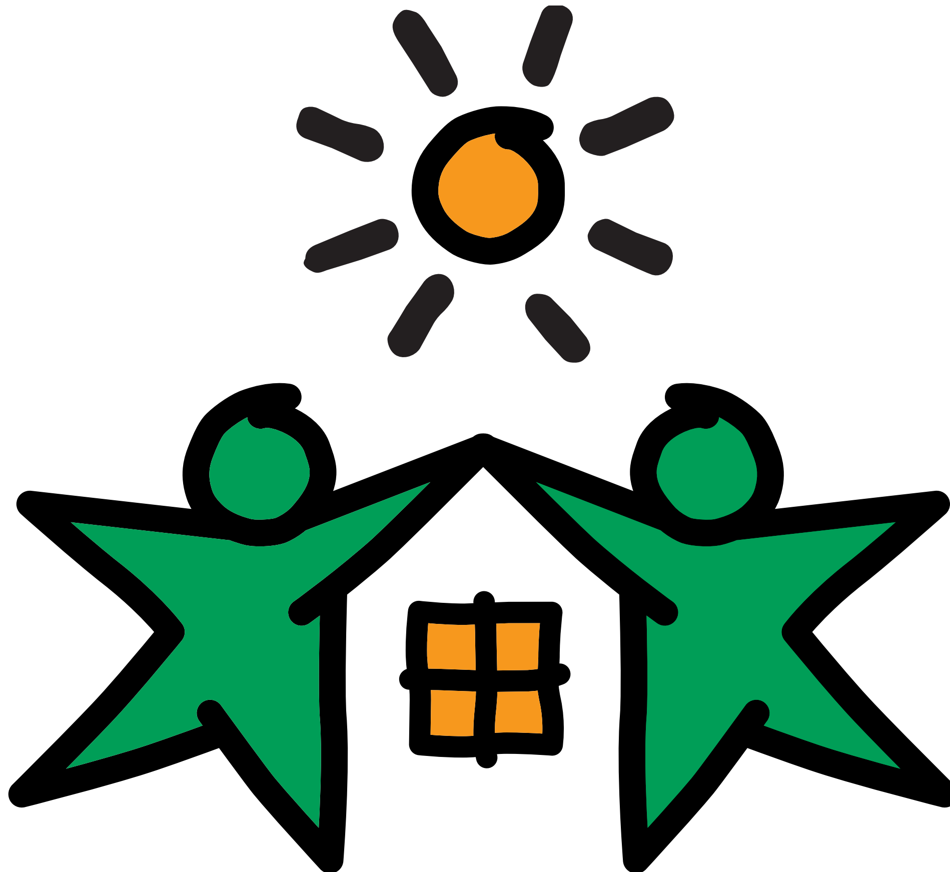
The Alameda County Medical Home Project



Resources for Children with Special Health Care Needs and their Families

May 2005

Project funded by the California HealthCare Foundation
Updates funded by Every Child Counts/First 5 Alameda County
Printing funded by Alameda Alliance for Health

ACMHP_0_0505.pdf

Acknowledgements

Project of:
The Alameda County Committee on Children with Special Needs

Outreach, Education, Compilation and Editing by:
The Alameda County Medical Home Project of Lucile Packard Children's Hospital
Laurie A. Soman, MSW, Project Director
Mara K. McGrath, MPH, Project Co-Manager
Barbara A. Brochard, RPT, Project Co-Manager

ACMHP Resource Binder adapted from:
"Resources for Children with Special Health Care Needs and their Families in California September, 2002," The Los Angeles Medical Home Project for Children with Special Health Care Needs

Graphic Design by:
Ann McDonald-Cacho, McDonald Advertising, Berkeley, CA / ANN@mcads.com

Authorized Logo use:
The National Center of Medical Home Initiatives logo is a registered servicemark.
Limited use of the mark was granted to the ACMHP by:
Lauri Levin, Manager, Technical Assistance
The National Center of Medical Home Initiatives for Children with Special Needs / American Academy of Pediatrics

The ECC/First 5 Alameda County logo is a registered servicemark.
Limited use of the mark was granted to the ACMHP by ECC/First 5 Alameda County

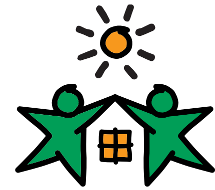
Project funded by:
The California HealthCare Foundation

