Children and Youth with Special Health Care Needs

Section 7000
CYSHCN Orientation

Contents

Washington State Department of
Health

Alert! Each section listed in this table of contents has been created with a built-in link to take you directly to it—simply hover over the line item and Ctrl and Click to go directly to the page.

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7000 Introduction

This section continues to use a number of acronyms that are listed in the Appendices.

Welcome to the Children and Youth with Special Health Care Needs (CYSCHN) Program!

The purpose of the CYSHCN Orientation Section in the Manual (**Section 7000**) is to provide useful information for CYSHCN Coordinators and other Public Health Nurses and public health professionals working with children and their families. Each local program is unique. This section is designed to provide useful information whether you are a new coordinator or are a highly experienced coordinator looking for information and resources. It is by no means a complete discussion on the topics included here. There are many resources online as well as opportunities to learn from other coordinators who share their wisdom and experience with each other. Most regions hold regular (bi-annual or quarterly) meetings to learn about other resources and activities. The state CYSHCN Program is available for technical assistance and consultation and we learn a lot from local programs' wisdom and experience. Most importantly, we learn so much from the families that we are privileged to serve!

We encourage you to add information specific to your county and any other helpful materials you have accumulated along the way so that this CYSHCN Orientation Section becomes a practical guidebook for your day-to-day use.

7100 Role of the CYSHCN Coordinator

Children and Youth with Special Health Care Needs (CYSHCN) Coordinators are formally trained in a health care field and often, though not always, are Nurses or Social Workers. The primary role of CYSHCN Coordinators is to facilitate access to needed care and resources for children and youth with special health care needs (CYSHCN) and their families. This may take various forms. A few examples include making sure the front desk at your organization has information on resources to assist families, providing support during a home visit, making sure your local medical provider has resources to assist families within their office, and participating in local and regional partnerships, meetings and activities related to systems and/or policy development to increase access to health care and related resources for CYSHCN and their families.

In addition, CYSHCN Coordinators whose local program focuses on direct services may identify potential problems, prevent secondary complications for children who are at high risk, as well as identify early health and developmental concerns. Your work as a coordinator is not just with the CYSHCN but is also about the impact of imperfect service systems to meet the child's needs. Those impacted by a lack of access to needed services include the child, their family, and the community.

Some of your activities *may* include the following, depending on your program's capacity and the priorities for CYSHCN and families in your community:

Identifying a child's potential/actual health or developmental needs; and/or

- Identifying family strengths, concerns, priorities, and resources.
- Providing information about:
    - Child's health or developmental status;
    - How to reduce risk factors for poor health, nutritional, or developmental outcomes;
    - Developmentally appropriate experiences to promote growth and development;
    - Typical family responses and feelings;
    - Dental/oral health;

- o Mental and behavioral health;
- o Safety and injury reduction;
- o Available therapeutic and family support services; and/or
- o Connecting families to resources and services.
   - ▪ Working with local medical offices.

If you are new to the CYSHCN Program, you may have many questions on what you should be doing as the Coordinator of the CYSHCN Program. If you are from a smaller county, you may have many other duties as well as the CYSHCN Program. The information in this section will briefly review the possible roles of the CYSHCN Coordinator with regard to community involvement and care coordination.

Local

The role of the CYSHCN Coordinator varies depending on the capacity of the local health jurisdiction (LHJ) and the needs of CYSHCN and families within that jurisdiction. An important function of local CYSHCN programs is to assure access to care coordination or resource coordination for the CYSHCN in their community. How this work is accomplished depends on the resources available within the community and the capacity of the LHJ. Some Coordinators conduct home visits, assessing the child and family's needs and connecting them to needed resources. Others provide linkages to services through a one-time telephone call or clinic visits. The CYSHCN Coordinator may work closely with the local school district to assure health and related services for CYSHCN are in place for school age children in their community. Please note—the level of care coordination may range from very simple (assuring through a telephone call that the child has health care coverage, is enrolled in managed care or has a medical provider and has transportation to the provider) to very complex (including a home visit). If the local CYSHCN program does not have the resources to do a minimal amount of CYSHCN care or resource coordination, they should contact the state CYSHCN Program and their contract manager for help in deciding how to use the funds in their Maternal Child Health Block Grant consolidated contract for CYSHCN in their community.

- ▪ Care coordination is a critical element of high quality pediatric primary care (also known as the "medical home" model of care- for more see section 7200, below). Care coordination generally includes the concept of connecting children and their families to comprehensive health care and community resources and supports. The term "care coordination" is often used interchangeably with "case management" or "patient navigation" or even "resource coordination." A review of the literature shows variations in specific definitions, adds even more terms (care management, care navigation, disease management) and demonstrates that experts in the care coordination field have not agreed upon a standardized definition. Ideally, care coordination would be provided through a child's primary care provider or a specialty provider. Because there is currently no consistent payment or funding source that reimburses pediatric medical providers for this kind of care coordination, it often falls to local and state CYSHCN programs, state direct service programs (such as the Developmental Disabilities Administration) and other community providers to provide whatever level of care coordination is possible with that program's resources (for more on this, see http://cahpp.org/wp-content/uploads/2016/03/Care-Coordination-Conundrum.pdf).

7110   Frequently Asked Questions About Your Role

There are many questions about local CYSHCN programs. The following information, in Q & A format, is an attempt to answer some commonly asked questions Some diagnostic and treatment services may be considered for financially eligible CYSHCN clients who are 18 to 21 years of age (for more on this, see **Section 6000** in this Manual).

Q: How is the Children and Youth with Special Health Care Needs program funded?

A: The WA State Department of Health receives funding through the Title V Maternal and Child Health Block Grant (MCHBG). The Title V MCHBG is the nation's oldest federal-state partnership. It aims to improve the health and well-being of women (particularly mothers) and children. Title V is a partnership with State Maternal and Child Health (MCH) and Children and Youth with Special Health Care Needs (CYSHCN) programs, reaching across economic lines to support such core public health functions as resource development, capacity and systems building, population-based functions such as public information and education, knowledge development, outreach and program linkage, technical assistance to communities, and provider training. Each year, Congress sets aside funding for the MCHBG. Individual state portions are then determined by a formula, which considers the proportion of low-income children in a particular state compared to the total number of low-income children in the entire U.S. States and territories must match every four dollars of federal Title V money that they receive by at least three dollars of state (non-federal) money.

All US states and territories including Guam, American Samoa, Northern Mariana Islands, Palau, Marshall Islands, Federated States of Micronesia, Puerto Rico, and the Virgin Islands receive Title V funding. In FY 2016, states reported reaching over 76 million pregnant women, infants, children—including those with special health care needs—and others, through the Title V Block Grant. (For additional information, see https://mchb.tvisdata.hrsa.gov/).

CYSHCN are considered a special population within the broader MCH population, and there are specific and unique expectations for state CYSHCN programs in the Title V law, codes and regulations. At least thirty-percent of the state's MCHBG is allocated specifically for children and youth with special health care needs. Further, in the state's annual reports to the MCHB, state must demonstrate that 30 percent of funding are spent on CYSHCN as well as 30% for preventive and primary care for children and that no more than 10% of funds are spent of program administration.

Title V remains the only Federal program that focuses solely on improving the health of all mothers and children and makes a special effort to build community capacity to deliver such enabling services as care coordination, transportation, home visiting, and nutrition counseling, which complement and help ensure the success of State Medicaid and SCHIP medical assistance programs. Since each of these activities have different funding streams and eligibility requirements, it is important to know what these are. To illustrate, each of the Medicaid Managed Care Plans all provide a level of care coordination but these may differ in scope or intensity depending on the need, it is important to contact the specific plan for information. Another example are the Maternal Infant Early Childhood Home Visiting (MIECHV) programs managed in partnership with THRIVE and DCYF. These Home Visiting Programs each have different eligibility requirements such as first time pregnancy or age of child.

WA Department of Health CYSHCN program staff are funded with a variety of funding streams including MCHBG, Medicaid, and other federal grants that the department has been awarded. For additional information on the Title V Block Grant, see AMCHP's publication *"1935-2010 75 Years of the Title V Maternal and Child Health Services Block Grant."*

Q: How do I know what kinds of activities I should be doing?

A: The Department of Health (DOH) operates a streamlined contracting process with local health jurisdictions (LHJs) referred to as the "Consolidated Contract" or "Con-Con". The Department provides funding to the LHJs for a variety of programs and services, and DOH produces one multi-year contract that then includes specific statements of work for each specific program. This allows for combined operational processes such as invoicing and payment, along with a simplified amendment process. The funding from DOH awarded to an LHJ for the CYSHCN Program is included as a separate statement of work in the Consolidated Contract as a portion of the funding allocated from the federal MCHBG.

At least thirty-percent of dollars are earmarked for Children and youth with special health care needs. Many activities are determined at the local level. The requirements can be found in the yearly CYSHCN Focus of Work document and in **Section 3000**.

However, outside of the MCHBG, local health departments may have other funding sources which allow them to make other decisions about what kinds of activities staff are doing such as the Maternal Infant Early Childhood Home Visiting (MIECHV) Programs like Nurse Family Partnership.

Q: Where do I get the answers to questions about the WA State CYSHCN Program?

A: There are several places to find answers about the CYSHCN Program. Looking in the different sections of this CYSHCN Manual, talking to other CYSHCN Coordinators in your region or the rest of the state. The DOH posts a variety of information including a CYSHCN Coordinator list. Additionally, there are quarterly regional meetings that you can attend in person or through conference call. There is also information posted at http://www.doh.wa.gov/YouandYourFamily/InfantsChildrenandTeens/HealthandSafety/ChildrenwithSpecial HealthCareNeeds describing the program. Coordinators are always encouraged to call each other or always feel free to call or e-mail staff members at the CYSHCN Program at DOH. These are great places to start!

Q: Where do I document my work with children and their families?

A: Each local program determines what type of charting system they use to document the work that they do with families and children. Some programs have access to sophisticated Electronic Medical Systems and others have paper files. It is critical that whatever system you use, that it is secure and that health information is protected according to HIPAA. In addition, each local program has access to the Child Health Intake Form Database also known as CHIF. There are also quarterly CYSHCN Measures that local CYSHCN programs submit as part of their Consolidated Contract deliverables and include:

▪ Completing intake and renewal process into Child Health Intake Form (CHIF) Automated System on all infants and children receiving assistance and accessing services through the local Children and Youth with Special Health Care Needs (CYSHCN) Program, and as well as children residing in the jurisdiction who are receiving services from Neurodevelopmental Centers, maxillofacial review boards, and who are accessing Diagnostic and Treatment Fund dollars through the Newborn Screening Program;

▪ Submitting quarterly CHIF data to the State Department of Health. Required fields include ProviderOne number, county code of residence, client name, zip code, date of birth, sex, race, economic level, third-party payment sources, ICD 10 diagnosis code, additional involvement.

Q: What is Child Health Intake Form (CHIF) Automated System?

