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# The Best Beginning

Partnerships Between Primary Health Care  
and Mental Health and Substance Abuse  
Services for Young Children and Their Families

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**WRITTEN BY**

Elisa A. Rosman, Deborah F. Perry, and Kathy S. Hepburn

*Georgetown University National Technical Assistance Center for Children's Mental Health*

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# Background

**Project Purpose** In the past decade, interest and activities in the interface between primary health care and mental health and substance abuse services have increased markedly among the many stakeholders who care about positive outcomes for young children’s mental health and well-being. Building on that increased interest, this document was developed as a resource to give health care providers and policy makers at all levels an overview of a range of innovative efforts across the country where health care providers have attempted to treat families as a whole, provide care in the context of a medical home, identify mental health and substance abuse disorders earlier, and make successful referrals and linkages to community-based mental health and substance abuse services and supports.

Primary health care providers represent a significant and natural point of contact for young children and their families. Being able to intervene early with caregivers of infants and toddlers through primary health care can promote children’s mental health and well-being, prevent or delay later negative outcomes, promote protective factors and decrease risk factors associated with negative child outcomes, and may prevent the need for intensive and expensive care at a later age.

**This document includes a relevant literature section, eight case studies of primary care sites using innovative approaches to serve pregnant women and/or families with children birth to three years old, a synthesis of these approaches, lessons learned, and strategies to assist others in replicating these approaches.** Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services, this project is an outgrowth of SAMHSA’s intra-agency Children and Families Matrix Workgroup.

## Selection Criteria for Sites

This project sought to identify pediatric settings that had successfully incorporated at least some of the following innovative approaches into their ongoing delivery of primary care:

- **Creating a medical home:** The American Academy of Pediatrics (AAP) first put forth the notion of the medical home in 1992 and has since updated its definition to include an entity that provides care that is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective” (American Academy of Pediatrics [AAP], 2002, p. 184). In a true medical home, the physician engages in a relationship based on mutual trust and shared responsibility with the family.
- **Providing comprehensive mental health, substance abuse and developmental screening:** AAP defines screening as a “brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment” (American Academy of Pediatrics [AAP], 2001, p. 192). Screening is voluntary and conducted with parental consent. Early identification of caregiver mental health and substance abuse concerns need to be addressed too, since their mental health and well being significantly affects that of their young children.
- **Providing facilitated referrals:** A facilitated referral is defined as a trusting and ongoing relationship among a member of a primary care clinical team, the family, and the community for the purpose of successfully referring a patient to community-based services and supports (Hanson, Deere, Lee, Lewin & Seval, 2001). This is similar to the function of the physician described in the AAP’s definition of the medical home. It is differentiated from such traditional linkage referrals as simply giving a family a list of names.
- **Providing family-centered care:** The Institute for Family-Centered Care identifies the guiding principles of family-centered care as recognizing the vital role of families in insuring the health of all family members; adopting a strengths-based approach to care; recognizing the importance of emotional, social, and developmental support in health care; working with families in decision making and empowering families; involving patients and families as experts to improve quality of services; and facilitating peer to peer support (National Institute for Family-Centered Care, n.d.).

- **Demonstrating cultural and linguistic competence:** Cultural and linguistic competence is an approach to delivering primary care services grounded in the assumption that services are more effective when they are provided within the most relevant and meaningful cultural context for the people being served. The term *cultural competence* refers to sets of guiding principles intended to increase the capacity of primary care providers to meet the needs of diverse communities, including racial and ethnic minorities. These principles include value, acceptance, and respect for diversity; capacity, commitment, and systems in place for cultural self-assessment; consciousness of the dynamics inherent when cultures interact; continuous expansion of institutionalized cultural knowledge; and service delivery models, modes, and adaptations to accommodate diversity. (Modified from Cross, Bazron, Dennis, & Isaacs, 1989). In addition, linguistic competence represents the capacity of the agency or practice and its personnel to effectively communicate with persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities (Modified from Goode & Jones, 2002).

### Setting the Stage: National Efforts to Integrate Behavioral Health and Primary Care

There have been a number of national initiatives that have sought to change the way mental health and substance abuse (also referred to as behavioral health) services are delivered to young children and their families. Each initiative has addressed the gap in comprehensive services available in primary care settings from a different vantage point. Some have been funded with federal funds, others through foundations.