Project updates funded by:
Every Child Counts/First 5 Alameda County

Printing funded by:
Alameda Alliance for Health

Please Note: The ACMHP has made every effort to ensure that the information contained herein is accurate to date. We apologize for any errors that may have occurred in the preparation of this resource. This information is designed to be shared with others who may benefit from it. Photo-copying information from this binder and/or electronic file sharing of portable document format (pdf) files contained on the companion ACMHP CD-Rom is permissible.
The Alameda County Medical Home Project / May 2005

Table of Contents



Introduction

A	**Health Services**	**A**
	Health Services Overview Chart	1
	Medi-Cal	3–4
	Child Health and Disability Prevention (CHDP) Program	5
	Healthy Families Program	7
	Kaiser Permanente (KP) Cares for Kids	9
	Access for Infants and Mothers (AIM) Program	11
	Income Limit Tables	13–14
	California Children Services (CCS)	15–16
	Genetically Handicapped Persons Program (GHPP)	17
	Newborn Hearing Screening Program (NHSP)	19–20
	Nutrition Services	21
	Women, Infants, and Children (WIC) Supplemental Food Program	23
B	**Mental Health Services**	**B**
	Mental Health Services for Children	1
	Alameda County Department of Behavioral Health Care Services (BHCS)	3–5
C	**Oral/Dental Health Services**	**C**
	Oral Health Care Programs and Services	1–2
D	**Family Assistance**	**D**
	CalWORKS	1–2
	Food Assistance Programs	3
	Housing	5
	In-Home Supportive Services (IHSS)	7–8
	Supplemental Security Income (SSI) Benefits	9–10
	Transportation	11–14
E	**Family Support & Advocacy**	**E**
	Intoduction to Family Support & Advocacy Programs	1
	Alameda Alliance for Health (AAH) Health Education Classes	3
	Area Board V	5
	Blind Babies Foundation (BBF)	7
	California Dept. of Insurance (CDI) Consumer Communication Bureau	9
	California Dept. of Managed Health Care HMO Help Center	9
	Center for Independent Living (CIL)	11–12
	Child Protective Services (CPS)	13
	Community Alliance for Special Education (CASE)	15

continued on next page

— Blank Page —

Table of Contents (continued)

E Family Support & Advocacy (continued) **E**

Disability Rights Education and Defense Fund (DREDF)	17
Every Child Counts/First 5 Alameda County Family Support Services	19–20
Family Resource Network (FRN)	21
Family Violence Law Center (FVLC) + Domestic Violence Resources	23–24
Health Consumer Alliance (HCA)	25
Office of the Patient Advocate	27
Office of Client's Rights Advocates (OCRA)	29
Parental Stress Services (PSS)	31–32
Procedural Safeguards Referral Service (PSRS)	33
Protection and Advocacy (PAI)	35
Respite Care	37–38
Western Center on Law and Poverty (WCLP)	39

F Educational & Developmental Services **F**

Child Development and Behavioral Pediatrics	1
Early Start	3
Head Start	5
Regional Center of the East Bay (RCEB)	7–11
Section 504 of the Rehabilitation Act	13–20
Special Education	21–24

G Transition to Adult Services **G**

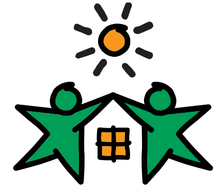
Adolescent Health Transition Project (AHTP)	1–28
Department of Rehabilitation (DR)	29–30
Disabled Students Programs and Services (DSPS)	31
Regional Occupational Centers and Programs (ROCP)	33
WorkAbility Programs	35–36

H Forms **H**

- ACMHP Referral and Feedback Form with Consent
- Alameda County Community Resources Wall Laminate - reduced size sample
- Alameda County Resource Referrals - "Rx-pad" sample page
- CCS Application for Services
  - English - Alameda County / Spanish - Alameda County
- CCS Referral Form
- Early Start Referral
- Family Resource Network (FRN) Referral
- Modified Checklist for Autism in Toddlers (M-CHAT)
  - Scoring / English / Spanish
- Wellness Program Request Form - Alliance Members
  - English / Spanish / Chinese / Vietnamese

— Blank Page —

Alameda County Medical Home Project Introduction



There are many resources available for children with special health care needs (CSHCN) living in Alameda County; however, understanding the various service systems providing support can be a daunting task. Each program has its own regulations, eligibility requirements and funding streams.