A: The Child Health Intake Form (CHIF) Automated System is the client intake process for the data collection system in the CYSHCN Program. In January 1995, the CHIF Automated System was implemented statewide by installing a software package into existing LHJ computers and transmitted from LHJs to the CYSHCN Program on diskettes. In January 2003, the computer program was converted to a "Windows" application and provided a more convenient way for agencies to use their own data and create reports. In addition, local agency staff established standard reporting criteria at state-wide CHIF trainings that improved CHIF instructional information.
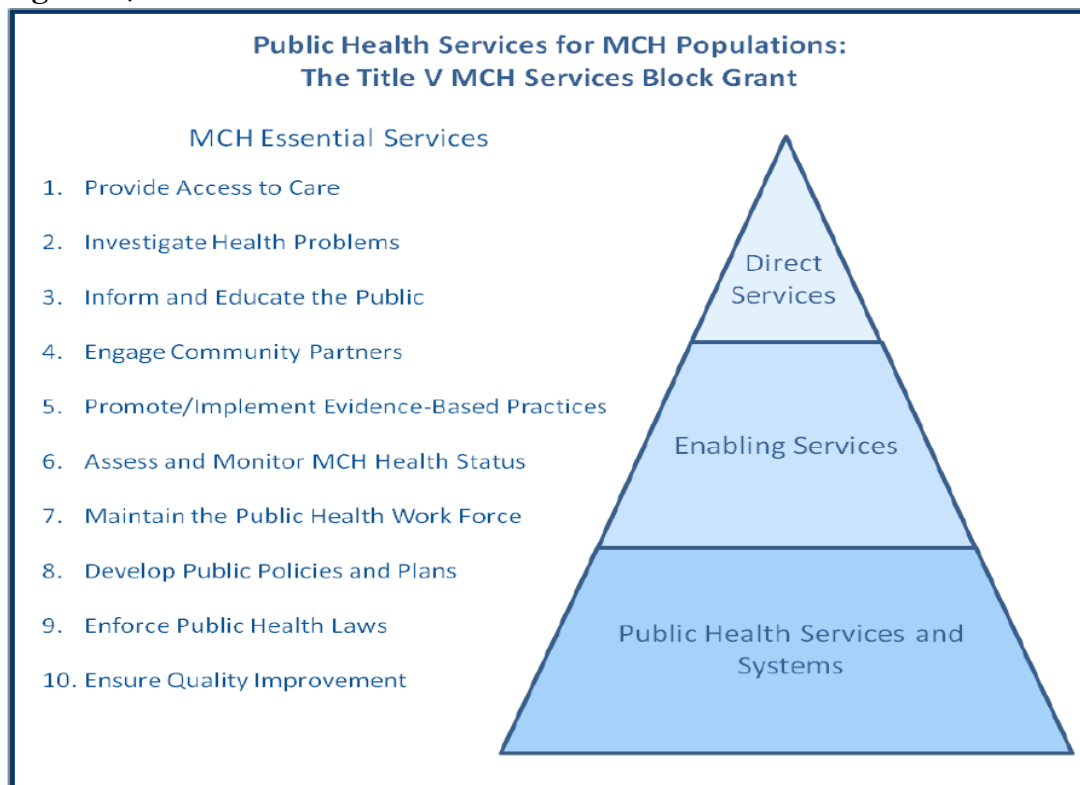
In September 2007, local agency staff started submitting CHIF client data electronically to the Department of Health through a web-based secure file transfer. Please see **Section 5000** for details.

Q: *When do I CHIF?*

A: A CHIF (Child Health Intake Form) should be completed on all infants and children receiving assistance and accessing direct and/or enabling services[1] through the local Children and Youth with Special Health Care Needs (CYSHCN) Program, as well as children residing in the jurisdiction who are receiving services from Neurodevelopmental Centers (NDCs), maxillofacial review boards (MFRBs), and who are accessing Diagnostic and Treatment Fund dollars through the Newborn Screening Program (please note that this will most likely change at some point in FFY19 as the CHIF Redesign Project is completed and the new system is rolled out – NDCs and possibly MFRBs may be required to enter their own data into CHIF). Information on the definition of "serve" and other details are explained in **Section 5000**.

CHIF requires a minimum amount of interaction be done with families of children with special needs in order to complete the required elements in the CHIF. This information may be obtained through a telephone interaction or a clinic visit as well as the more complex home visits. Please refer to **Section 5000** for information on how to complete, what the required data elements are, and how to submit the CHIF data. Additionally Section 5000 provides commonly used ICD-10 codes. MCH Block Grant-funded services for CYSHCN are categorized into 3 levels – direct services, enabling services, and public health services and systems – that align with MCH Essential Services (see Figure 1).

Figure 1.[2],[3]

Public Health Services for MCH Populations:
The Title V MCH Services Block Grant

MCH Essential Services

1. Provide Access to Care
2. Investigate Health Problems
3. Inform and Educate the Public
4. Engage Community Partners
5. Promote/Implement Evidence-Based Practices
6. Assess and Monitor MCH Health Status
7. Maintain the Public Health Work Force
8. Develop Public Policies and Plans
9. Enforce Public Health Laws
10. Ensure Quality Improvement

Direct Services

Enabling Services

Public Health Services and Systems

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[1] In general, you should CHIF a child when the local CYSHCN Program is providing any direct care and/or referring a child and family to a needed resource, providing care coordination or case management, or other assistance to a CYSHCN and their family.

[2] Institute of Medicine. (1988). *The Future of Public Health*. Washington, D.C.: National Academy Press

[3] Public Health in America. (1994), Washington, DC: US Public Health Service. Essential Public Health Services Working Group of the Core Public Health Functions Steering Committee

Direct Services – Direct services are preventive, primary, or specialty clinical services to pregnant women and children, including children and youth with special health care needs, where MCH Services Block Grant funds are used to reimburse or fund providers for these services through a formal process similar to paying a medical billing claim or managed care contracts. Examples include, but are not limited to, preventive, primary or specialty care visits, emergency department visits, inpatient services, outpatient and inpatient mental and behavioral health services, prescription drugs, occupational and physical therapy, speech therapy, durable medical equipment and medical supplies, medical foods, dental care, and vision care.

Enabling Services – Enabling services are non-clinical services (i.e., not included as direct or public health services) that enable individuals to access health care and improve health outcomes where MCH Services Block Grant funds are used to finance these services. Enabling services include, but are not limited to: case management, care coordination, referrals, translation/interpretation, transportation, eligibility assistance, health education for individuals or families, environmental health risk reduction, health literacy, and outreach. State reporting on enabling services should not include the costs for enabling services that are reimbursed by Medicaid, CHIP, or other public and private payers. This category may include salary and operational support to a clinic or program that enable individuals to access health care or improve health outcomes. Examples include the salary of a public health nurse who provides prenatal care in a local clinic or compensation provided to a specialist pediatrician who provides services for children and youth with special health care needs.

Public Health Services and Systems– Public health services and systems are activities and infrastructure to carry out the core public health functions of assessment, assurance, and policy development, and the 10 essential public health services. Examples include the development of standards and guidelines, needs assessment, program planning, implementation, and evaluation, policy development, quality assurance and improvement, workforce development, and population-based disease prevention and health promotion campaigns for services such as newborn screening, immunization, injury prevention, safe-sleep education and anti-smoking. State reporting on public health services and systems should not include costs for direct clinical preventive services, such as immunization, newborn screening tests, or smoking cessation.

Q: *Where do I find forms?*

If you can't find the forms you need in the CYSHCN Manual, talk to your agency about agency-specific forms you may need. Once again, contacting other CYSHCN Coordinators or the DOH CYSHCN staff may be helpful.

Q: *How do I access Diagnostic and Treatment Funds? What are the eligibility requirements?*

A: The process to access these funds is outlined in **Section 6000**. Three phrases should be kept in mind whenever you consider covering an item or service for a child: "medically necessary", "payer of last resort" and "being Medicaid eligible". This is not always an easy process to determine as WA Medicaid is complex and figuring out if there is coverage for services is not always easy to determine. Many answers are in **Section 6000**; however, you can always call or e-mail a DOH CYSHCN staff member for help.

Q: *What services does my client qualify for?*

A: There are many services available for children and youth with special health care needs and their families. Different families qualify for different services. One of the most important concerns is determining if the child and family have insurance. There are many opportunities to help access insurance. The best place to start is WithinReach's Family Health Hotline - 1-800-322-2588. They can help connect families to insurance (primarily Medicaid) as well as WIC, Basic Food, just to mention a few!

You find out basic information on your client, such as the age, diagnosis, whether they qualify for Medicaid as well as the needs of the family when completing an intake or having a structured interview to help identify the

needs of the family. You can then begin the process of finding appropriate services. Consider calling the Answer for Special Kids (ASK) Line at WithinReach (1-800-322-2588) or going to the WithinReach website.

WithinReach has a comprehensive listing of available services and resources that can help you decide what to offer the child and family.

Q: How do I screen and refer children who might have developmental delays?

A: Children who present with potential developmental concerns warrant a referral to their medical provider for screening and evaluation. One possible role of the CYSHCN Coordinator is in assuring developmental screening is performed for all children, whether they have an identified special health care need or not. This will vary from county to county. You may be doing developmental screening on children yourself if you still do home visits or provide some direct care. Or, you may work with others to build a comprehensive system of universal developmental screening system in your community. LHJs can choose to be a part of a statewide initiative to promote universal developmental screening (UDS) through funding in the Maternal Child Health Block Grant Consolidated Contract; talk to your LHJ MCH lead if interested.

For children birth to three, you can also contact a local Family Resources Coordinator (FRC) who can help with the assessment process for the Early Support for Infants and Toddlers (ESIT) through the Department of Children, Youth and Families (DCYF), http://www.dcyf.wa.gov/. If the child qualifies for ESIT, the FRC can arrange the appropriate services. You can also assist families by reviewing child development materials on ParentHelp123 located at https://www.parenthelp123.org/child-development. You can also support families to complete developmental screening for their child at https://www.parenthelp123.org/child-development/child-development-screening-public and recommend that they provide consent for the results to be shared with their child's pediatrician (and child care provider if relevant). Additional local resources for families can be found at https://www.parenthelp123.org/resources.

Developmental screening takes a closer look at how a child is developing. The child will get a brief test, or parents/caregivers will complete a questionnaire about the child. The tools used for developmental and behavioral screening are formal questionnaires or checklists based on research that ask questions about a child's development, including language, movement, thinking, behavior, and emotions. Developmental screening can be done by a doctor or nurse, but also by other professionals in healthcare, community, or school settings.

Developmental Screening is a regular part of some of the well-child visits for all children even if there is not a known concern and is performed at specific points in time. It may also be performed whenever a caregiver expresses concern about a child. Generally, developmental screenings are performed at ages 9, 18, and 24 - 30 months. These are screenings – should an issue be noted, refer to the child's primary care provider for additional screening, diagnosis, treatment and/or referral. For additional information on developmental and other screening schedule, go to the American Academy of Pediatrics' Bright Futures information at: https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx.