- **Starting Early Starting Smart (SESS)** was funded through a unique public-private collaboration between SAMHSA and the Casey Family Programs. In 1997, this initiative began with a 12-site, four-year national study, which sought to demonstrate the efficacy of integrating behavioral health services into settings where young children and their families access other services and supports. Five of the sites were primary health care practices, and seven were early childhood programs. Serving women and children through age 7, each site provided a comprehensive array of behavioral health screening (for the mothers and their children) and facilitated referrals to assessment and treatment services within a relationship-based framework (i.e., SESS staff

created ongoing, supportive relationships with families based on trust and mutual respect, and these relationships served as a foundation for all services and supports). A rigorous research component documented the differences in a range of outcomes for young children and their families.

- **Early Head Start (EHS)**, funded by the U.S. Department of Health and Human Services, Administration for Children and Families, was added to the Head Start portfolio in 1994 to focus on providing comprehensive services to low-income, pregnant women and young children through age two. Services are focused on enhancing the infant's/toddler's development and include the establishment of a medical home for ongoing health care for the child; ongoing developmental screenings; comprehensive pre-/post-natal services for mothers, especially help with post-partum depression; and referrals to community providers who have established relationships with the EHS program locally. When Congress established the EHS program, it also funded a rigorous, large-scale, random-assignment evaluation to examine a broad range of family and child outcomes. The evaluation was conducted in 17 sites by local university-based researchers, with the cross-site work conducted by Mathematica Policy Research, Inc., and Columbia University's National Center for Children and Families.
- **Healthy Steps for Young Children** was launched in 1994 as a national demonstration project by the Commonwealth Fund. It was later continued by the Robert Wood Johnson Foundation and a group of over 100 funding partners. The project was designed to determine the efficacy of embedding a developmental specialist into pediatricians' offices as a strategy to improve access to high quality preventive, developmental services. The addition of Healthy Steps specialists (usually a nurse, nurse practitioner, early childhood educator, or social worker with child development expertise) meant that a broad range of families' concerns could be addressed during a primary care visit. Healthy Steps for Young Children sites provided ongoing developmental screenings for children, parent support and education (in particular, help for mothers who were depressed), and targeted referrals to community resources. The three-year National Evaluation was published in 2002, and the national initiative now provides guidance for expansion of this model in pediatric and primary care practices across the country.

- **Assuring Better Child Health and Development (ABCD)** is an initiative launched by the Commonwealth Fund in 1999 to improve access to preventive and developmental services for low-income children. This project funded systems-change efforts in four states (North Carolina, Utah, Vermont, and Washington), all of which were led by the state Medicaid offices. An evaluation identified three outcomes: A broader array of health and developmental services available through changes to billing and reimbursement policies, strengthened screening, surveillance and assessment services for young children, and improvements in care coordination. These successes led to the ABCD II initiative that Commonwealth is currently funding in five states: California, Illinois, Iowa, Minnesota, and Utah.
- **Medical Home:** Work on the development of the medical home construct has benefited from the leadership of AAP and has been supported by the federal Health Resources and Services Administration (HRSA) within the U.S. Department of Health and Human Services as part of their efforts to improve access to services for children with special health care needs under Title V of the Social Security Act. This initiative focuses attention on the need for an ongoing source of primary care for children that is “accessible, continuous, comprehensive, coordinated, compassionate, and culturally effective” (AAP, 2002; p. 184). HRSA has funded a series of medical home grants designed to promote the adoption of best practices as well as to evaluate the effectiveness of this approach in improving quality and outcomes.
- **Bright Futures Mental Health** is a set of anticipatory guidance materials developed by a multidisciplinary panel of experts, under the direction of Dr. Michael Jellinek, with funding provided by HRSA. Released in 2002, the Bright Futures Mental Health materials contain in-depth guidelines for addressing mental health within a developmental context, facilitating the incorporation of a variety of screening tools and educational materials into primary care practices. HRSA has also made grant funds available to study the impact of the Bright Futures Mental Health initiative. Currently, AAP is working to incorporate additional mental health and substance abuse screening tools into a tool kit accompanying a revised version of the Bright Futures Guidelines.

