

CHILDREN WITH SPECIAL HEALTH CARE NEEDS
NORTHWEST WASHINGTON REGIONAL MEETING
December 9, 2015 12:00 – 2:00
Telephone conference call

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Polking, Christy	P	DOH @1:00		
		P = present; * = added today		

Meeting notes:

- County updates: see below.
- Student project discussion—knowing the wait times for diagnostic evaluation was useful in Whatcom County to obtain new grant funding. EHDDI at DOH eager to partner re: audiology should we have that interest/time to pursue. Student materials are available electronically by request via Judy Ward.
- Billing MCOs for case coordination—King County made a start some time back with one of the MCOs, but did not work out. Ellen agreed to help initiate connections between MCOs and LHJs for local CSHCN staff to contract with MCOs for care coordination. Look at HCA webpage under medical home for reimbursement rates.
- Children in Foster Care—Coordinated Care contract as the MCO statewide to begin in April. Some counties have no Coordinated Care providers. Whatcom has no local providers yet are listed as a Coordinated Care county. Question for Communication Network meeting: *What will happen to children in foster care residing in counties that do not have an adequate network of Coordinated Care providers?*
- MCO Case Managers have been helpful to CSHCN staff on individual client issues. Few referrals to LHJ CSHCN are received from MCOs. Kate posed and will write out a question for the Communication Network meeting—something like: *Where do MCO case managers see gaps in care*

and where could we LHJ CSHCN staff use our strengths to improve services/health of children with special health care needs?

- Diagnostic/treatment funds—Christy shared new schema for distributing funds. All to request funds from central treatment dollars instead of allocation by county. We need to think outside the box. Some things paid at 85%, some at 100%. For example: Orthotics, sign language DVD, breast pumps, baby scales, sensory toys, full body swing, sensory camps, Camp Prov, music therapy. Look at the manual—many clarifications there.
- CHIF/ICD10—Christy and Ellen provided information in tandem. Short Form Guide for CHIF Automated System: Provider One number now required for all CHIFs. Client name, gender, BD is sent to HCA--no diagnosis is sent. Long range purpose is to improve case management for CSHCN children within the MCOs. Short range purpose is to Meet MCHBG Contract Requirement. CHIF system update still in process, at least 6 months away.
- ICD10 5231-Commonly Diagnosed Conditions of CSHCN available for use, but not required. Do not use codes longer than 6 digits in CHIF. Let Christy know if you need a hard copy ICD10 book.
- 2016 NW Region meeting dates—will query group re: 5th Thursdays in March, June, and September. December TBD.
1/6/16—Addendum: NW Region meetings in 2016 will be 10:00 – 2:00
 - ✓ 3/31/16 Skagit Family Resource Center, 320 Pacific Place, Mt. Vernon
 - ✓ 6/30/16 Snohomish Health District, Auditorium, 3020 Rucker Avenue, Everett
 - ✓ 9/29/16 Island County Public Health, Commissioners' Hearing Room, Coupeville
 - ✓ 12/??/16 Telephone conference call—time/date to be determined.

Questions for Communication Network meeting:

- What will happen to children in foster care residing in counties that do not have an adequate network of Coordinated Care providers?
- Where do MCO case managers see gaps in care and where could we LHJ CSHCN staff use our strengths to improve services/health of children with special health care needs?

County updates/issues:

Clallam: Caseload remains the same. CM is still providing home visits, office visits and telephone calls. Families continue to need support with transportation to out of county specialty providers. The last several months there has been an increase in families seeking dental care.

Island: Parent to Parent: we attended the DDC along with Skagit County P2P. Heather stated the details of the meeting very well. We had a Down Syndrome Gathering in November, a large turn-out for such a small community. We started a new monthly Spanish support group and a support group for newly diagnosed or suspecting a diagnosis.

Jefferson: Jefferson County Public Health hired a new Community Health Director, Dunia Faulx, who will start in December. A new public health nurse was hired in September to cover one of the county's public schools. She has been working closely with the CSHCN coordinator who is also a school nurse. With CSHCN expertise and health department team support, they are able to provide extended health coordination services for students birth-21, beyond the typical scope of school nurses.

King: Kate has assumed CSHCN Coordinator duties and is working to transition into the position. Working on ICD-10 changes and getting information out to our staff. Continuing to improve identification of CSHCN in our new EPIC charting system. Planning to meet with local hospital NICU staff to discuss CSHCN services.