Validated developmental screening tools generally take a short time to perform and increases the ability to identify a developmental delay or issue at an early age. With a screening tool, identification of a developmental disability is about 70-80% compared to 30% without a screening tool. Additionally, identifying a mental health problem using a screening tool increases from 20% without a tool to 80-90% with a tool. Again, if you see an issue, refer to the appropriate medical professional for a diagnosis and treatment plan.

Statewide initiatives related to developmental screening and referral to responsive services include a focus on ensuring that professionals who interact with children birth to 5 years old and their families receive training regarding developmental screening and where to refer children and families for appropriate services that will support children's optimal development. Medical and child care providers have been the primary recipients of these continuing-education opportunities. A specialized area of focus within this broader effort has been

increasing workforce capacity related to screening, assessment, and treatment of young children's social-emotional development (e.g., Autism Spectrum Disorder). Efforts to support families' improved connection with developmentally-, culturally-, and linguistically appropriate services include expansion of Community Asset Mapping and Help Me Grow. Efforts to improve ability to track UDS data through a data share agreement with HCA and creation of a UDS database are also in progress.

Resources for Developmental Screening

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics. The *Bright Futures Guidelines* provide theory-based and evidence-driven guidance for all preventive care screenings and well-child visits. Bright Futures content can be incorporated into many public health programs such as home visiting, child care, school-based health clinics, and many others. Materials developed especially for families are also available in English and Spanish. Bright Futures provides theory-based and evidence-driven guidance for all preventive care screenings and well-child visits. Bright Futures content can be incorporated into many public health programs such as home visiting, child care, school-based health clinics, and many others. Materials developed especially for families are also available. To learn more, go to: https://brightfutures.aap.org/Pages/default.aspx

Ages and States Questionnaires® (ASQ) provides reliable, accurate developmental and social-emotional screening for children between birth and age 6. Drawing on parents' expert knowledge, ASQ has been specifically designed to pinpoint developmental progress and catch delays in young children—paving the way for meaningful next steps in learning, intervention, or monitoring.

American Academy of Pediatrics (AAP): Healthy Child Care America is coordinated by the American Academy of Pediatrics (AAP) Early Education and Child Care Initiatives and is partly funded by the Office of Child Care (OCC), Administration for Children and Families (ACF), and the Maternal and Child Health Bureau, HRSA, US Department of Health & Human Services. Information on Bright Futures can be found on their webpage at http://healthychildcare.org/bfutures.html

Centers for Disease Control and Prevention – Developmental Monitoring and Screening has lots of information on developmental screening and milestones. As well as links to other sites of interest.

WithinReach – Child Development offers information about developmental milestones and screenings. WithinReach also has one-line developmental screening tool (Ages and Stages Questionnaire (ASQ)) and information for parents on their ParentHelp123 page. This organization also offers assistance to families needing connections to community-based supports and services.

Q: *Does the CYSHCN Program have any Case Conference Confidentiality Guidance?*

A: At some of the Regional or local meetings, you may decide that it would be beneficial to hold a case conference or other type of meeting to address complex situations that have arisen for specific children and families.

Here is some guidance. First, know your agency's rules and regulations around confidentiality. Make sure that you are up to date with any agency required trainings.

When having your team meeting or case conference, we think that it is important you have ground rules during the presentation and discussion.

1)   Don't use client names and/or on your sign-in sheet, add a place for people's initials next to their names when they sign in at the beginning of the meeting. This will indicating our awareness of the confidentiality and HIPAA. You could also put this at the top of the sign-in sheet: "As a public health professional, I have taken HIPAA training and I understand HIPAA rules and regulations" or something similar.

2) In addition, ask everyone, before coming, to read this document on the HIPAA Privacy Rule: https://www.hhs.gov/sites/default/files/privacysummary.pdf and have copies available at the meeting.
3) Finally, there should be an introduction before the start of the case discussion in which "ground" rules around how you plan to discuss cases without violating client confidentiality. Some good guidance when discussing confidential information: Share the least amount of information, with the fewest people, for the shortest time.

Q: *What resources are available to help me with nutrition or feeding issues?*

A: If the concern is a nutrition or feeding issues, you may want help from a registered dietitian. Your agency may have the name of a registered dietician or you may call the Statewide Nutrition Contract Coordinator at UW at http://depts.washington.edu/cshcnnut/nutserv/index.html or (206) 685-1297. For children on Medicaid, there is a Medical Nutrition Therapy program that can be accessed at http://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides#m and scroll down to the Medical Nutrition Therapy program guide. Contact the individual Medicaid Managed Care Plan if you need assistance in accessing the MNT benefit. See CYSHCN Manual **Sections 4000** or **10630** for additional information.

Q: *Where do I find growth charts?*

A: Growth charts are found on the CDC website http://www.cdc.gov/growthcharts/ . More growth chart references are in the Nutrition Section of this Notebook.

Modules on understanding and using growth charts can be found:
http://www.cdc.gov/growthcharts/educational_materials.htm

Q: *Who should be the care coordinator for a child between birth and three years of age if the child has developmental delays? What is the difference between the FRC's role and that of a Public Health CYSHCN Coordinator?*

A: Ideally, each community should have an integrated and collaborative system in place to make sure children and families are served well and with a minimum of confusion. This is often not the case, and local CYSHCN programs as well as the state CYSHCN Program can lead or participate in collaborative activities to create such a system. Each child's special needs must be considered, and the family must be an equal partner in decision-making for all aspects of their child's care, including who they want to act as their care coordinator. Legal requirements for eligibility vary between programs and need to be considered, as well. Hopefully, the following training and job criteria for each of these important community partners will be helpful in considering the best fit for the child's and family's needs:

Q: *What is a Family Resources Coordinator?*

A: Family Resources Coordinators (FRC) are trained through the Early Support for Infants and Toddlers (ESIT) program and learn the skills needed to work with families and with other providers in their communities. The focus of the FRC is to ensure that children with developmental delays are given access to early intervention programs which enable the child to develop to his fullest potential.

FRC processes may include:

- Coordinating all services across agency lines;
- Serving as a single point of contact in helping parents to obtain the services and assistance they need;
- Assisting parents in gaining access to early intervention services and other services identified in the family service plan developed for each child;
- Coordinating the provision of early intervention services and other services that the child needs or is being provided; and/or

Facilitating the timely delivery of available services; and continuously seeking appropriate services and situations necessary to benefit the development of each child being served for the duration of the child's eligibility.

Q: What are the Care Notebook and Care Organizer?

A: The Care Notebook and Care Organizer are tools for families who have children and youth with special health care needs. Families use Care Notebooks to keep track of important information about their child's health and care. This makes it easier to find and share key information with their child's care team.

The webpage provides information on how to build a care notebook and offers a variety of tools and worksheets to assist families. Multi-lingual worksheets are available including English, Spanish, Vietnamese, Russian, Chinese and Somali. The link is https://medicalhome.org/families/organizing-your-paperwork.

You can also get care plans and information for your teen as he/she transitions to adult health care http://depts.washington.edu/healthtr or https://medicalhome.org/families/transition/. Additional resources for adolescent transition, can be found at http://www.gottransition.org/.

Q: What is my role in the community?

Your level of involvement in your local community is dependent on the needs and capacity of your local health jurisdiction. Many coordinators find themselves participating on the Interagency Coordinating Council (ICC), Medical Home Team, Safe Kids Coalition, Oral Health Coalitions, as well as providing organization and input to care coordination meetings, schools, and child abuse or neglect teams that may be present in your community. There is no "right way" to become involved and participate in these meetings. Check with your supervisor about their expectations and budget. CYSHCN Regional meetings are also a great place to exchange ideas on what other coordinators are doing. The state CYSHCN Program has Power Point presentations on the background of CYSHCN and Title V that are available to you when you participate in community meetings and need information on the Title V program. A more detailed discussion on the mission and philosophy of the State CYSHCN program is available in your CYSHCN Manual, **Sections 1000** and **2000**. **Section 3000** contains a list of clinical and administrative activities as well as involvement in your local community.

Q: What are things I can do to help my families advocate for themselves?

Often CYSHCN Coordinators receive calls from families when things go wrong and they are not sure what avenues are open to them. CYSHCN Coordinators can always contact DOH CYSHCN Program staff to assist. However, there are state and local resources that are also there to assist families. While this is not an exhaustive list, we are including some resources that may be of assistance.

For larger group complaints:

Disability Rights Washington (DRW)
www.disabilityrightswa.org | www.rootedinrights.org

Disability Rights Washington (DRW) is a private non-profit organization that protects the rights of people with disabilities statewide. Our mission is to advance the dignity, equality, and self-determination of people with disabilities. We work to pursue justice on matters related to human and legal rights.

For Individual/family issues
1. Office of Developmental Disabilities Ombuds
   DD Ombuds Complaint line 833.727.8900
   www.ddombuds.org | www.rootedinrights.org

2. It could be your local parent to parent has this information. There are some really good resources on this page including state and local elected officials.
http://www.kitsapcountyparentcoalition.com/resources.html

3. PAVE – Partnerships for Action, Voices of Empowerment https://wapave.org/

4. Governor's Office is a point of contact for Americans with Disabilities Act issues.
http://www.ofm.wa.gov/sites/default/files/public/legacy/policy/50.50.htm

5. There is also a Human Rights Commission
Law Against Discrimination (RCW 49.60)
Washington State Human Rights Commission
http://hum.wa.gov/

7200 What is a Medical Home?

A Medical Home is an approach to providing health care in a high-quality and cost-effective manner through a partnership between families and providers. Children receive the care they need from a primary care provider with referrals and access to other health care professionals including dental providers, specialists, and others. The main components of the medical home model of care are:

Accessible: Care is easy for the child and family to obtain, including geographic access and insurance accommodation.

- Family-centered: The family is recognized and acknowledged as the primary caregiver and support for the child, ensuring that all medical decisions are made in true partnership with the family.

- Continuous: The same primary care clinician cares for the child from infancy through young adulthood, providing assistance and support to transition to adult care.

- Comprehensive: Preventive, primary, and specialty care are provided to the child and family.

- Coordinated: A care plan is created in partnership with the family and communicated with all health care clinicians and necessary community agencies and organizations.

- Compassionate: Genuine concern for the well-being of a child and family are emphasized and addressed.

- Culturally Effective: The family and child's culture, language, beliefs, and traditions are recognized, valued, and respected.

For more, visit www.medicalhomeinfo.org and www.medicalhome.org.