These efforts represent examples of national initiatives that have sought to integrate screening for children’s developmental issues, as well as screening and services for adult mental health and substance abuse issues, with an array of behavioral health services and supports. Many of these projects have had a research or evaluation component that has allowed data to be gathered on the effectiveness of these strategies. None of these initiatives has been universally accepted and implemented, leaving instead a patchwork of innovations, lessons learned, and a set of ongoing challenges that the pediatric community must sort through in trying to meet the behavioral health needs of young children and their families.

**Why it Matters:  
Prevalence Rates  
of Mental  
Health and  
Substance Abuse  
Disorders and  
Impacts on  
Children and  
Families**

**Adult Mental Health.** According to data from the U.S. National Comorbidity Survey Replication, in a given year, approximately 26 percent of the adult population meets the criteria for some form of mental disorder (Kessler, Chiu, Demler, and Walters, 2005). Focusing specifically on depression, rates of depression among mothers of young children are high, with different studies finding rates anywhere from 12 to 50 percent, depending on the measures used (Gurian, 2003). This risk appears to be exacerbated for mothers of young children living in poverty (Pettersen and Albers, 2001). In comparison, approximately 7 percent of the general adult population is affected by major depressive disorder at any given time (Kessler et al., 2005).

The effect of maternal depression, not only on the women themselves but also on their infants and young children, has been well documented. Less data have been collected on the impact of depression in fathers. As young as two months of age, infants of depressed mothers can show difficulties in engaging in social interactions as well as in their ability to regulate their states (i.e., calm themselves when upset) (Weinberg and Tronick, 1998). As children grow, having a depressed mother puts them at increased risk for both internalizing (e.g., depression) and externalizing (e.g., acting out in classrooms) symptoms, as well as behavior problems in general (for a review, see Rosman and Yoshikawa, 2001). Maternal depression may also affect very specific parenting practices. Mothers reporting a high level of depressive symptoms are significantly less likely to engage in prevention practices such as car seat use and covering electrical plugs (McLennan and Kotelchuck, 2000). Another study found that both mothers and

fathers who experienced more depressive symptoms were less likely to maintain daily nap, meal, and bedtime routines or to read to their child daily, all of which are activities that contribute to improved health, development, and school readiness (Young, Davis, Schoen, and Parker, 1998).

**Substance Abuse.** According to data from the National Survey on Drug Use and Health (2005), an estimated 22.5 million persons aged 12 or older in 2004 were classified with substance dependence or abuse in the past year (9.4 percent of the total population). Specifically, the rate of substance dependence or abuse<sup>1</sup> was 8.8 percent for youths aged 12 to 17, 21.2 percent for persons aged 18 to 25, and 7.3 percent for persons aged 26 or older. Further, there were 4.6 million adults with both serious psychological distress and a co-occurring substance use disorder in 2004. In their review of the literature, Werner, Joffe, and Graham (1999) cite studies that demonstrate the “wide range of important morbidity experienced by the children of substance-abusing families” (p. 1099). Children whose mothers abuse substances while pregnant are more likely to experience birth defects and developmental delays, and, as they grow, they are more likely to experience emotional disorders, anxiety, and conduct disorders, as well as school problems. Children of women who abuse alcohol have also been found to be at increased risk of experiencing unintentional injuries, and this risk increases for children who have two parents with alcohol problems. These children are also at increased risk of physical and sexual abuse. It is clear that parental mental health and substance abuse places children at higher risk for a broad range of compromised developmental outcomes (Werner et al., 1999).