Kitsap: Continued separation of responsibilities via 3 PHN's at 0.1. Community Partnerships/attended meetings: Family Interagency Community Council (FICC), Kitsap Early Support for Infants & Toddlers (ESIT)/Early Intervention Service (EIS) mtg. Medical Home Leadership Network. Newly strengthened partnerships with ARC of Kitsap/Jefferson County, OESD 114 Nursing Program Specialist OESD 114 and Kitsap Parent Coalition (KPC). Outreach and Activities: Leading organization of electronic system for child health notes to be sent out to providers (currently determining best practice for email send-out); collaborated with Kitsap Strong Director re: ACE's Child Health Note; discussing methods to support Holly

Ridge/KPC regarding strengthening local Father's Network; Continued organization of community resources in order to build online repository for County residents, in conjunction with planned KPHD CSHCN website updates planned for January 2016 and meeting set-up with Bremerton School District Nurses.

San Juan: The CYSHCN Coordinator continues also as the Family Resource Coordinator for the Early Support for Infant and Toddler Program. Kristen Rezabek has just come on board to work with Tamara Joyner in support of the Program. Kristen is a Registered Dietician and has a very strong background in working with families with special needs children. Kristen is also an FRC for the ESIT program for San Juan Island, the most populated in the county. A new program called SafeCare Home Visiting, is being implemented in February, using county tax funds designated for mental health support. Families do not need to be income eligible to participate. Hiring has begun for those who will be delivering services and training is scheduled for January. Tamara will be attending the orientation to better understand how CYSHCN and SafeCare can collaborate and support families with high needs. The ECEAP program is now managed under Community Health Services in the county (along with WIC, CYSHCN, ESIT, MSS MCHC), providing a closer communication loop and easier collaboration with CYSHCN. Community Health Services has been interviewing for our open School Nurse position at the San Juan Island School District. SJISD has a high percentage of students with special needs. The School will also be very involved in supporting the CYSHCN Program services.

Skagit: Skagit County Public Health is in ongoing transition. Child & Family Health Division, which houses CSHCN, will likely be re-named Prevention and Wellness Division. Jennifer will transition CSHCN Coordinator role to Stephanie Peterka, RN, who has been working as NFP nurse, has experience working in CSHCN and other public health programs elsewhere. Emily Molina will continue to work with program as Community Health Worker. Continuing work to develop Skagit Multi-disciplinary Autism Review Team (SMART) to provide autism diagnosis locally. Dr. Afridi, who is the Center of Excellence provider for Whatcom County's GIDES program, is now also the medical director of SPARC and can see 1-2 children per month in Skagit once the SMART team is fully operational. Finalizing processes, hoping to work with first child/family in the next couple of months to give our process a trial run. Many thanks to Gail and the GIDES team for their generous sharing of forms, processes, etc.! Still hoping to launch a CSHCN/DD information and referral line. Multi-organizational partnership in Skagit is hosting a film festival featuring topics of relevance to Skagit County families. In March we will be showing The Horse Boy, a film about a family of a boy with autism who goes to Mongolia to seek help for him. The County has switched to a new phone system. Jennifer's phone number is now 360-416-1529. Emily's is now 360-416-1523. Stephanie's contact info is speterka@co.skagit.wa.us, 360-416-1526.

Parent 2 Parent: Fall 2015--We attended a one day statewide P2P training in SeaTac. Maria Nardella, DOH CSHCN Program Manager, presented on a variety of DOH grants and their impacts to our programs. She specifically highlighted the Great LINC grant and the partnership with the MCOs and WithinReach to provide comprehensive care management and resources. We heard from WithinReach, as well as, the MCOs on their services. Jill McCormick, Family to Family Health Information Center/PAVE, presented on the Affordable Healthcare Act. Sue Elliott, Arc of Washington, presented on legislative updates and the 2016 short session. Greg Schell, newly retired from the Father's Network, facilitated a panel discussion amongst seasoned P2P coordinators on successful tips for P2P program coordination. There were many opportunities to network in person among our regions and across the state. This rare networking opportunity is extremely valuable. Many of us stayed for a second day conference hosted by DDA, Arc of Washington and Informing Families/Building Trust on a variety of DD topics. In Skagit County, we hosted our 9th Annual Down syndrome Buddy Walk with a tremendous turnout and response from our communities. We continue to offer a variety of services in English and Spanish. In January we will begin to offer a few new support groups specifically targeting Hispanic families, the Anacortes community, parents of students in transition (ages 14-21) and restarting our mother's support network. We recently received a small F2F HIC grant to offer some additional educational seminars targeting our Hispanic population. We look forward to a new year filled with a variety of connection points for CSHCN families. We are also rolling out a new marketing campaign and increasing our partnerships with local school districts to reach families new to our area or those who weren't captured in the 0-3 range.