According to the 20011-12 National Survey of Children's Health about 18% of children in Washington State have special health care needs and less than half (47%) of those have a medical home. The questions asked of parents in the National Survey of Children's Health serving as indicators of a medical home were:

- Whether or not the child has a personal doctor or nurse
- Whether or not the child has a usual source for sick and well care
- Whether or not the child's care is family-centered
- Whether or not they have problems getting needed referrals for their child
- Whether or not the child and family have access to effective care

coordination when needed

The state CYSHCN program is charged with developing and implementing strategies to improve the Maternal Child Health Bureau's (MCHB) Performance measure on Medical Home, the percent of children with and without special health care needs, ages 0 through 17, who have a medical home. The State CYSHCN Program works on this performance measure through partnerships, leadership, contracts and other program activities. A comprehensive description and specific standards for medical home can be found in the *Standards for Systems of Care for Children and Youth with Special Health Care Needs* located online at http://www.lpfch.org/publication/standards-systems-care-children-and-youth-special-health-care-needs

Q: *What is the history of Medical Home?*

1967   The first known documentation of the term "medical home" was written by the American Academy of Pediatrics (AAP) Council on Pediatric Practice in Standards of Child Health Care, which says "For children with chronic diseases or disabling conditions, the lack of a complete record and a "medical home" is a major deterrent to adequate health supervision."

1974   Council on Pediatric Practice held a meeting to begin developing a policy statement to address the delays and gaps in healthcare for children; the AAP made a commitment to the "Every child deserves a Medical Home" principle. Interesting to note, there was a discussion at that time about the term "Medical Home" replacing "family physician" and "pediatrician" but the AAP Board of Directors rejected the idea.

1977   AAP Board of Directors published a statement noting "Quality care is also best provided when all the child's medical data are together in one place (a medical home), readily accessible to the responsible physician or physicians."

1979   Medical Home concept began to evolve from a repository for medical records to a method of providing primary care which would address the total needs of the child and family.

1980's   Dr. Calvin Sia from Hawaii developed a method for delivering care in his practice which involved the inherent relationship between the parent and the pediatrician. He led the movement in Hawaii to have the medical home concept adopted into Hawaii's Child Health Plan. He suggested that the pediatrician is the point of first contact for the child and family; linkages for resources and services must be ensured.

1989   MCHB awarded a grant to Hawaii Medical Association to develop a medical home curriculum for pediatricians caring for children and youth with special health care needs. Four other states, including Washington, developed a similar curriculum.

1999   Shriners Hospitals, AAP, MCHB. NACHRI (National Association of Children's Hospitals and Related Institutions), Family Voices all endorsed a curriculum promoting Medical Home.

2000   Medical Home becomes MCHB National Performance Measure

The above information has been taken from several articles in the Supplement to the journal, Pediatrics, vol. 113, no 5, The Medical Home.

Where does the CYSHCN Coordinator fit into the medical home model of care?
Depending on the roles of the CYSHCN Coordinator, they may have a direct link to medical home. As you do intakes, it is important for you to ask families where their child is getting their medical care and to ensure that you establish any needed connections with the child's primary and/or specialty care providers.

It is important to note that not all providers have a practice that meets the criteria of a medical home. In 1999 the AAP outlined the components of a medical home with the understanding that the family is the primary source of strength and support for each child and that the family is the primary care coordinator for their own child.

Bonnie Strickland in Pediatrics, Vol 113, No 5, May 2004, noted that "Care coordination may be the element that most distinguishes a medical home from a traditional pediatric practice." The CYSHCN Coordinator often acts as a care coordinator for the children with special needs in her community and is in the unique position to know and understand the needs of each family, advocate for family-centered care, and promote each child's need to have a medical home.

The CYSHCN Coordinator has the opportunity to:

- meet with the pediatricians and other medical professionals in the community to promote medical homes.
- explain the purpose and services of the local and state CYSHCN Programs.
- provide resource information.
- become part of the child's medical home by providing care coordination for the family.

For more information on the promotion of Medical Homes in Washington State and how you can become involved, contact the Medical Home Leadership Project.

7300 Family Centered Care

Family-centered care is foundational to providing excellent health care and coordination of services for children with special needs. Part of the process of developing capacity at the local level is to create meaningful opportunities for families of children and youth with special health care needs to partner, advise, lead, and advocate on behalf of their children and other CYSHCN at regional meetings, and also simply to encourage their attendance. The state CYSHCN Program has increased their capacity to meaningfully partner with and engage families in a meaningful way in program planning and implementation of programs over the last decade. Your partnership at the local level to promote inclusion of the family perspective in meetings will lead to the best possible innovations in program planning for your community. Some examples of family-centered care are included at the end of this chapter.

Family-Centered Care

What is family-centered care? Why does it matter? How does it fit with our overall mission? And finally, what can we do to advance the practice of family-centered care? Where do we start? Bringing the voices and perspectives of families directly into the planning, delivery, and evaluation of health care services leads to improvements in quality and safety. Studies and experience increasingly show that when healthcare administrators, providers, and families work in partnership, the quality and safety of health care rise, costs decrease, and provider and patient satisfaction increase.

Core Concepts

Dignity and Respect. Health care practitioners listen to and honor family perspectives and choices. Family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.

Information Sharing. Health care practitioners communicate and share complete and unbiased information with families in ways that are affirming and useful. Families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.

Participation. Families are encouraged and supported in participating in care and decision-making at the level they choose.

Collaboration. Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation, and evaluation of services.

Family Participation in Care and Decision-Making -- A Self-Assessment

- ☐ Are policies, programs, and staff practices consistent with the view that families are viewed as allies for their children's health, safety, and well-being?
- ☐ Are families encouraged and supported to participate in care planning and decision-making for their children?
- ☐ Are the cultural and spiritual beliefs and practices of families respected and incorporated into care planning and decision-making?
- ☐ Do I work to create an environment in which families feel supported and comfortable enough to speak freely?

Adapted from the Institute for Patient and Family-Centered Care 10/2015

http://www.ipfcc.org/

Family-to-Family Support

When families who have children with similar needs share information, concerns, and strategies with each other they find essential comfort and support and learn new ways of coping. The following questions offer a framework for thinking about how to facilitate family-to-family support in your organization or other community organizations that provide supports and services to families,

Do we or a partner organization within our community:

- ☐ Routinely offer families opportunities to meet and talk with other families sharing similar experiences?
- ☐ Maintain updated resource lists of key contacts for family-led support organizations, including support for fathers, extended family members, and families who speak other languages?
- ☐ Hire family members as staff to facilitate family-to-family support?
- ☐ Offer families resources to communicate with each other in a variety of ways? These may include: family-to-family newsletters, phone networks, social gatherings such as coffee hours or pizza nights, spaces in hospitals, clinics, and community programs for informal conversations, such as outdoor areas and family lounges, family-to-family bulletin boards
- ☐ Provide meeting space and logistical support including child care and transportation for family support groups?

To learn more, visit this page and scroll down to number 8, Family-Centered Care:
www.mchnavigator.org/trainings/competencies.php

Family Advisors

A family advisor is a family member who has experience with complex healthcare systems and can offer their perspective regarding system strengths and barriers.

The CYSHCN Program supports family-professional partnerships and culturally responsive, family-centered systems of care by connecting trained family leaders to leadership and advisory opportunities in planning, policy, program development and continuous quality improvement. These partnerships include ongoing collaboration with Washington State Fathers Network, PAVE/Family to Family Health Information Center, Medical Home Leadership Network teams, Open Doors for Multicultural Families and many others organizations and other state agencies across the state. CYSHCN relies on parents, caregivers and youth to identify strengths and areas of

concern as well as priorities from a family perspective. The Program supports opportunities to develop personal networking systems with other families and organizations, as well as training and leadership opportunities at the local, regional, state and national levels. The DOH CYSHCN Family Engagement Coordinator supports a Washington State Leader Initiative with the above-mentioned partners with goals of supporting families, children and individuals in Washington State, including families in culturally and linguistically diverse communities and those with special health care needs, to be healthy, safe, informed, resilient and included. If you'd like to be connected with a family advisor in your community, contact the state CYSHCN Program at 360-236-3507 or cshcn.support@doh.wa.gov.
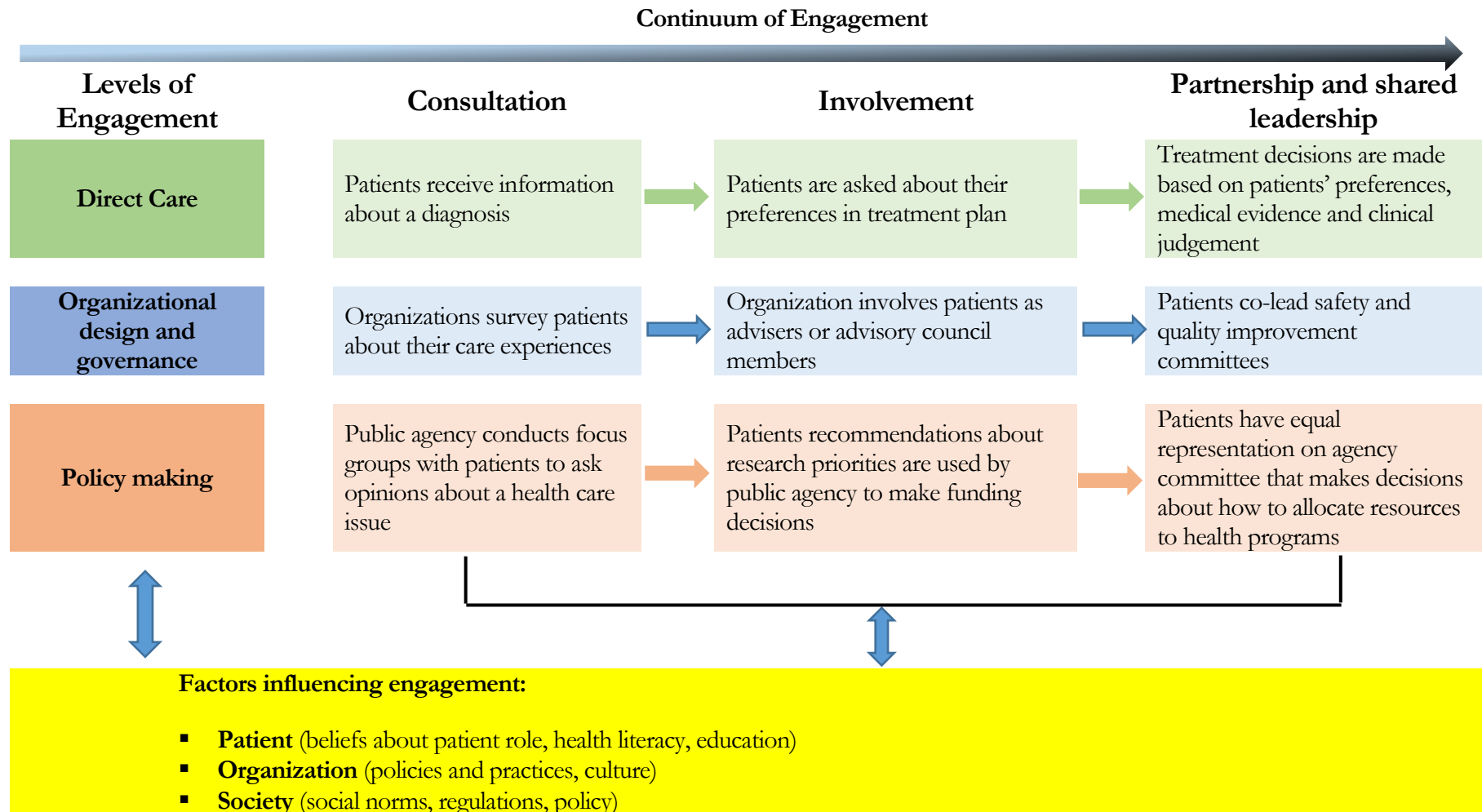
If you are working within your community to identify family advisors, look for individuals who have demonstrated an interest in partnering with providers in their care or the care of their child. Consider those who have offered constructive ideas for change and who have a special ability to help staff to better understand the family perspective.