Goal The goal of the ***Alameda County Medical Home Project for Children with Special Health Care Needs Resource Guide*** is to aid providers and their staff in making appropriate referrals by providing a "snapshot" of each program, including:

* Eligibility requirements
* Services provided
* Application procedures
* Contact information for each resource

Guide Sections The Resource Guide is divided into eight sections. A digital version of each section will also be provided in portable document format (pdf) on the Resource Guide companion compact disc (CD).

A) Health Services
B) Mental Health Services
C) Oral/Dental Health Services
D) Family Assistance
E) Family Support & Advocacy
F) Educational & Developmental Services
G) Transition to Adult Services
H) Forms

The Medical Home The American Academy of Pediatrics (AAP) description of The Medical Home is included in this introduction. Making appropriate referrals is one of the ways in which providers and their staff can offer coordinated care consistent with the Medical Home model. A Medical Home is an approach to care to better meet the needs of children with special health care needs and their families. It is a way to provide health care for these children in a high quality and cost-effective manner. The basic components of a Medical Home include care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent.

We hope that this resource material will be useful to you and the families that you serve. If you have questions or comments, please contact us. We welcome your partnership in furthering the ideals and objectives of The Medical Home in our community.

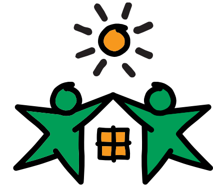
Contact Information **(510) 540-8293**
(510) 601-3913 FAX

The Alameda County Medical Home Project (ACMHP)
of Lucile Packard Children's Hospital

Project funded by the California HealthCare Foundation
Updates funded by Every Child Counts/First 5 Alameda County
Printing funded by Alameda Alliance for Health.

— Blank Page —

The Medical Home



The AAP and the Medical Home

"**The American Academy of Pediatrics (AAP) believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.** It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with them. These characteristics define the "medical home." In contrast to care provided in a medical home, care provided through emergency departments, walk-in clinics, and other urgent-care facilities, though sometimes necessary, is more costly and often less effective."[1]

The following characteristics of a Medical Home have been developed by the Alameda County Medical Home Project from materials published by the AAP and the Center for Medical Home Improvement. These are intended to give primary care providers concrete actions that can be incorporated into their medical practices toward the goal of becoming a Medical Home for children with special health care needs (CSHCN).

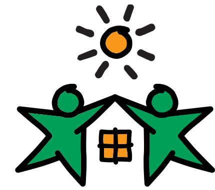
[1]American Academy of Pediatrics, "Policy Statement: The Medical Home," *Pediatrics*, Vol. 110, No. 1, July 2002. pp. 184–186.

Contact Information

(847) 434-8000	**National Center of Medical Home Initiatives**
(847) 228-6432 FAX	**for Children with Special Needs**
	American Academy of Pediatrics
	141 Northwest Point Blvd, Elk Grove Village, IL 60007
email	**medical_home@aap.org**
Web site	**http://www.medicalhomeinfo.org**
AAP Policy site	**http://aappolicy.aappublications.org**
(603)653-1480	**Center for Medical Home Improvement**
(603)653-1479 FAX	**Hood Center for Children & Families**
	Children's Hospital at Dartmouth-Hitchcock Medical
Center	
	One Medical Center Drive
	Lebanon, New Hampshire 03756-1479
Web site	**http://www.medicalhomeimprovement.org**

— Blank Page —

Alameda County Medical Home Project Medical Home Characteristics



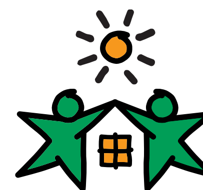
Alameda County Medical Home Project (ACMHP) Characteristics of a Medical Home