Snohomish: Interviews completed for vacant 0.5 PHN position—good candidate identified/in process. Continuing work with local homeless shelter for women and children—many eligible for CSHCN, need linkage to medical home and other services. Found local resource for portable cribs and delivered to shelter in support of safe sleep. Began processing CHIFs from new NDC—hoping for direct entry of CHIF by NDC staff instead of CSHCN staff. PHN embraced writing success stories as requested—beginning to collect monthly, for example: 4 year old African American boy, living in shelter in Everett with asthma. Child using albuterol inhaler 3 times per night and coughing all night long. Able to determine that he was not getting his singular and steroid inhaler. Then was throwing up singular every morning and I encouraged mom to crush it and put it in ice cream. Now he takes all meds and feels much better. Helped facilitate child getting another spacer for albuterol to be used at school, get an epi-pen for peanut allergy and get in to MD to learn how to use that. Taught mom about calling MD, going to walk in clinics, etc when child having asthma symptoms. Lots of coordination with RN at MD office.

Parent 2 Parent: The Arc of Snohomish County continues to provide ongoing Parent to Parent support to families raising children with intellectual and developmental disabilities. This past quarter The Arc trained 9 new volunteers as Helping Parents and IEP Parent Partners (languages represented: English, Spanish, Mandarin). Volunteer Helping Parents continue to be matched with requesting parents whose child has a new diagnosis or challenging experience related to their diagnosis. IEP Parent Partner volunteers support parents with Special Education concerns and accompany requesting parents to school IEP meetings. Regular Arc family supports include: Sibshops, Fathers Network, Mothers Network, Lego Club, Caregiver Support, Connecting Families, and Snohomish Autism Spectrum Support Information & Education (SASSIE). This quarter's Arc family events included: Arc Heroes Walk, Arc Film Festival, Arc at Camp Prime Time, Arc Harvest Festival, and Arc Holiday Festival.

Whatcom: As CSHCN Coordinator, I continue to work with community partners in Whatcom Taking Action to improve our local system of care for children and youth with special needs so that each family experiences coordinated, family-centered care and support, regardless of their point of entry. We have very limited capacity in the Whatcom County Health Department to provide direct services and are working with our community partners to make best use of our capacity. We no longer have a .5 FTE public health nurse position designated as serving CSHCN. The direct services that we do provide are conducted as a part of Whatcom Taking Action. We continue to work with Taking Action's Single Entry Access to Services (SEAS) for CYSHCN, located at the Opportunity Council. SEAS referrals have grown dramatically. In 2014, 556 children were referred to SEAS. As of the end of November, 2015, 746 children have been referred. (In October alone, 106 children were referred!) We've acquired funding to add an additional .5 FTE SEAS Navigator, and have submitted a grant to enable the new .5 FTE to be increased to 1.0 FTE. Whatcom Taking Action's General Interdisciplinary Developmental Evaluation System (GIDES) for children with suspected Autism Spectrum Disorders (ASD) began accepting clients on June 15, 2015. So far, 94 children have been referred to GIDES. Of those, 71 have completed a needs intake and navigation services through our Single Entry Access to Services (SEAS) line, 52 have received care coordination services, and 29 have completed the GIDES Assessment. We have partnered with a local pediatric neurologist, who provides ASD diagnostic services for GIDES clients after they have received the GIDES Assessment. This represents a dramatic increase in our local capacity for ASD diagnosis and prevents many families from having to travel to the nearest major metropolitan area (Seattle) to obtain diagnostic services. Twice a year, Whatcom Taking Action (through the Whatcom County Health Department) conducts a survey of evaluation wait times for young children. In winter of 2014, the wait for local autism evaluation services was 6 – 8 months, compared to .75 – 3 months in summer of 2015, after GIDES implementation. Although wait times for GIDES have subsequently increased due to tremendous demand for this service, overall, the implementation of GIDES has reduced the wait time for evaluations, compared to what is typical locally and at Seattle area evaluation clinics. We continue to post informational handouts for families on our Taking Action website at www.whatcomtakingaction.org. We're also working on formatting the most recent Child Health Notes with our local contact information so that we can post them onto the website. Submitted by Gail Bodenmiller, LICSW