## Benton-Franklin Counties – Carla Prock and Karen Weidert
- Continuing to meet monthly with Feeding Team for care coordination purposes.
- Bi-Weekly NICU discharge planning meetings with Kadlec and FRCs; continuous referrals. When Kadlec SLP attends, children with feeding concerns are flagged for discussion on Feeding Team.
- Large amount of NICU referrals appear to be linked with IDM origin. Also many extreme preemies, maternal substance use, & complex family situations.
- Child Health Notes being sent quarterly and posted on our website.
- Work 1st CSHCN referrals ~1-3 monthly.
- September 14, 2016 Project LAUNCH Brookes training on ASQ-3 & ASQ:SE-2.
- CPC child mental health services with family, PCP, navigators.
- Continue to link families with Birth to 3/school district special services, responding to Autism Center and People for People.

## Chelan-Douglas Counties – Carol McCormick
- COE care coordination meetings occur every third Tuesday at 7:00 AM. Community Collaborators include FQHC Pediatrician, Confluence Pediatrician, two school districts, private practice therapists, parents, public health, ESD. We have one ESD ABA therapist providing consultation to eight school districts. Her territory is enormous. Catholic Family and Child Services has hired two ABA therapists, one is getting clinical oversight hours.
- UDS/Project Launch: We trained seven Early Learning staff members at a high school day care center. Other trainings are scheduled.
- ACE’s: The Coalition for Children and Families has revisited the strategic plan and is ready to move forward with renewed emphasis on educating the community. ACE trainings have occurred for more staff at our CSO and Eastmont Middle School staff.
- Both school districts in our counties are reporting insufficient staff for Special Education. All are reporting being overwhelmed by teacher to student ratios.
- Early Intervention is running at capacity. Referrals are beyond capacity. Some is due to staff being out sick but there are more referrals and not enough motor therapists. There are adequate speech therapists for the time being.
- We are seeing an uptick in Children with Special Health Care Needs with families having less support, more social problems and need for case management.
- Our local hospital, Confluence Health has hired a pediatric case manager.

## Grant County – Carol Schimke
- We are seeing an increase in referrals for high risk children. Coordinating more visits with community partners (i.e. Stepping Stones Feeding and Growth Clinic, Life Care Solutions RD, Achieve Center SLP, and Moses Lake Birth-Three program).
- Adding a bilingual Community Health Worker to the CSHCN Program to help with Care Coordination. In March 2016 we lost one of our PHN’s that was helping in the CSHCN Program so this will be a great addition to the program.
- Participating in the DSSGC Columbia Basin Buddy Walk on September 24, 2016 and will be sharing a booth with our local P2P.
- Work First referrals increased in August.

## Kittitas County – Michele Cawley
- Opportunities for developmental screening continue to be offered through the Kittitas County Early Learning Coalition and providers. The Parent Child Early Learning Events
Discussion:

start next week and are scheduled through June. Parents are seeking assistance with the transition to school for children with special needs and help with IEPs.

• Last year, our largest school district’s IEPs were reviewed by OSPI and 12 out of 15 IEPs were noncompliant. The district attributed noncompliant IEPs to procedural errors and a lack of professional development. The district now has an online system which should improve compliance. A recent repeat internal audit designated 50 of 100 random files compliant. A year ago, only 10 of 100 random files were compliant. The district is working to have staff certified as trainers, making the district one of a few in the state that can offer training to nearby districts for a fee.

• Last year, birth to age 2 children needing services went from 22 to 35 students, a 59% jump. The developmental preschool went from 31 to 49 students, a 58% increase. K-21 level saw a 13% increase from 387 to 436 students. Overall, from birth to 21, there was a 15% increase, from 409 students to 471. There was an increase of students with severe disabilities and more students with autism and developmental delays.

• A three-year average of graduation rates for the state is 57.9%. The state drop-out rate, also a three-year average, is 17.9%. Drop-out rates for students with special needs are almost double what they are for general education students.

• We have three school districts without school nurses and another district in need of a half-time nurse. Not all Emergency Care Plans were complete prior to the start of school.

Okanogan – Crisha Warnstaff

• This past quarter I have reviewed CSHCN files, scheduled and completed home visits with families throughout the county with the assistance of an interpreter, as the majority of visits are with Spanish speaking only families. All families visited are connected to their health specialists. All are also connected to dental care for their child with the majority going to see pediatric dentists in Wenatchee. In preparation for the visits, I reviewed the CSHCN manual and updated forms.

• In regards to ACES – there is an ACES subcommittee that met last week. The members are looking at how to implement the ACES survey in various community settings. In regards to UDS, I am in the infancy planning stages to make connections with health care providers to determine next steps.

Walla Walla – Valerie Rembold

• Valerie has retired effective September 30, 2016. Notes are from regional call per Carol McCormick. Case management, home visiting and office visit with WIC, telephone and care conferences also attended some Pediatric visits with clients that proved helpful on various levels. Walla Walla has been getting many referrals for transportation to Spokane and Seattle. Cases are complicated with problems around durable medical supplies, childcare, schools. There have been problems with pre auth/managed care assigning preemies to unknown providers and time is expended helping to get changed to provider they really are seeing causing delay in referrals for urgent visits.

• Birth to three is trying transdisciplinary model; one therapist goes and consults with the others (Physical goes and consults with speech etc.) means she has to increase referrals to hospital therapies.

• There are more refugees arriving in Walla Walla. The Housing Authority is providing housing in various communities. There are several cases of fathers working in Seattle but can’t afford housing in Seattle. Problems with the Refugee establishment: time consuming: need to get language lines, wrong spelling of child name, and problems with care cards.

• Megan Ziebolt is the new Administrator/Director of Walla Walla Public Health. Suzanne Bassham is the new Population Health Manager, in charge of Personal Health.

Yakima County – Tracie Hoppis (CSHCN, P2P and CLP)

What’s new:

• Held initial meeting with care coordinators from Children’s Village and one primary care practice. The purpose of meeting was to do preparatory work for a community approach.
### Discussion:

- to care coordination. This approach is to use community asset mapping to increase awareness about where families who have CSHCN receive care coordination and consider all opportunities for collaboration.
- Parent to Parent partnering with CV WAAA staff to offer Autism 200 series, starting in November.
- 2nd Annual Buddy Walk planned for October 15; over 200 participants registered.
- P2P Statewide Conference next week- September 21-22; training on DDA Waiver, Office of the Ed Ombuds, grant writing, ACA and mental health, supporting a family when their child dies.
- P2P hosting Cyber safety night for parents- November 1; presentation by Yakima Police Dept. and CV Medical Director.
- P2P hosting Endowment Trust Fund presentation- October 12.

### CLP

- We have a new team member – ENT in Wenatchee, Elizabeth Dunham, MD who also has experience repairing cleft palates.

### Successes:

**CSHCN/P2P**

- Work with families- always rewarding!
- Regular CSHCN and P2P meetings/staffing; lots of collaboration!
- 39 Health Home Clients

### CLP

- Team Coordinator participated in a project with 6 of parents to look at what we are doing well and what can be improved. We learned to individualize the family’s experience at the team meeting. We also learned that interpreters can be scheduled for dental and orthodontic appointments if the child has Provider One. This will be shared with the team and we’ll begin implementing this.

### Barriers:

**CSCHN/P2P**

- Continued challenges with caseload capacity.
- Connecting with families this time of year is difficult due to parent work schedules associated with agricultural work.