Seek individuals who are able to:

- o Share insights and information about their experiences in ways that others can learn from them.
- o See beyond their personal experiences.
- o Show concern for more than one issue.
- o Listen well.
- o Respect the perspectives of others.
- o Interact well with many different kinds of people.
- o Show a positive outlook on life and a sense of humor.
- o Speak comfortably in a group with candor.
- o Work in partnership with others.

Patient and Family Engagement

There are many definitions of patient and family engagement. Instead of defining, the Health Affairs article, Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies, presents a framework of patient and family engagement. The article demonstrates how a promising A Multidimensional Framework **For Patient and Family Engagement in Health and Health Care** (diagram below) assists with improving better better-quality health care, more-efficient care, and improved population health.

Continuum of Engagement

Levels of Engagement	Consultation	Involvement	Partnership and shared leadership
Direct Care	Patients receive information about a diagnosis	Patients are asked about their preferences in treatment plan	Treatment decisions are made based on patients' preferences, medical evidence and clinical judgement
Organizational design and governance	Organizations survey patients about their care experiences	Organization involves patients as advisers or advisory council members	Patients co-lead safety and quality improvement committees
Policy making	Public agency conducts focus groups with patients to ask opinions about a health care issue	Patients recommendations about research priorities are used by public agency to make funding decisions	Patients have equal representation on agency committee that makes decisions about how to allocate resources to health programs

Factors influencing engagement:

- **Patient** (beliefs about patient role, health literacy, education)
- **Organization** (policies and practices, culture)
- **Society** (social norms, regulations, policy)

Source: Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies.

7400 Adverse Childhood Experiences (ACES) and a Trauma Informed Approach

Childhood experiences, both positive and negative, have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity. As such, early experiences are an important public health issue. Much of the foundational research in this area has been referred to as Adverse Childhood Experiences (ACEs).

According to the [Centers for Disease Control and Prevention (CDC), the Adverse Childhood Experiences (ACE)](#) Study is one of the largest studies ever done to look at the relationship between experiences in childhood and adult health and well-being. The [ACE study](#) was a collaboration between the CDC and Kaiser Permanente's Health Appraisal Clinic in San Diego.

This and other research has demonstrated that early childhood traumas trigger a stress response that damages a child's developing brain, and that this damage can contribute to a range of social, emotional and health problems in later life, from suicide and substance abuse to diabetes, heart disease and cancer.

In the ACEs study, researchers identified a set of 10 experiences that can affect brain development: physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, a mentally ill or depressed parent, a substance abusing parent, witnessing domestic violence, incarceration of a family member, and loss of parent due to abandonment/death/divorce. A landmark study by Kaiser Permanente and the US Centers for Disease Control and Prevention with over 17,000 plan members found that:

- **ACEs are common** – Most of us (7 in 10 people) report at least one ACE.
- **ACEs tend to occur together** – The overwhelming majority of people (95%) who have had one ACE have had more than one.
- **The risk of health and social problems increases with the number of ACEs** – People with more ACEs may be at higher risk for heart disease, cancer, and early death; and have less success at school and work.

The CYSHCN Coordinator has a role in understanding and using the information from the ACES study. LHJs can choose to implement activities in their community that relate to ACES in their Consolidated Contract.

Why is it important for me to know about ACEs?

CYSHCN Coordinators are uniquely positioned to talk with parents about what we are calling NEAR Science — Neuroscience, Epigenetics, Adverse Childhood Experiences, and Resilience — especially about how their ACE histories may be impacting their lives and may influence their parenting.

Because some CYSHCN Coordinators work with families in the home setting, the relationship occurs within each family's comfort zone. As a result, CYSHCN Coordinators have the opportunity to ask, listen, and affirm. CYSHCN Coordinators need to be highly skilled in building trust and creating safe spaces for meaningful conversations, and be well-versed in the art of family support.

In addition, looking through the lens of ACES, you can be a more effective partner with families to help make needed changes in their lives. For more specifics on how to implement and use this in your work, go to THRIVE Washington's webpage for the [Near@Home Toolkit](#).

For more information including literature and web resources, see:

- Department of Health (DOH) – Adverse Childhood Experiences:

http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/MaternalandChildHealthBlockGrant/AdverseChildhoodExperiences

- THRIVE WA: https://thrivewa.org/nearhome-toolkit-guided-process-talk-trauma-resilience-home-visiting/#sthash.VQ1oo9Sd.dpuf
- The ACEs Public-Private Initiative (APPI)
- Washington State ACEs Action
- Centers for Disease Control and Prevention – Injury Prevention & Control: Division of Violence Prevention
- NEAR@Home Toolkit. https://thrivewa.org/work/trauma-and-resilience-4/

What is a Trauma Informed Approach?

According to SAMHSA's concept of a trauma-informed approach, "A program, organization, or system that is trauma-informed:

1. Realizes the widespread impact of trauma and understands potential paths for recovery;
2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist re-traumatization."

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.

SAMHSA's Six Key Principles of a Trauma-Informed Approach

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific:

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, Historical, and Gender Issues

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

Resources:

- The National Council for Behavioral Health: https://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare/
- Trauma-Informed Approach and Trauma-Specific Interventions: http://www.samhsa.gov/nctic/trauma-interventions
- The Trauma Informed Care Project: http://www.traumainformedcareproject.org/

7500 Motivational Interviewing Strategies and Techniques

What is motivational interviewing and how does this pertain to my work?

Motivational interviewing (**MI**) refers to a counseling approach in part developed by clinical psychologists Professor William R Miller, Ph.D. and Professor Stephen Rollnick, Ph.D. Motivational Interviewing is a method that works on facilitating and engaging intrinsic motivation within the client in order to change behavior. MI is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with non-directive counseling, it's more focused and goal-directed. It departs from traditional Rogerian client-centered therapy through this use of direction, in which therapists attempt to influence clients to consider making changes, rather than non-directively explore themselves. The examination and resolution of ambivalence is a central purpose, and the counselor is intentionally directive in pursuing this goal.

The purpose for including this in this orientation section is for CYSHCN Coordinators and their co-workers to understand an effective, evidence-based approach to working with families. This approach has the benefit of empowering individuals to make changes in their lives. Through the guidance of a CYSHCN Coordinator, families may become the driver of change.

In a nutshell, the primary goals or the Three "E's" of motivational interviewing are to:

1. Engage clients,
2. Elicit change talk, and
3. Evoke motivation to make positive changes from the client.

For example, change talk can be elicited by asking the client questions, such as "How might you like things to be different?" or "How does _____ interfere with things that you would like to do?"

For working with parents on making changes in parental behavior such as not smoking around children or other health-related issues such as nutrition and exercise, Motivational Interviewing can be a great strategy for you to assist families. The American Academy presents a Motivational Interviewing Based Strategies to Help Parents of Young Children. This video reviews the elements of MI and provides great examples of working with parents on strategies related to their child's health.

Another example is a HHS-Head Start webinar called Using Motivational Interviewing Techniques to More Effectively Partner with Parents. This webinar examines how to more effectively partner with parents through use of motivational interviewing strategies. It also includes video highlighting these proven strategies. A transcript of the presentation is also available.

It is important to understand that change may occur quickly or may take considerable time, and the pace of change will vary from client to client. Knowledge alone is usually not sufficient to motivate change within a client, and challenges in maintaining change should be thought of as the rule, not the exception. Ultimately, practitioners must recognize that motivational interviewing involves collaboration not confrontation, evocation not education, autonomy rather than authority, and exploration instead of explanation. Effective processes for positive change focus on goals that are small, important to the client, specific, realistic, and oriented in the present and/or future.

While there are as many variations in technique as there are clinical encounters, the spirit of the method, however, is more enduring and can be characterized in a few key points:

1. Motivation to change is elicited from the client, and is not imposed from outside forces.

2. It is the client's task, not the counselor's, to articulate and resolve the client's ambivalence.
3. Direct persuasion is not an effective method for resolving ambivalence.
4. The counseling style is generally quiet and elicits information from the client.
5. The counselor is directive, in that they help the client to examine and resolve ambivalence.
6. Readiness to change is not a trait of the client, but a fluctuating result of interpersonal interaction.
7. The therapeutic relationship resembles a partnership or companionship.

Additional Resources

- AAP: Supporting Behavioural Change in Parents Using Motivational Interviewing
- Head Start. Using Motivational Interviewing Techniques to More Effectively Partner with Parents.
- The HRSA-SAMHSA Center for Integrated Health Solutions includes links to multiple resources to learn more about MI.
- The National Center on Early Childhood Health and Wellness has developed a Motivational Interviewing Suite that includes videos, debriefs, and an accompanying video guide, one of which features a home visitor talking to a parent about a positive depression screening. Although the materials were developed for an Early Head Start/Head Start audience, they provide examples of how to use MI strategies in everyday conversations with families.
- The Motivational Interviewing Network of Trainers (MINT) website provides information about the latest MI research and upcoming trainings and events in the United States and abroad.
- The Center for Evidence-based Practices at Case Western Reserve University offers information about MI consulting and training to support organizations that want to implement an MI program. The Center also provides free PDF resources that can be downloaded:
    - The MI Reminder Card (Am I Doing This Right?) is a helpful visual aide with questions to support practitioners' awareness of their attitudes, thoughts, and communication style.
    - The Readiness Ruler is a tool to help people evaluate their desire to change their behavior and their confidence in making this happen.
- Motivational Interviewing Strategies and Techniques: Rationales and Examples: http://www.nova.edu/gsc/forms/mi_rationale_techniques.pdf

7600 Cultural Humility & Cultural Competence

Cultural Humility

Reflections on Cultural Humility
Given the complexity of multiculturalism, it is beneficial to understand cultural competency as a process rather than an end product.

Authors: Amanda Waters and Lisa Asbill
http://www.apa.org/pi/families/resources/newsletter/2013/08/cultural-humility.aspx

Cultural diversity and the rising emphasis on evidence-based practice within the field of psychology have sparked dialogues regarding cultural competence among mental health professionals. Additionally, with increasing racial and ethnic diversity in our nation, there is also a growing multiracial population (Jones & Bullock, 2012) we must consider when delivering services. Given the complexity of multiculturalism, it is beneficial to understand cultural competency as a process rather than an end product. From this perspective, competency involves more than gaining factual knowledge — it also includes our ongoing attitudes toward both our clients and ourselves.