**Child Behavioral and Emotional Disorders.** Finally, millions of children themselves experience behavioral and emotional problems, with early childhood being a critical time for onset of these problems. Estimates of national prevalence rates of young children

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<sup>1</sup> Respondents are classified as dependent on or abusing specific substances based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV) (American Psychiatric Association [APA], 1994). The questions on dependence ask about health and emotional problems associated with substance use, unsuccessful attempts to cut down on use, tolerance, withdrawal, and other symptoms related to substance use. The questions on abuse ask about problems at work, home, and school; problems with family or friends; physical danger; and trouble with the law due to substance use.

with psychosocial problems are between 10 percent and 21 percent, while rates specifically for externalizing problems can be as high as 25 percent (Powell, Fixsen, and Dunlap, 2003). In infants and toddlers, these problems can manifest themselves as an inability to regulate emotions and form secure attachments (e.g., strong, enduring affective bonds with caregivers), while in preschoolers, they often manifest themselves as challenging behaviors such as being disruptive in child care or school settings. While many children go undiagnosed and untreated, in 1997 there were, nonetheless, almost 120,000 preschoolers (1 out of 200) between the ages of birth and six who received mental health services (New Freedom Commission on Mental Health, 2003).

### Why Focus on Infants and Toddlers?

New findings in neuroscience, child development, developmental stress research, and infant psychiatry have established that rapid brain development during the prenatal period and from birth to age three lays a critical foundation for healthy subsequent development. Essential capabilities related to cognition, language acquisition, emotional regulation, and interpersonal relatedness are developed through a continuous interplay of biology and experience (Shonkoff and Phillips, 2000). Early experiences, including the quality of relationships with parents and/or primary caregivers (e.g., grandparents, foster parents, other relatives, etc.), play a prominent role in providing positive experiences for healthy development. Equally important is that children's development is significantly tied to the health and well-being of their parents. Research indicates that millions of parents are affected by a mental health and/or substance abuse disorder, which may compromise their ability to provide for their child's physical and emotional well-being. Sixty-eight percent of women and 55 percent of men who experience a mental illness during their lifetime are parents (Nicholson, et al, 2001). And in 2001 more than 6 million children lived with at least one parent who abused or was dependent on alcohol or an illicit drug during the past year; approximately 10 percent of children involved in this study were aged five or younger (SAMHSA, 2004). Children who have a parent with a mental illness and/or substance abuse disorder are at greater risk for the development of psychosocial problems, including developing later substance abuse and/or mental health problems of their own.

### Why Screen: The Need for an Intergenerational Approach to Screening in the Primary Care Setting

Primary health care providers represent a significant point of contact for young children in the first few years of life. They see families on a frequent basis and are in a key position to intervene early by screening the family as a whole, as appropriate, when identifying mental health and substance abuse problems in parents/caregivers *and* when conducting behavioral/emotional screens of infants and toddlers. The most basic argument for more comprehensive developmental screening is that it can lead to early identification of social-emotional and biological problems. That identification could lead to a referral for preventive or treatment interventions by behavioral health and medical specialists. The American Academy of Pediatrics defines screening as a “brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment” (AAP, 2001, p. 192). The SAMHSA statement on screening and early detection highlights several principles that communities and providers should adhere to in implementing screening programs. These include:

- “do no harm;”
- screening must be voluntary, with parental consent (in the case of children);
- screening instruments must be valid and reliable, and the person administering them must be qualified and trained;
- screening must be done in a culturally competent manner;
- screening should never be used to make a diagnosis, but should, instead, be followed by in-depth assessment; and,
- confidentiality must always be ensured (Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2005).

Screening is a tool for identifying individuals who show certain indicators of a specific condition (e.g., developmental delay, mental health disorder, or substance abuse problem) and who need further evaluation. This is differentiated from assessment, which is conducted in order to determine a diagnosis and treatment plan. For example, developmental screening can be a tool for a primary care provider to move beyond the child’s physical health and to open a door for more thorough evaluation, if warranted. This is especially important for infants and toddlers, as early identification leads to earlier intervention and treatment.

The federal programs that currently require young children to be screened regularly are Medicaid and the Infants and Toddlers Programs under the Individuals with Disabilities Education Act (IDEA). The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program is Medicaid's child health program for children ages from birth through age 21. Under EPSDT, all children must receive screening services, which include a comprehensive health and developmental history. The IDEA Amendments of 1997 mandate early identification of and intervention for disabilities in children as young as possible. While IDEA focuses primarily on screening children at risk for a wide range of physical and developmental disabilities, there has not been a focus on children at risk for serious behavioral/emotional problems. In fact, only eight states currently report serving children "at-risk" under their Part C eligibility definitions (Danaher and Armijo, 2005).