Optimal Medical Home Characteristics	
Accessible	• All families have telephone access to and emergency care available from the practice, 24 hours a day, 7 days a week. • Evening and weekend appointments are available in the practice. • Practice is accessible by public transportation. • All families are informed that they have access to their child's record, facilitated by staff within 24–48 hours. • Children with special health care needs (CSHCN) are identified by either a marker on their charts or in the computer database. • Extra time for an office visit is scheduled for CSHCN. • Physical access, social needs and other visit accommodations are addressed at the visit and are documented for future encounters. • Staff ask about any new problems when scheduling appointments. Chart documentation is updated and staff are prepared ahead of time ensuring continuity of care.
Family-Centered	• The family is recognized as the principal caregiver and expert in their child's care, and youth are recognized as the experts in their own care. • Feedback from families of CSHCN regarding their perception of care is gathered through systematic methods (e.g. suggestion boxes, surveys, focus groups, or interviews) and there is a process for staff to review this feedback and to begin problem solving. • Staff meets regularly to gather staff input about practice improvement ideas specifically in the area of care and treatment for CSHCN. Efforts are made toward related changes and improvements.
Comprehensive	• The current social, emotional, educational, and health status of the child is assessed at each visit. • The team (including primary care provider (PCP), family, and staff) develops a plan of care for CSHCN which details visit schedules and communication strategies and home, school and community concerns. Practice back up/cross coverage providers are informed of these plans. • Families are referred to non-medical services in the community that meet their specific needs such as family support options, respite care, equipment vendors, or transportation. • Significant office knowledge is available about family and medical resources and insurance options. Assessment of family needs leads to supported use of resources and information to solve problems (Title V, SSI, Healthy Families). • The practice learns about issues and needs related to CSHCN from the local medical home coalition and professional publications and organizations. Providers incorporate new information into practice care activities.

ACMHP Characteristics of a Medical Home (continued)

Optimal Medical Home Characteristics (continued)	
Continuous	• The practice includes both children and adolescents. • Providers utilize a flexible approach to "aging" and "aging out" so that maturing CSHCN may stay in the practice throughout various transitions and until an adult PCP is identified. • When a child is hospitalized, the provider or other practice staff meets with the discharge planning team to assist with the child's transition back to the community.
Coordinated	• Families and youth are supported to play a central role in care coordination. • The PCP or other practice staff assists the family in setting up the specialty appointment and communicating the clinical issues to that specialist. Together, the PCP and the family agree on a point person for care coordination. • The PCP discusses the results of the specialty visit with the family and questions are answered. • Practice staff participates in the child's IFSP or IEP process either by phone, letter or at the actual conference, if requested by family. • Practice maintains current electronic records to identify and quantify populations and to track selected health indicators and outcomes, including hospitalizations and emergency room visits.
Compassionate	• The practice actively takes into account the overall family impact when a child has a chronic health condition by considering all family members in the care plan. Staff will assist them to set up family support connections when families request it. • The practice informs the family of resources for support and advocacy and facilitates the connections; they advocate on a family's behalf to solve specific problems pertinent to CSHCN.
Culturally Competent	• The practice provides a translator or interpreter for families who speak no English or who speak English as a second language. • The practice distributes materials that have been translated into the primary language the family uses. • A family's beliefs, rituals, and customs are solicited and an attempt is made to incorporate them into the treatment plan.

Medical Home Acronyms



A

AAH	Alameda Alliance for Health
AAP	American Academy of Pediatrics
AB 3632	Typically a mental health referral made by teacher (also known as AB 2726)
ABA	Applied Behavioral Analysis
ACCESS	Intake/Referral Alameda County Department of Behavioral Health Care Services (BHCS)
ACMHP	Alameda County Medical Home Project
ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactive Disorder
AHTP	Adolescent Health Transition Project
AIM	Access for Infants & Mothers Program
ASL	American Sign Language
AT	Assistive Technology
AUT	Autism (CDE disability category)

B

BBF	Blind Babies Foundation
BHCS	Department of Behavioral Health Care Services

C

CalWORKS	California's Temporary Aid to Needy Families (TANF) program
CASE	Community Alliance for Special Education
CCS	California Children's Services
CDE	California Department of Education
CDI	California Department of Insurance
CEC	Council for Exceptional Children
CH	Communicatively Handicapped
CHAMP	Children's Health Access and Medical Program
CHDP	Child Health & Disability Prevention Program
CHO	Children's Hospital Oakland
CIL	Center for Independent Living
CMH	Community Mental Health
CMS	Children's Medical Services
COE	County Office of Education
CSHCN	Children with Special Health Care Needs
CPS	Child Protective Services
CQI	Continuous Quality Improvement

D

DB	Deaf-Blindness (CDE disability category)
DD	Developmental Disabilities
DDS	Department of Developmental Services
DEAF	Deafness (CDE disability category)
DHHS	Department of Health and Human Services
DIS	Designated Instruction and Services
DMH	Department of Mental Health
DOB	Date of Birth
DR	Department of Rehabilitation
DREDF	Disability Rights Education and Defense Fund
DSPS	Disabled Students Programs & Services
DSS	Department of Social Services
DX	Diagnosis