> *Cultural humility is one construct for understanding and developing a process-oriented approach to competency. Hook, Davis, Owen, Worthington and Utsey (2013) conceptualize cultural humility as the "ability to maintain an interpersonal*

stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]" (p. 2).

Three factors guide a sojourner toward cultural humility. The first aspect is a **lifelong commitment to self-evaluation and self-critique** (Tervalon & Murray-Garcia, 1998). Underlying this piece is the knowledge that we are never finished — we never arrive at a point where we are done learning. Therefore, we must be humble and flexible, bold enough to look at ourselves critically and desire to learn more. When we do not know something, are we able to say that we do not know? Willingness to act on the acknowledgement that we have not and will not arrive at a finish line is integral to this aspect of cultural humility as well. Understanding is only as powerful as the action that follows.

Recognizing that each person brings something different to the proverbial table of life helps us see the value of each person (Tervalon & Murray-Garcia, 1998). When practitioners interview clients, the client is the expert on his or her own life, symptoms and strengths. The practitioner holds a body of knowledge that the client does not; however, the client also has understanding outside the scope of the practitioner. Both people must collaborate and learn from each other for the best outcomes. One holds power in scientific knowledge, the other holds power in personal history and preferences.

Finally, cultural humility includes aspiring to **develop partnerships with people and groups who advocate for others** (Tervalon & Murray-Garcia, 1998). Though individuals can create positive change, communities and groups can also have a profound impact on systems. We cannot individually commit to self-evaluation and fixing power imbalances without advocating within the larger organizations in which we participate. Cultural humility, by definition, is larger than our individual selves — we must advocate for it systemically.

Multiracial and multiethnic individuals and families illustrate the cultural richness of our diverse nation. As care providers, we have a responsibility to recognize and value the diversity of our clients. We must enter our therapeutic relationships with cultural humility, acknowledging that we are always in the process of learning and growing.

Cultural humility, like family-centered care, can be a new concept. Not only are CYSHCN coordinators supporting families who have children with special health care needs, they are also working with people from other cultures and different degrees of acculturation. There is no one-size-fits-all approach to working with families. Ongoing self-assessments (self-checks) are needed along with supportive supervision and self-care! These are tough jobs. But more about self-care later.

Recognizing and valuing the unique perspectives of people, identities, and points of view, and doing so in an environment where all people feel safe and respected is an important part of our work to address and eliminate barriers to systems and services. The following are select resources compiled and/or created by Association of University Centers on Disability (AUCD) to increase diversity and ensure cultural and linguistic competence in our publications and events. AUCD members and the general public are encouraged to read, cite, and implement these ideas in their work.

Portrayal of People who are *differently abled*
The words you use and the way you portray individuals who are *differently abled* have important implications for your work. People who are *differently abled* are, first and foremost, people. Labeling a person with a condition can be disrespectful and dehumanizing. Therefore it is preferable to use people-first language. People-first language places the emphasis on the person instead of on the disability when discussing most intellectual and developmental disabilities. For example, instead of saying "Down syndrome person," it is preferable to say, "person with Down syndrome." Additionally, when choosing language that emphasizes what people can do instead of what they can't do is empowering. To emphasize capabilities, avoid negative words that portray the person as passive or suggest a lack of something, such as victim, invalid, or defective. For example, rather than

saying "Wheelchair-bound; confined to a wheelchair" you could say a "Person who uses a wheelchair". Another illustration is rather than saying someone "is non-verbal; can't talk" use instead "Person who uses a communication device; uses an alternative method of communication".

Some disability self-advocates prefer identity-first language. Identity-first language emphasizes that the disability plays a role in who the person is, and reinforces disability as a positive cultural identifier. Identity-first language is generally preferred by self-advocates in the autistic, deaf, and blind communities. It is important to note that whether a person with a disability prefers people-first or identity-first language is not universal.

If you are unsure as to whether you should use people-first or identity-first language in order to be respectful, the best thing to do is to ask people themselves.

Cultural Competence

Cultural Competency in Health Services and Care

The University of Washington's Medical Center provides   information specific to medical, illness and death beliefs for a variety of cultural groups in   Washington State. Culture Clues™ are tip sheets for clinicians. They are designed to increase awareness about concepts and preferences of patients from the diverse cultures served by University of Washington Medical Center. Culture Clues™ are as listed:

- o   A Communication Guide -- All Cultures
- o   Albanian
- o   Chinese
- o   Deaf
- o   Hard of Hearing
- o   Korean
- o   Latino
- o   Russian
- o   Somali
- o   Vietnamese

Language cards provide graphics and phrases in languages other than-English to assist in communication between patients, families, and their care providers. Outpatient and inpatient versions for each language cover a wide variety of situations and needs and are available for the following languages:

- o   Amharic
- o   Chinese
- o   Farsi
- o   Japanese
- o   Korean
- o   Russian
- o   Somali
- o   Spanish
- o   Tagalog
- o   Vietnamese

The National Center for Cultural Competence (NCCC) at Georgetown University's Center for Child and Human Development offers cultural competency self-assessment tools. There are numerous benefits to self-assessment. Such processes can lead to the development of a strategic organizational plan with clearly defined short-term and long-term goals, measurable objectives, identified fiscal and personnel resources, and enhanced consumer and community partnerships.

Self-assessment can also provide a vehicle to measure outcomes for personnel, organizations, population groups and the community at large.

The NCCC views self-assessment as an ongoing process, not a one-time occurrence. It offers organizations and their personnel the opportunity to assess individual and collective progress over time.

What are CLAS Standards?

Culturally and linguistically appropriate services (CLAS Standards) is a way to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and achieve health equity. CLAS is about respect and responsiveness: Respect the whole individual and Respond to the individual's health needs and preferences.

Health inequities in our nation are well documented. Providing CLAS is one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language, health professionals can help bring about positive health outcomes for diverse populations.
The provision of health services that are respectful of and responsive to the health beliefs, practices, and needs of diverse patients can help close the gap in health outcomes.

The pursuit of health equity must remain at the forefront of our efforts; we must always remember that dignity and quality of care are rights of all and not the privileges of a few. For more information, go to: https://www.thinkculturalhealth.hhs.gov/clas/what-is-clas

Online Resources

- American Psychological Association and Cultural Humility
- Cultural and Linguistic Competence Health Practitioner Assessment
- Cultural Competence and Cultural Humility
- Cultural competence and cultural humility: A critical reflection on key cultural diversity concepts
- Cultural Self-Assessments
- Department of Health and Human Services. Think Cultural Health
- Institute on Disability – Portrayal Issues
- Rationale for Self-Assessment
- The DOH also hosts many "Health Equity, Cultural Competency and Social Determinants" resources at https://www.doh.wa.gov/CommunityandEnvironment/HealthEquity
- The Social Work Practitioner and Cultural Humility
- To access the 2017-2019 DOH LANGUAGE ACCESS PLAN, please contact the CYSHCN Program

7700 WorkFirst Public Health Children with Special Health Needs (CWSN) Initiative

The goal of this initiative is for the CYSHCN Coordinators to provide DSHS WorkFirst staff with an assessment of families that have children with specials needs who are currently receiving Temporary Assistance for Needy Families (TANF) and are required to enter the work force to reduce poverty. This program is a working partnership between the DSHS WorkFirst staff and Local Health Jurisdictions (LHJs). A professional nursing evaluation will provide input to DSHS WorkFirst staff on the following:

- Determining the child's special medical, developmental, or behavioral needs;
- The impact of those special needs on the ability of the parent to participate in WorkFirst activities; and
- Assisting parents to access appropriate community resources and programs for special needs

children, including childcare services.

Referrals for this program are from DSHS WorkFirst staff only.

Each Local Health Jurisdiction has the opportunity to have a contract with the local DSHS Region to provide Public Health Nursing home visits and assessments.

See Appendices for the WorkFirst manual.

7800 Home Visiting

Home Visiting
Not all CYSHCN Coordinators visit children and families in their homes. Much of the work of the Coordinator is now done by telephone in many counties. If you still do home visiting, this section introduces you to the challenges and rewards of home visiting and includes a perspective by Public Health Nurse, Debra Means. Many new CYSHCN Coordinators have not had more than an introduction to home visiting and have asked for some basic guidelines. Please note that this chapter is informational only and does not replace or take precedence over any guidance on Home Visiting that your LHJ or another funder may have provided.

Home Visiting: A Public Health Nurse Perspective

Deb Means (retired), Lincoln County Health Department

Home visiting affords you as the nurse, social worker or parenting aide a unique opportunity. That of meeting the child and family in their natural environment. It is here that you need to set aside all pre-conceived notions, judgments, and feelings about how a house "should be kept".

The only time that clutter or uncleanliness in a home should be addressed is when it threatens the well-being of the child and/or family in an impending manner. The more that you can put aside your values and feelings about the situation, especially in the early visiting period when you are establishing trust and rapport, the quicker that trust will come to you from your client. You are probably making visits for a specific purpose (i.e. parenting instruction & observation, prenatal care, breastfeeding issues, etc.). These purposes need to be the focus of your visit—not what the home appears like. As you continue to establish trust you may be able to guide and support some changes in household care, or you may not.

When preparing to contact a new client/family for a home visit try to schedule in advance by phone. Tell them how you received the referral, what the purpose of your visit is and about how long you plan to be there. Be considerate of their time schedules (naptimes w/small children, meals, school hours, etc.) in requesting an appointment. If you are not able to schedule in advance because no phone is available and the appointment can wait a week or so consider mailing out a notice explaining briefly why you are coming and a phone number they can call if that date/time is not going to work for them. If you aren't able to schedule in advance because of urgency expect that the client may not appreciate you just showing up expecting them to let you in. Be sure to offer them some hope and advocacy even though the reason you were sent may not be a positive one. You have an opportunity to offer honesty with some guidance and possibly concrete steps to take to make a change in their lives.

Being prepared for your visit is another important factor in your success in home visiting. That means have a topic to discuss during the time of your visit prepared (i.e. the initial intake, home safety, second trimester fetal growth and development along with anticipatory guidance, etc.). Include handouts, maybe even a short video if you have a player or the family has some form of computer or even internet access where you can access a YouTube video.

In being prepared as part of your initial and first follow up visits, ask the client/family to identify personal goals and dreams that you can work on with them. Whether this is a plan in writing, using the card sort method or similar methods remember to allow the client to have some control. Without their direct participation you will not reach your goals either (which should coincide with theirs).

However, be prepared for a crisis that may push your plan right out the window and in fact, cause you to schedule an additional visit if your topic is of vital importance. Keep on hand for all visits (in your bag of tricks!) emergency information such as phone numbers for the electric company, phone company, housing authority, legal aid services, etc. These numbers along with a pad of plain paper for you to write step-by-step instructions are sometimes the most valuable part of your visit. Don't hesitate to make the first call for the client as you have the opportunity to model appropriate phone etiquette when dealing with a difficult situation.