Advocates for expanding screening services have noted the promise of primary health care settings as screening sites for both children and their caregivers. Halfon and his colleagues note that more than 95 percent of infants and toddlers have a regular source of health care, with this figure as high as 85 percent even for uninsured children (Halfon, Regalado, McLearn, Kuo, and Wright, 2003). While it is necessary that all young children receive appropriate health care, which includes behavioral health elements, it is not sufficient. The *context* in which the child is growing and developing is critical—including the health and well-being of the child's primary caretakers. The fact that a child's parents are present in the primary care setting, suggests a key opportunity to use a "two-generation approach" for health (Shonkoff and Phillips, 2000).

Not only are pediatric primary care providers in a unique position to reach a large number of families, but research also suggests that families want screening and they want follow-up. Kahn et al. (1999) surveyed over 550 mothers bringing young children (18 months or younger) to pediatric primary care sites. Eighty-five percent of the women said they would welcome or not mind being asked about the specific conditions addressed in the study (significant/serious illness, smoking, alcohol problems, depressive symptoms, risk for unintended pregnancy, emotional/verbal abuse, physical abuse, and self-assessed fair/poor health). Ninety percent said they would welcome or not mind an offer of help with making appointments with an adult care provider (i.e., receiving a

facilitated referral) if they were affected by one of these issues. In a focus group study of young mothers, Heneghan, Mercer, and DeLeone (2004) found that mothers were open to discussing parenting stress and depression with their child's pediatrician, provided a trusting relationship had been established first.

Not only is screening recommended for parents, but a good deal of research points to several effective screening tools that could be used to assess both adult mental health and substance abuse issues and children's emotional and behavioral disorders. Looking at adult mental health and substance abuse issues, Werner et al. (1999) recommend that screening for alcohol and other drug abuse begin with the prenatal visit and focus on how substance abuse can affect parenting and the home environment. They recommend measures such as the CAGE Questionnaire and the Alcohol Use Disorders Inventory (AUDIT). Moving to maternal depression, Olson et al. (2002) review literature that suggests that a screening that uses only two questions—"During the past month, have you often been bothered by feeling down, depressed, or hopeless? During the past month, have you often been bothered by having little interest or pleasure in doing things?"—can be just as effective as longer questionnaires.

Finally, multiple tools exist for screening young children. Levitt and Jensen (2004) provide a thorough overview of available measures, including the Pediatric Symptom Checklist, which is a parent-report instrument. While many of these measures have been designed for older children, several have versions designed for younger children. AAP, in their surveillance and screening guidelines, acknowledges that screening for behavioral and psychosocial problems in young children can be especially challenging. However, they offer a list of specific tools that doctors can employ, such as the Temperament and Atypical Behavior Scale, Child Behavior Checklist, The Carey Temperament Scales, Eyberg Child Behavior Inventory, Pediatric Symptom Checklist, and Family Psychosocial Screening (AAP, 2001).

It is also possible that something more basic than a formal questionnaire can be used as a screening tool—parental concerns. Glascoe (1997), working with a sample of over 400 children between the ages of 21 and 84 months, used the Parents' Evaluations of Developmental Status to elicit parent concerns. It is

a two-question-measure that takes less than three minutes to administer and asks parents one open-ended question about concerns, followed by questions about concerns in each developmental domain. Glascoe found that parents' concerns were highly sensitive predictors of developmental problems and that the absence of concerns was also generally associated with typical development, leading her to conclude that "...parents' concerns can be safely recommended for use as a screening tool" (p. 527).

In summary, the prevalence of mental health and substance abuse challenges in families with young children, along with the known impact of these problems on young children's development, point to the need for more pediatric and family health care providers to focus on the family as a whole and for screening [of both children and caregivers], as appropriate, for behavioral health problems. This is particularly important in pediatric settings that serve a high percentage of low-income families with young children, because rates of maternal depression, domestic violence, and substance abuse are higher in this population (Knitzer, 2000), as are rates of behavioral problems in young children (Qi and Kaiser, 2003). In order to promote the adoption of innovative approaches to integrating behavioral health into pediatric primary care settings, we sought out examples that could be synthesized and shared in this document.

