Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

Contact Information	*Judy Ziels, facilitator of Whatcom Taking Action* *360-778-6130; jziels@whatcomcounty.us* *Which organizations were involved in developing this project suggestion?* *Whatcom Taking Action, which is a county-wide collaborative that includes members from pediatrics, specialty services, behavioral health, K-12 education, families, early learning, higher education, family support services and DSHS*
Project Title	*Centralized intake and system navigation for children with complex needs OR* *Single Entry Access to Services (SEAS), the project title for local implementation*

Rationale for the Project

Problem Statement: The current fragmentation of our system of care results in a lack of efficiency of service provision and creates a barrier accessing services for families. It is well documented that the complexity of the system of care often results in delay of needed services for children and their families. The result of this delay can be the need for more intensive and costly services later. We can look to the literature to see examples of cost-savings for early intervention for developmental and behavioral concerns through avoidance of later services (1). According to the 2009-2010 National Survey of Children with Special Health Care Needs, 15% of Washington State children ages 0-17 have a special health care need and yet, according to the Washington State's Department of Early Learning Annual Performance Report Data Summary, only 2.28% of children 0-3 were served during federal fiscal year 2013 in Washington State's Early Support for Infants and Toddlers program. The disparity between the prevalence estimates of children with special needs and the service numbers for our state's early intervention program demonstrates an opportunity for increased identification and service to children before there is a need for more intensive interventions.

Providing a local centralized method of intake along with system navigation for children with special needs and their families will serve to address the following goals of health care improvement:

- Increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations.
- Improve health outcomes for Medicaid and low-income populations.
- Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

(1) The National Research Council and the Institute of Medicine of the National Academies. Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities. Washington, DC: National Academies Press; 2009.
Reynolds AJ, Temple JA, White BA, Ou SR, Robertson DL. Cost-Benefit Analysis of the Child-Parent Center Early Learning Education Program. Child Development, 2011; 82(1): 379-404.
Washington State Department of Health. Issue Brief: Screening for Developmental Delay. April 2009.

Supporting Research: Help Me Grow National Center and Washington State's Help Me Grow affiliate, WithinReach, have demonstrated the effectiveness of combining a centralized intake, data collection and outreach. The supporting research can be found at the Help Me Grow national center at www.helpmegrownational.org.

Project Description

Which Medicaid Transformation Goals[i] are supported by this project/intervention? Check box(es)

- ☒ Reduce avoidable use of intensive services
- ☒ Improve population health, focused on prevention

Which Transformation Project Domain(s) are involved? Check box(es)

- ☒ Care Delivery Redesign
- ☒ Population Health Improvement – prevention activities

In order to improve coordination among providers, increase access to care for children with special needs and their families and increase utilization of preventive services, we propose the establishment of a centralized intake system. The intake system should include a comprehensive assessment of need for the child of concern and the family and provide navigation to the services needed. By addressing the needs of the child and family, services in all areas can be provided, often times before the need for costly interventions. It is critical that the needs of the family are also supported so that they have the capacity to meet the needs of the children in their care. The centralized intake and navigation service results in increase coordination among health, behavioral, developmental and social services and reduces the burden of complex referral systems for providers and families alike. In order to provide locally appropriate care and improve coordination among providers, this project should be implemented on a county or regional level with the focus population of children 0-21 who are at risk for or have special needs and their families. These children and youth include those with health concerns, developmental concerns and behavioral health concerns. Below is a simplified description of the service provided to some of the clients during the two-year implementation of the program in Whatcom County.

a. 1,014 parents, caregivers or medical professionals working with children birth to three with concerns about atypical development, needing primary developmental evaluations or second opinions, seeking access to wrap-around supports, information on client rights, in-home versus facility-based care options, respite support for medically fragile infants, etc.
b. 12 caregivers of young adults aged 18 to 21 who needed information about services beyond the K-12 system, including access to respite for the caregivers
c. 35 parents, caregivers and professionals with youth aged 12 to 18 in need of help circumventing a bottleneck in the youth's access to services, help managing behavioral issues related to the youth's disability or information on supports in advance of the youth becoming an adult.
d. 106 caregivers and professionals in support of children ages 5 to 12 seeking information about, behavior management issues, including access to programs that could appropriately complement school day supports for working parents, access to resources locally rather than in Seattle or further away, their rights through a K-12 Individualized Education Plan (IEP), 504 Plan or other federal/state protection etc.
e. 268 referrals of children ages 3 to 5 whose delays became more apparent as they entered new settings, who needed developmental evaluations, location of specialists, alternatives for care after expulsion from a child care, etc.
f. 36 children/families facilitated into a local evaluation clinic for autism spectrum disorders.