Most clients will value that you took the time to help them deal with an urgent issue and be more willing to participate in what you have to present during that same visit or at another visit time. It is often helpful during the initial visit to inform the client of the purpose of your visits and get them to share or think about what their goals might be. Working toward a mutual goal will be much more satisfying for both you and your client. As often as possible be the primary contact for the client. If you know that you will be leaving a position and no longer seeing the same clients in home, it is advisable to contact the client by phone, send a note in the mail, or inform them at your last home visit with them. Be sure to tell them who their next contact will be (if you know) and whom they can contact if they have concerns in the interim.

> If you don't feel safe, what should you do?
>
> Who do you call first, second, or third?
>
> When do you call?
>
> If you are hurt on the job, what do you do?
>
> Can I change my visitation schedule without notifying anyone?
>
> Are the families we serve informed of the agency's safety policies?

Safety

Safety in home visiting is of utmost importance. You would be wise to leave a schedule of visits with a central person in your office and check out at the end of the day if you are not returning to the office.

There are four cornerstones of safety for home visits: **Awareness, Assessment, Attitude and Action**

Awareness
Setting boundaries sets the tone for the professional relationship

Assessment
Know where you are going – add the things about directions, etc.

Evaluate risk factors before, during, and immediately after your home visit

Using safety assessment forms can help you to develop and sharpen your "safety lens." This can help you recognize more hazards and the speed at which you can spot them.

Car checklist

Entrance to home

Other Hazards

Animals: Many people have animals. It is always a good idea to check about animals during your initial intake or when planning your first home visit.

Communicable diseases and health hazards: being in contact with many families increases the risk of spreading communicable diseases.

Drug and Chemical Hazards: Some signs of drugs or hazardous chemical in a home are more obvious than others. If you get a feeling that things are not right – trust your instincts – to know when to leave or ask for help.

Weapons: It is better to assume that every home may have a weapon of some kind in it. And that every client can access a weapon. Be alert.

Attitude
What are you taking into the home?

Self-reflection – it is our professional responsibility to monitor ourselves and closely work on our own issues sometimes with the help of reflection and reflective supervision

Action
Be accountable for your safety.

Before the visit:
- Always let someone know where you are going
- Review intake form for possible concerns of violence or substance abuse
- Mentally rehearse the visit and what you need to accomplish
- Don't wear excessive jewelry and Do dress appropriately
- Take your ID with you but do not wear your ID cord around your neck
- Where comfortable shoes with low or no heels
- Carry a cell phone with you, when possible

Approaching the house:
- Be aware of your surrounding
- Park your vehicle in a way that you can make a quick exit, if necessary
- Do not block anyone's parking space
- Lock valuables in the trunk of your vehicle

During the visit:
- Be aware of the exits from the home
- If possible, keep yourself between the client and the door
- Sit near an exit or facing the hallway so you can view hall and bedrooms
- Use non-threatening body language and remain calm and polite
- Respect the client's home and their emotions
- Listen to your instincts and feelings
- Be cautious and use common sense
- Leave if you feel threatened or if you notice unlawful or peculiar behavior
- Report your concerns to your supervisor
- Report your concerns to police when necessary

Physical Appearance:
- Your appearance can work against you when dressing for safety

Consider the following:
- Religious or political symbols
- Jewelry – avoid flashy jewelry as this makes you a potential target
- Long hair – wear it up
- Shoes – be comfortable and allow for mobility. Do not wear high heels.
- Ties and scarfs – may be a choking danger.

Emergency Information:
Some numbers you should have available for the communities that you are serving:
- Emergency
- Police and Fire (non-emergency)
- Supervisor
- Ambulance
- Taxi company
- Towing company
- Your car's service garage
- Traffic report station
- Weather information
- Roadside Assistance

Information and phone numbers your supervisor should have:
- Next-of-kin (work telephone #)
- Next-of-kin (home telephone)
- Your family physician
- Other medical Issues, such as diabetes, Medic Alert Bracelet, etc.?

Several things to consider when doing home visits:
1. Be aware of weapons. Place a note in the file to alert others working in the home and consider discussing the weapon with the client or family and asking them to remove it or relocate it (This could be a teachable moment if children are in the home). Unlocked guns in a home with children are a CPS issue and they should be notified.
2. If you see a crime or suspicious situation, do nothing different at the time (other than leave as soon as possible!). When you are safe, always report to your supervisor and then report to the authorities. There does not need to be a crime to report a suspicious situation.
3. If you find yourself in a danger, unable to leave the situation, but can access a phone call 9-1-1 or the office with a statement similar to: "Hello this is MR/MRS/MS (your full name) checking for my messages." Your full name will immediately alert the person (usually a receptionist) that there is a problem. Next say: "I'm on schedule at (Clients Name) home or I'm off schedule and am still at (Clients Name) home"—so that your location is known and appropriate help can be sent. Repeat this statement until reception understands.
4. If you are going into a potentially risky situation and can take a cellular phone with you –that is advisable.
5. If possible pre-program the phone for 9-1-1.
6. If you are still concerned about safety but feel strongly that the visit needs to be made consider asking someone to go with you on a joint visit. You can advise your client that this will be happening as a routine follow-up of one another or you can just arrive with an extra person.

I know that most of this information may seem like common sense, however, seeing it in writing validates it for you. You have a unique opportunity and not all of you will decide that this is "your cup of tea". Home

visiting is a method for client/family-centered care and you should feel free to make a change when needed for you or the client.

The Do's and Don'ts on Home Visits

Do	Don't
Call before you go	Go in the dark
Tell a co-worker where you are going	Take weapons
Be aware of your surroundings	Enter if there is a crowd
Trust your gut feelings	Enter unless you feel safe
Assess the neighborhood before visit	Sit in your car
Take someone with you	Leave your car unlocked
Park your car in view of the house	Sit in front of a window or door
Have your keys accessible	Take valuables with you
Wear your identification badge	Challenge behavior
Identify yourself	Rely on a cell phone
Be polite	Be a hero

Guidelines for Safety for Community Home Visitors

Preparation at Home and Office

- Tell someone where you are going and when you expect to return.
- Keep your work calendar up-to-date with your scheduled appointments including names and addresses of families that you are going to visit.
- Always be aware of your surroundings; use good common sense and think prevention.
- Be familiar with the location of public telephones. You don't need money to call 911.
- Get sufficient rest to remain alert for your work day.
- Dress appropriately. Select bright colored clothing with pockets. Wear clothes that make it easy for you to move fast. Leave expensive jewelry at home. Wear a simple watch.
- Carry a noise-making device such as a whistle.
- Make sure personal electronic equipment (pager, cell phone, etc.) is working properly and have a fresh or charged power supply.
- Have all emergency numbers posted at home.
- Have available extra keys to your home and car. Don't put names tags on key rings.
- Carry the extra keys on your person at all times.
- Travel light – do you really need a purse? Carry only what you really need, avoid having to make

repeated trips to your car.

- During the work day, listen occasionally to a local all-news radio station, if available.

- Make note of the weather reports, travel restrictions, and any unusual police or fire activity in the area where you will be working.

- Organize your day well. Check your schedule, read unfamiliar charts or records, check with your supervisor on anything questionable.

- Call every client and confirm your visit and expected time of arrival. Listen to the client, listen for problems.

- Take only what supplies you will need for the day. Organize your nursing bag according to your visit schedule prior to leaving for visit.

- Keep your purse locked in the trunk of your car. Place it there when you are at home, not in the public's view. It is best not to take it into the clients' homes.

- Finalize your schedule. Place current schedule information into Outlook calendar and allow others to view. Include client name, address and phone on calendar.

- Do not carry large sums of money. Do not wear expensive jewelry.

- Community Travel

- If uncertain about location, use a map book or ask someone who knows. Never guess location or access. Know where you are going before leaving for visit. Assure correct location is entered on Outlook calendar.

- Know the area you are going into – read the charts, have a good map source, or access directions in the computer. Clarify with client when setting up appointment, or ask others familiar with the area. Develop a rapport with the community.

- If you use a map, it must be current and quality issue. Map books with a scale of 1 inch equal to 2,000 feet are ideal. There are many mapping programs online that may be of use.

- Avoid alleys and unsafe short cuts. Stay on the main thoroughfares.

- If you are lost, never follow anyone. Instead, you should: (a) accept verbal directions; (b) call the office; or (c) ask a police officer, firefighter, letter carrier, business owner, or gas station attendant to assist you.

- Never enter a residence that appears unsafe. If the situation appears unsafe, go to a safe area and notify your first line supervisor.

- Make the time of your visits as early as possible. Arrange work schedule so new or questionable visits are early in the day. You'll be less likely to find loiterers congregating on street corners. A good rule is to conduct visits during the same time as school hours. Anticipate weather and road conditions.

- If using public transportation, know the schedules, alternate route(s), and stops before and after your stop. Sit in the front half of buses, if possible. Have extra fare available. Have backup transportation available (e.g. taxicab, family or friend with a car). Travel light. Consider having a portable cell phone.

- Show authority in your walk, talk, and look. Routinely make eye contact. When appropriate, use informal greetings with strangers. Your actions say two things: "I belong here," and "I'm in control."

- Look around you when entering immediate neighborhoods. Check street activity.

- Avoid walking where there are shrubs and tall hedges.

- Park close to the client's home. Choose a parking space that is in the open and near a light source that offers the safest walking route to the dwelling. If possible, try to park where you can see your car from inside the home and try to watch it periodically during the home visit. Allow sufficient space for quick pull-out if needed. It is always better to park on the street than in a driveway. That way, there is no danger of being blocked in when you want to leave.

- If you have to park in visitor parking a long distance from the apartment you are planning to visit, be sure that you know where the manager's office is located.

- Watch for rubble and broken glass that can flatten a tire or a ditch that can immobilize your car.

- Park in the direction you want to go when leaving the home visit. Beware of dead-end streets.

- If you suspect that a car is following you while you are walking, cross the street and go in the opposite direction.

- If someone is walking behind you, and you think you are being followed, enter a business establishment.

- Listen and observe while on the street.

- As much as possible, keep your strong hand free of items. Whenever possible wear cross-strap bags with straps over your shoulder with the flap opening against you.

- If approaching a group, move to the outside and pass by quickly. If necessary and possible, cross to the other side of the street without attracting attention. Remember, maintain that demeanor of I belong here, - I'm in control.

- If confronted, react! Approaches such as "Do you know the time," "Are you lost," " Do you have change for…," etc. may very well be a prelude to an attack. If you must answer, do so in the negative and remain on the move. Do not stop and become distracted (e.g. looking at your watch or checking the change you have).

- If your car is surrounded by loiterers, approach with caution and ask them to leave, or return to the client's home and call building security or 911.

- TRUST YOUR GUT!