# Methodology for Site Selection

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The federal team generated the criteria for selecting the sites to be interviewed. Specifically, interviews were to be conducted at between six and nine pediatric settings that:

- Served pregnant women and/or families with children under the age of four;
- Integrated screening for adult mental health and substance abuse issues into their primary care practice;
- Integrated developmental screening for children into their routine primary care practice;
- Implemented a medical home model; and,
- Provided facilitated referrals in the context of ongoing relationships with the family and community-based providers.

An Expert Workgroup was established as part of this project. Members convened to provide guidance on the selection of sites and the development of the interview protocol. A national call for nominations was initiated in the spring 2005 through two primary strategies: contacts with national experts in integrating behavioral health into pediatric care and emails on relevant list-serves (e.g., the State Early Childhood Comprehensive Services grantees; Early Head Start technical assistance). Sites were asked to provide a brief description of how they had addressed each of the selection criteria. Fifteen sites submitted complete applications and often included additional documentation. The federal team in collaboration with the research team at Georgetown University reviewed these applications and made the final site selections. An effort was made to have a mix of rural and urban sites, as well as

sites that served different populations (e.g., children enrolled in Medicaid; families from varied ethnic/racial groups). Eight sites were selected for in-depth interviews.

The authors gathered interview data both on-site and through telephone interviews. On-site visits were made to four sites: Beaufort, South Carolina; Los Angeles, California; Seattle, Washington; and Washington, D.C. Data were collected at the four remaining sites through telephone interviews with multiple informants. For each site, a variety of respondents was interviewed, including: lead pediatricians, family members, mental health and substance abuse providers, and front-line pediatric staff. Interview data was then synthesized into case studies.

# Case Studies

The Case Studies section provides basic information about each of the eight sites, including an overview; history and mission; demographic information about the area where the site is located and the population served; information about staff composition, as well as the strategies employed for staff development; and information about financing for services rendered. A synthesis of the strategies each site used to address the core constructs addressed in this study (i.e., medical home, family-centered care, comprehensive screening, facilitated referrals, mental health and substance abuse services, and cultural and linguistic competence) is presented in subsequent sections (beginning on page 45).

## Beaufort Pediatrics

Beaufort, SC

BEAUFORT PEDIATRICS (AT-A-GLANCE)		
Site Description	Staffing/Staff Development	Financing
<p>Large, rural pediatric practice committed to “improving preventive and developmental services to patients under the age of 5...”</p> <hr/> <p>15,000 patients 60 % Medicaid 50 % African-American, 45 % Caucasian, 5 % Latino</p>	<p>7 Physicians 1 Nurse practitioner 20 Additional staff 2 Social workers</p> <hr/> <p>Evening staff meetings Lunchtime trainings Plan, Do, Study, Act cycle tool to affect change</p>	<p>Medicaid (60 %) Self-pay (20 %) Private insurance (20 %)</p> <p>Bill 96110 code to pay for screening services</p>

**History and Mission:** Located directly across from the hospital on a quiet road a few blocks from downtown Beaufort, Beaufort Pediatrics is at first glance a low-key, small-town doctors’ office. Following the Bright Futures model, the practice’s goal is to “improve preventive and developmental services to patients under the age of five, so that our patients are healthy and safe, capable of sustained attention and life-long learning, able to participate in productive interpersonal relationships, and appropriately moderate

*Beaufort Pediatrics*  
*Continued*

their emotions.” Another goal is to ensure that parents and the community emotionally nurture all children. To reach this goal, Beaufort Pediatrics is working towards a greater awareness of and attention to the needs of the whole family, as well as the emotional, social, and educational needs of children. There are color-coded charts taped to the wall in the nurses’ stations to remind nurses and doctors which screening tools to use for children and families of various ages. The corresponding color-coded tools themselves lie on the counter. Another memo reminds the doctors of the billing codes for various screenings. The number of screens each doctor completes weekly is tracked through insurance documentation.