Since January 2013, 1,004 (68%) of referrals to SEAS have come from medical or other service providers, with pediatricians a leading source. This assures the primary provider's expertise is complemented by more advanced developmental evaluations and educational and social supports core to the comprehensive services needed by the referred child/youth and their families. Family members comprise the second largest source of referrals at 449 (30.5%). The program has grown exponentially, doubling its service numbers each year. In 2015, more than 800 children were served in this program navigating them to health care, developmental and behavioral services as well as connecting families to social services, transportation and other support programs in the community. We believe the growth in referrals, in large part, has been due to the simplification of the process for families and providers alike which was done by creating a single entry point for services.

The primary objectives of the project include:

- Find children in need of special services support as early in their life as possible to maximize the child's potential, especially from populations currently experiencing health disparities
- Reduce the stress on parents and family members of CYSHCN when faced with not only their child's challenges but also a confusing array of federal, state, local governmental and private insurance regulations, service options and costs
- Reduce the probability that when faced with system complexity, a family would –to the detriment of their child-- delay seeking help or otherwise "fall through the cracks"
- Support our local community of pediatricians, therapists and other providers battling time constraints and confusion due to the complexity of the system of care

Partnerships: WithinReach, the local implementing agency for Help Me Grow, would be the natural statewide partner for this project. Each locality that implements would need to establish partnerships with their local primary care, specialty care, behavioral

health, educational, family support and basic needs service providers.

Core Investment Components

- Proposed activities and cost estimates ("order of magnitude") for the project, assuming a community population of 200,000.
  a) Outreach to public and medical or other providers who interface with families of children with special health care needs: 30 service units @ a cost of $4,500 annually
  b) Navigating incoming calls/referrals to appropriate community resources and entitlements: 900 service recipients with one to five service episodes at an annual cost of $123,000
  c) Referring medical provider follow-up re services rendered to referred families and any additional evolving needs: averages one to three per referral. Costs included in b) above.
- Best estimate (or ballpark if unknown) for:
  - How many people you expect to serve, on a monthly or annual basis, when fully implemented: 900-1000
  - How much you expect the program to cost per person served, on a monthly or annual basis. $138 per family per year.
- How long it will take to fully implement the project within a region where you expect it will have to be phased in: 6-12 months
- The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline: We don't currently have the data needed to calculate ROI.

Project Metrics

Our local implementation of a centralized intake service and system navigation has been noted as "best practice" from outside the community and has received state-level recognition as well as inquiries from other counties as to how to implement it. Our key performance measures are as follows:

- Increase early identification of children with special health care needs to facilitate earlier and less costly interventions than if untreated until a later developmental stage.
- Increase efficiency of multiple provider services and reduce potential duplication of effort to child/family through service brokerage offered by Navigators.
- Increase rate of paid service appointment fulfillment/reduce number of no-shows for compensable appointments due to family stress and logistical complications for served families.
- Reduce lag in identification of children with special health care needs from non-English speaking households by increasing proportionality of race/ethnicity of served children/families relative to the childbearing demographics of Whatcom County.
- Reduction of the number of children who upon arrival at the K-12 system's door still are in need of an Individualized Education Plan (IEP) and the associated special education public expenses that go along with that designation. Early identification and collaborative service provision to children/families in need should lead to a contrast in IEP rates for those served by system navigation and those who did not.
- Longer range, we'd also like to establish a system to measure the reduction in the number of children displaced from their care/educational settings due to behaviors stemming from special needs. Early identification, early intervention, increased family education/self-advocacy skills and collaborative intervention plans by SEAS-affiliated providers should help our community achieve fewer suspensions and expulsions of children from child care, preschools and K-12, which tend to only exacerbate a child's setbacks rather than address them.

We are currently working with a limited database and are eager to look at funding options to help us access a database that will allow us to gather data on the information above as well as additional information that will help us to enhance this program.

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