Client's Residence

- Never enter a building that appears vacant (i.e., apartment doors open; no curtains on windows; boarded up windows, etc.) If you feel unsafe making a visit, go to a safe location and notify your first-line supervisor.

- Pause at the door before knocking and listen. If you hear loud quarreling, sounds of fighting or some other disturbance leave immediately.

- You are an invited guest in the home. Although the client and family control the environment, you must manage or control the visit. Be polite but firm if you need an adjustment in the environment. Focus on the client's well-being.

- Be cautious of pets; protect your feet and ankles with your bag. Make a note with the directions to the home where there is a pet in the area you need to be wary of.

General Safety Guidelines with Dogs

- Dog owners are seen by their dogs as the dog pack leader.

- Visitors usually pose no threat to the dog as they are not members of the pack and thus remain friendly.

- Precautions should be taken to avoid dogs that are unleashed and unfamiliar.

- When calling a new client prior to the initial visit, inquire about aggressive dogs.

- Let the client/family member know the arrival time for the visit and request the dog's confinement.

- Lower your hand to the side of your leg and "wag one finger." This is a universal friendly sign from one dog to another. This action lets the dog know that he does not have to defend himself, his territory, his food, or his toys or get rid of competition for a mate.

- Assess the stance of the animal. If the dog approaches in an aggressive manner, shout "Go lie down" loudly and make as much or more fuss than the dog is making. Usually, if your voice and action show no fear, the dog will not actually attack. Throw large stones just close enough to the dog to bounce near but not actually hit it. Several rocks thrown in rapid succession may assist in warding off the dog.

- Remember: never try to run away from an aggressive dog. This will encourage it to attack. Move slowly to the house or car. Carry a large stick and sweep it through the air. This deters aggressive dogs.

- Avoid distractions in the home. Select a good area in which to perform the required clinical assessment. If possible sit as close to the door as possible.

- Always have a clear path to an exit.

- Before going into another part of the dwelling or using the phone, ask permission.

- Remember you are a guest in their home. Follow them, never lead.

- Safeguard your supplies and personal belongings at all times.

- If the situation ever becomes out of hand or uncertain, leaving is recommended.

- Document anything unusual in the record or visit report and bring it to the attention of your immediate supervisor.

- Do not get on an elevator if you feel uncertain about the other occupants. Feel free to exit the elevator if you feel uncomfortable, even if it is embarrassing. Wait for another elevator. Do not use the stairs. When you are on the elevator, stand next to the control panels by the emergency button. Do not push the stop button.

- If the apartment building hallways have men or teenagers loitering, do not enter, or have a family member meet you at the outside entrance and escort you to the apartment.

- If someone is about to threaten you, scream loudly, "Fire!"

- If you are threatened by a purse snatcher, do not attempt to resist him or her. Give him or her purse or wallet.

- If an assailant does not have a weapon and attempts to physically harm you:

  (a) Run to a location where there are people;
  (b) Strike using your bag, a fingernail file, a comb, a pen, etc;
  (c) Bite the assailant's arm or hand if he or she covers your mouth to prevent you from screaming;
  (d) Scratch his or her face and eyes;
  (e) Scream "Fire!" and attempt to free yourself;
  (f) Kick male assailants in the groin;
  (g) Don't panic!

- Do not give out your home telephone number to clients. Do not carry your or your family's home address with you.

If You Are In A Tight Situation

- Don't show fear. Try not to show any facial expression.
- Control your breathing.
- Speak slowly and lower the pitch of your voice, talk from your diaphragm. Watch your hands so they don't move nervously.
- Maintain eye contact, but don't try to stare anyone down.
- Don't challenge, but be assertive, especially if lewd comments are made.
- Check your watch, say you need to call your office because they are waiting for your call.
- Don't tolerate nonsense or crazy behavior, rudeness, or name calling.
- Repeat what you are there for. Stand up and leave.

Personal Transportation

Your car is your field office. It must be reliable, safe, and easy for you to drive.

Consider the following points:

- Maintenance is a must. A poor battery or badly worn brakes will let you down at the most inconvenient times. Have your car inspected regularly, especially the battery, ignition, cooling, and tires.
- Keep the fuel level reasonable – fill up when the tank is between one-half and one-quarter filled. In cold climates, keeping the tank at least half filled will help prevent moisture buildup.
- Check the windshield washer fluid, wipers, all lights, and horn.
- Carry safety items such as a flashlight, jumper cables, tow strap, "Call Police" sign, duct or electrical tape, flat tire repair, highway warning devices, and standard hand tools. The two best safety items are your cell phone and a reliable auto club.
- Keep the interior clear of all items that may attract attention. Do not keep money, a cell phone, or purse in plain view or on seats. Keep the doors locked and windows up at all times. Use a heater and air conditioning for climate control.
- TRUST YOU GUT! Do not enter homes when you suspect that an unsafe situation exists.
- There are many resources on-line about home visiting, check with your health department or agency's policies.

Resources

- **BE SAFE: A guide to home visits and off-site activities from Providence Healthcare**
  http://giic.rgps.on.ca/files/Be%20Safe%20Guide%20to%20Home%20Visits%20from%20Providence%20Healthcare.pdf
- **Home Visitor's Handbook: For the Head Start Home-Based Program Option**
  https://eclkc.ohs.acf.hhs.gov/hslc/hs/resources/ECLKC_Bookstore/PDFs/05F613A8CC15D89DAFE1D1568DB0719A.pdf
- **HOME VISITOR SAFETY: MIECHV Program Training Module**
  http://healthandwelfare.idaho.gov/Portals/0/Children/HomeVisiting/Home%20Visitor%20Safety%20Training.pdf

7900 Nutrition Resources

Resources and Helpful Websites

UW Nutrition: http://depts.washington.edu/cshcnnut/

CDC Growth Charts: www.cdc.gov/growthcharts.

Locating WIC offices: https://resources.parenthelp123.org/resoure_finder

WIC approved formulas: http://www.doh.wa.gov/YouandYourFamily/WIC/WICFoods/InfantFormula

Apply for WIC: http://www.doh.wa.gov/YouandYourFamily/WIC/ApplyforWIC.aspx

Breastfeeding support: http://www.doh.wa.gov/YouandYourFamily/WIC/ BreastfeedingSupport.aspx

Medical Home website: www.medicalhome.org

Starting Point Guide: www.cshcn.org

What is WIC?: http://www.doh.wa.gov/YouandYourFamily/WIC.aspx

Income Guidelines: http://www.doh.wa.gov/YouandYourFamily/WIC/Eligibility.aspx

Formula Locator: http://similac.com/store-locator

Children and youth with special health care needs are at increased risk for nutrition and growth problems. They may require specialized nutrition products and closer monitoring of nutritional status. These children may benefit from a referral to a registered dietician with experience working with these children. The following resource, *Nutrition Interventions for Children with Special Health Care Needs* was written to meet the needs of nutritionists serving these children. Other providers have found this resource useful in describing the unique needs of this population. Interventions described in this resource should be undertaken with assessment and monitoring by an RD. http://here.doh.wa.gov/materials/nutrition-interventions

Formula Coverage in Washington State

WIC provides formula for eligible infants in Washington State. For medically necessary formula not available on WIC, eligible infants and children may receive formula through Medicaid. Specific criteria for accessing formula is available in the Medicaid Provider Guide found on line at https://www.hca.wa.gov/.

Nutrition Frequently Asked Questions

How do I monitor growth?

Two charts are available for plotting the growth of an individual child (WHO or CDC) www.cdc.gov/growthcharts. The CDC recommends using the WHO charts birth to 2 years and the CDC for > 2 years. Growth is assessed using serial measures of weight and length/height, plotted over time. A single measure of % provides a screen for nutritional risk requiring further assessment.

How do I monitor growth of a preterm infant?

Although preemie specific growth charts are available (IHDP, Fenton, and Olsen) they have some practical limitations and are used largely in hospital settings. Preterm infants can be plotted on CDC or WHO charts but growth measures (weight/length/OFC) should be corrected for prematurity.

How do I correct for prematurity?

Corrected age is determined by subtracting the number of weeks or months premature from the infant's chronological age. For example:

Baby J was born at 24 weeks and is now 6 months from his birthdate:

40 weeks -24 = 16 weeks or 4 months premature. 6 months-4 months = 2 months corrected age. Growth measures would then be plotted at the 2 months age.

How long do I correct?

Correct for prematurity until 2 years of age. A practical transition point from corrected to chronological age can occur when transition from one growth chart to another (i.e., 0-36 months to the 2 year-18 year chart).

What do I do when a child screens at nutritional risk?

Screening identifies factors associated with nutritional problems or a high likelihood of having or developing a nutrition problem. Initial interventions might include education, monitoring and a rescreen. If the child continues to screen at risk, a referral for further assessment by an RD is appropriate. An RD assessment may be referred to as Medical Nutrition Therapy (MNT).

For example: Baby M is 5 months old. Her weight is as the 5th percentile. Mom provides some information on feeding and intake. Mom is instructed on formula preparation and feeding frequency and a follow-up appointment for weight check in 1 month is made (screened at risk----> education---> rescreen). Baby M continues to gain weight at a lower than expected rate. A referral for Nutrition assessment and Intervention (MNT) by an RD is made. It is advisable to alert the child's primary provider about these concerns as well, as then you can coordinate with that office.

What constitutes Nutritional risk?

Screening risk factors may include but are not limited to the following: 1) Weight, length and/or weight/length $\leq 5^{th}$ percentile; 2) weight, weight/length $\geq 90^{th}$ percentile, or BMI 85-95th percentile; 3) anemia or alteration in other nutrition related labs; 4) feeding difficulties; 5) weight gain greater than or less than expected, often seen as shifts across growth channels; 6) inappropriate food choices, preparation or behaviors; and 7) disease specific: certain medical conditions such and cardio-respiratory, and malabsorbtive conditions are nutritional risk factors. Screening tools are available or you might consider working with an RD to develop a screening tool specific to you clinical and practice setting.

Resources

The following are some resources to assist you in your work. This list reflects only a handful of resources. Blank spaces are include for you to develop your own list of resources. See the Appendices for additional resources.

Children and Youth with Special Health Care Needs	
Organization	Website
The Lucile Packard Foundation for Children's Health:	http://www.lpfch.org/cshcn
Washington State Department of Health Children with Special Health Care Needs	http://www.doh.wa.gov/YouandYourFamily/InfantsChildrenandTeens/HealthandSafety/ChildrenwithSpecialHealthCareNeeds
The Association of Maternal & Child Health Programs	http://www.amchp.org/AboutAMCHP/Pages/default.aspx
Got Transition – resources and information for transition from pediatric to adult health care	http://www.gottransition.org/

Self-Care	
Organization	website
Self-care for professionals	http://au.professionals.reachout.com/self-care-for-professionals

Financial Resources	
Organization	website
National Organization for Rare Disorders	https://rarediseases.org/
State of Maryland – Children And Youth With Special Health Care Needs Resource Locator	http://specialneeds.dhmh.maryland.gov