**Setting and Population Served:** A relatively large percentage of the population that Beaufort Pediatrics serves is comprised of both minority and low-income families. Sixty percent of their patients receive Medicaid. However, they also see children from very wealthy families, as Beaufort County includes Hilton Head and its sprawling suburbs. There are currently approximately 15,000 charts at Beaufort Pediatrics. Their patients are 50 percent African-American, 45 percent Caucasian, and 5 percent Latino. Beaufort Pediatrics is the third largest pediatric practice in South Carolina.

**Staffing and Staff Development:** Seven doctors, one nurse practitioner, and 20 additional staff work at Beaufort Pediatrics. They also have two social workers on-site, one of whom works full-time and was originally co-located at the practice as part of a Maternal Child Health Bureau medical home grant. Her job is to monitor and coordinate services for all of the children receiving Title V benefits. The second social worker is in the office 10 to 15 hours a week to see children and families that the doctors refer for mental health services. During the week, the practice is open from 7:00 A.M. to 7:00 P.M. While appointments are preferred, walk-ins are accommodated. When parents call, they can request the specific doctor they would like to see. One of the receptionists speaks Spanish, which has led to a significant increase in Spanish-speaking patients.

Staff development can be difficult to schedule, since doctors stagger their hours to ensure coverage from 7:00 A.M. to 7:00 P.M. Meetings among the doctors are now typically held in the evening; receptionists have recently begun trying to schedule evening meetings as well. They have settled on sporadic lunchtime trainings (lunch is provided), along with weekly Tuesday morning meetings. These meetings usually focus on Plan, Do, Study, Act (PDSA) cycles, a tool being used to effect quick, small-scale change in clinical practices (Plsek, 1999). Once a problem is identified, PDSA calls for planning a specific adaptation, implementing it, studying the effects, and then acting on what is learned to launch a new cycle. At these meetings, everyone is assigned a specific task for the next cycle, and this functions to increase both involvement and ownership.

**Financing:** Beaufort Pediatrics has two full-time staff members devoted to billing, one for Medicaid and one for private insurance. Approximately 20 percent of their total revenue comes from patients who self-pay, and 20 percent comes from private insurance; the remainder is Medicaid revenue. One key innovation that Beaufort Pediatrics has discovered is that it is possible to bill for administering developmental and behavioral health screenings. The 96110 billing code can be used for four children's developmental and behavioral screenings used in the practice. The practice receives \$24 for each screening tool administered. The practice is using billing data to determine which doctors are conducting (and billing for) screenings, and then using that data to promote widespread adoption of screening throughout the practice via PDSA cycles. For the future, Beaufort Pediatric's strategic plan calls for hiring a PEP (Medicaid's Physicians Enhanced Program) compliance officer to ensure that patients' referrals are properly tracked and to encourage patients to make new appointments if they fail to keep an initial appointment.

**Foster Care Pediatrics**  
Rochester, NY

FOSTER CARE PEDIATRICS (AT-A-GLANCE)		
Site Description	Staffing/Staff Development	Financing
<p>Small, suburban primary care pediatric office based in the health department to provide high quality primary care and case management services to children in foster care.</p> <hr/> <p>670 children in foster care and their foster/birth parents 45% African-American 30% Caucasian 15% Latino 10% mixed ethnicity or ethnicity unknown</p>	<p>2 Physicians 3 Nurse practitioners .5 FTE Social worker 5.5 FTE Nurses 1 Health-aide 2 Clerks</p> <hr/> <p>Weekly clinical meetings for review and consultation Didactic trainings twice a month Consultation by partner mental health agency Annual retreat for staff Staff development opportunities in local community</p>	<p>Medicaid fee-for-service (100%)—including case management services</p>

**History and Mission:** Foster Care Pediatrics started in 1986 when Dr. Moira Szilagyi, then a medical resident, began to identify the need for “good, comprehensive medical care” for children in foster care in Monroe County, New York. Dr. Szilagyi began working with the deputy director of social services to start a task force to investigate issues related to health care for children in foster care. They discovered that 400 of the children in foster care had no doctor identified, and several hundred had not seen a doctor for their entire length of time in care (which was the norm for children in foster care nationally at that time). They determined that the most efficient and affordable model for improving services for these children would be serving them on-site, and the Monroe County Department of Health agreed. Two months after the practice got underway, a local pediatrician who had served on the initial task force became the director of the Monroe County Department of Health. He has been a staunch supporter of the practice’s philosophy. Foster Care Pediatrics’ mission is to provide high quality primary care and case management services to children in foster care. While providing medical care only to children, staff at Foster Care Pediatrics also considers their clients to include foster parents, casework staff, birth parents, attorneys, guardians, and other health care agencies that serve the children.