E

ECC	Every Child Counts/First 5 Alameda County
ED	Emotional Disturbance (CDE disability category)
EI	Early Intervention
EL or ELL	English Learner, or English Language Learner
EMD	Established Medical Disability (CDE disability category)
EPSDT	Early & Periodic Screening, Diagnosis & Treatment

F

FAPE	Free & Appropriate Public Education
FEP	Fluent in English Proficiency
FIG	Federal Income Limits
FPL	Federal Poverty Level
FRC	Family Resource Center
FRN	Family Resource Network
FSP	Food Stamp Program
FVLC	Family Violence Law Center

G

GHPP	Genetically Handicapped Persons Program

H

HCA	Health Consumer Alliance
HELP	Hawaii Early Learning Profile
HH	Hard of Hearing (CDE disability category)
HHS	Health and Human Services
HI	Hearing Impairment (Federal disability category - Deaf and HH inclusive)
HMO	Health Maintenance Organization

I		
	IA	Instructional Aide (educational paraprofessional)
	ID	Intellectual Disability (newer term for MR)
	IDEA	Individuals with Disabilities Education Act
	IDP	Infant Development Program
	IEP	Individualized Education Plan
	IFSP	Individualized Family Service Plan
	IHSS	In-Home Supportive Services
	IPP	Individual Program Plan
K		
	KP	Kaiser Permanente
L		
	LCSW	Licensed Clinical Social Worker
	LEA	Local Education Agency (School District)
	LEP	Limited English Proficiency
	LH	Learning Handicapped
	LRE	Least Restrictive Environment
M		
	M-CHAT	Modified Checklist for Autism in Toddlers
	MCH	Maternal Child Health
	MD	Multiple Disabilities (CDE disability category)
	MFCC	Masters in Family & Child Counseling
	MI	Medically Indigent
	MN	Medically Needy
	MR	Mental Retardation (CDE disability category) see also ID
	MTU	Medical Therapy Unit (CCS)
N		
	NHSP	Newborn Hearing Screening Program
	NE	Natural Environment
	NOA	Notice of Action (CCS)
O		
	OCR	Office of Civil Rights
	OCRA	Office of Client's Rights Advocates
	OH	Orthopedically Handicapped
	OHI	Other Health Impairment (CDE disability category)
	OI	Orthopedic Impairment (CDE disability category)
	OSEP	Office of Special Education Programs (Federal Dept. of Education)
	OT	Occupational Therapy

P	
PAI	Protection & Advocacy, Inc.
PCP	Primary Care Provider
PDD	Pervasive Developmental Disorder
PEC	Parent Empowerment Centers
PHC	Public Health Clearinghouse
PHN	Public Health Nurse
PIAT	Peabody Individual Achievement Test
PS	Program Specialist
PSRS	Procedural Safeguards Referral Service (special education compliance)
PSS	Parental Stress Services
PT	Physical Therapy
PTI	Parent Training and Information
R	
RC	Regional Center
RCEB	Regional Center of the East Bay
ROCP	Regional Occupational Centers and Programs
RSP	Resource Specialist Program (education)
S	
SC	Service Coordinator (usually Regional Center)
SDC	Special Day Class (education)
SEC 504	Section 504 of the Rehabilitation Act
SED	Serious Emotional Disturbance
SELPA	Special Education Local Plan Area
SH	Severely Handicapped
SHCN	Special Health Care Needs
SLD	Specific Learning Disability (CDE disability category)
SLI	Solely Low Incidence [Disability] (hearing, visual, orthopedic impairments and deaf-blindness)
SLI [also]	Speech and Language Impairment (CDE disability category)
SSA	Social Security Administration
SSI	Supplemental Security Income
ST	Speech Therapy
T	
TANF	Temporary Assistance to Needy Families (CalWORKS; formerly AFDC)
TBI	Traumatic Brain Injury (CDE disability category)
U	
UCP	United Cerebral Palsy
V	
VH	Visually Handicapped
VI	Visual Impairment (CDE disability category)

W

WCLP	Western Center of Law and Poverty
WIC	Women, Infants and Children (Nutrition Program)
WISC III	Wechsler Intelligence Scale for Children – III
WJEB-R	Woodcock-Johnson Psychoeducational Battery - Revised
WPPSI-R	Wechsler Pre-School & Primary Scale of Intelligence - Revised
WRAT3	Wide Range Achievement Test – Revision 3

— Blank Page —