, evaluation team members; public relations

*Interview Protocol
Continued*

Next we'd like to ask some questions about how you finance your project.

10. Describe the funding for your project.

BE SURE TO INCLUDE: Initial/start-up funding; current funding; major sources of reimbursement; overall budget, and how it is broken down

11. Do you bill for screening? Are you reimbursed for screening? How are decisions made about whether to provide non-reimbursable services?

12. Do you bill for facilitated referral and case management/care coordination? If so, what are the funding reimbursement sources?

13. Describe the payer mix for your program.

BE SURE TO INCLUDE: family co-pays; what private insurers pay for; managed care v. fee-for-service models; coverage of uninsured. Does your program use any major federal funding streams or collaborative funding efforts such as using pieces of other programs (e.g., outstation eligibility workers)? Do you find that there is a group of people who could be considered "underinsured" as a result of high deductibles and, if so, do you address that?

Please describe any systems you have in place for evaluating your project and determining its effectiveness.

14. What data do you have to demonstrate the effectiveness of your program/approach?

15. In what ways are you monitoring the impact and quality of your program/services?

BE SURE TO INCLUDE: What outcome measures do you use and how were they selected, developed, or adapted and by whom? How were families involved in the selection and development of outcome measures and the evaluation process? How is family progress tracked from intake through referral and how is family satisfaction assessed? Is there a feedback loop? Have you taken part in any national and/or local evaluation project?

Now we'd like to ask some questions about partnerships your program has in the community.

16. How does your program define (“know”) your community?

17. Describe ways in which you collaborate and partner with other community agencies, organizations, etc.

BE SURE TO INCLUDE: Who are the key partners (list them). How did the partnerships develop, and how are they sustained? How do these partners communicate with each other? Are services co-located? What do linkages look like? What information is made available to families about community programs and how do they find it?

18. How are community needs assessed? How do you evaluate the quality of the collaborative relationships with community and family partners?

Next, we want to better understand your approach to delivering culturally competent services.

19. What specific strategies have you used to ensure that the services you provide to families are culturally relevant?

Include prompts like: hiring people from the community served, specific training/professional development in cultural competence, translators, materials in multiple languages; interpreters for deaf families.

20. In what way do front-line providers gain information about culturally-specific issues that families raising young children are facing?

Ask about topics such as breast-feeding initiation and maintenance, discipline, introduction of solid foods, carrying toddlers, co-sleeping, inter-generational advice about child-rearing; *Maybe use some vignettes to explore this?*

21. How do front-line providers respond to questions about culturally-specific practices that families raise?

The questions in this section will also be explored with families directly

*Interview Protocol
Continued*

Finally, we are interested in helping other sites adopt some of these innovative strategies

22. What would be required to replicate this program?

BE SURE TO INCLUDE: What three things would you tell another program were essential to success? What would you do differently? What was easiest/hardest? What didn't you expect? What was surprisingly easy?

23. What lessons have you learned through both successes and failures that would be important for others starting a similar program?

24. Anything else we didn't ask that would be important for us to know?

3 Screening Tools Referenced

- Ages and Stages Questionnaire (ASQ)
<http://www.brookespublishing.com/store/books/bricker-asq>
- Bayley Scales of Infant and Toddler Development
http://harcourtassessment.com/haiweb/Cultures/en-US/Products/Product+Detail.htm?CS_ProductID=015-8027-23X&CS_Category=New+OT+Products&CS_Catalog=TPC-USCatalog
- Center for Epidemiologic Studies Depression Scale (CESD)
<http://patienteducation.stanford.edu/research/cesd.pdf>
- Connected KIDS screener (still under development, created as part of the AAP's Task Force on Violence Prevention)
- Denver Developmental II
<http://www.denverii.com>
- Desired Results Developmental Profile
<http://www.cde.ca.gov/sp/cd/ci/desiredresults.asp>
- Edinburgh Postnatal Depression Scale
<http://www.dbpeds.org/articles/detail.cfm?TextID=485>
- Gesell Developmental Assessment
http://www.childsday.com/gesell_assessment.htm
- Modified Checklist for Autism in Toddlers (M-CHAT)
<http://depts.washington.edu/uwautism/resources/chat.html>
- Parents' Evaluation of Developmental Status (PEDS)
<http://www.pedstest.com>
- Pediatric Symptom Checklist (PSC)
http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf
- Prenatal Socio-Environmental Inventory Form (PSEI) Orr, James and Casper, 1992
- Vanderbilt Assessment Scale for ADHD
<http://www.aap.org/pubserv/adhdtoolkit/d3.htm>

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