**Setting and Population Served:** While the patient load at Foster Care Pediatrics has ranged from 640 to 900 children, they currently serve 670 children. Approximately 45 percent of their patients are African-American, 30 percent White and 15 percent Latino. Thirty-five percent are under the age of five.

**Staffing and Staff Development:** Dr. Szilagyi runs the practice and works approximately 30 hours a week. The rest of the staff includes another physician, (whose time is donated by the University of Rochester) who works four hours a week; three nurse practitioners (one, four days a week, one for two days a week, and one on a per-diem basis); a half-time social worker on-site who primarily works on making facilitated mental health referrals, coordinating mental health programs, and supporting foster parents; five nurses (four public health nurses and one LPN); one health aide for hearing, vision, and clerical work, including entering immunizations in the county registry for foster children; two full-time clerks; and a volunteer, one to two days a week, who maintains the bulletin boards. Many nurses are on staff because of the large amount of case management responsibilities. According to a recent time flow study, staff members spend approximately half of their total time on primary care and half on case management.

Staff training at Foster Care Pediatrics is mainly conducted during weekly meetings. One nurse in the practice is responsible for quality assurance to ensure that charts are properly documented and up-to-date. This job is particularly critical, since charts may be requested by a court at any time. She audits ten charts per week and then reports back to the staff at weekly meetings. Typically, two staff meetings per month are didactic sessions on a current topic. There is also a full-day team-building retreat once a year, where they address such issues as how to combat compassion fatigue. In general, training is more informal than formal, although staff is encouraged to participate in any free training that is available.

**Financing:** The care coordination component of Foster Care Pediatrics used to be funded out of county general health dollars. Two years ago, a financial crisis resulted in Foster Care Pediatrics being cut out of the budget completely. The local Medicaid managed care (Monroe Plan), Rochester Safe Start (a program committed to preventing and reducing the harmful effects of

exposure to violence on young children), and the Department of Pediatrics at the University of Rochester agreed to pay for services for the year. According to Dr. Szilagy, this sent a strong message to the local political powers about how the community valued Foster Care Pediatrics. Furthermore, foster parents and case workers testified before the legislature on the practice’s behalf, so that the following year they again had their own budget line. Primary care services are all billed to Medicaid. They are exclusively fee-for-service, as the practice has waived out of Medicaid managed care. They are not set up to bill private insurance.

**Guilford Child Health, Inc.**  
Greensboro, NC

GUILFORD CHILD HEALTH (AT-A-GLANCE)		
Site Description	Staffing/Staff Development	Financing
Large, urban multi-site practice serving children and adolescents and their families who live at, or below, 200 percent of the Federal Poverty Line.	15 Physicians and 5 Nurse practitioners 1 Finance Director 2 each, Certified Medicaid coders and data entry staff	Medicaid Health Choice (NC’s CHIP program) County funds  Bill 96110 code from Medicaid to pay for screening services
30,000 patients 45% African-American 35% Latino 15% Caucasian 5% refugee/immigrant (including Vietnamese, Laotian, Montagnard, Ethiopian, and Somalian)	Written “protocols” to prepare and guide staff Monthly staff meetings Lunchtime trainings	

**History and Mission:** Guilford Child Health, Inc. (GCH), is a private, nonprofit medical practice responsible for serving children and adolescents in Guilford County, North Carolina, whose families live at or below 200 percent of the federal poverty line. GCH incorporates into its mission two primary goals: to serve the whole child, recognizing relationships in the family, school, and community; and to provide a medical home for the children and adolescents they serve. Because of GCH’s commitment to cutting edge, best practice for children and families, GCH, led by Dr. Marian Earls, has become a leader in the state, encouraging other primary care providers to incorporate screening into their practices. One of the principal ways this has occurred is through GCH’s

participation with the Medicaid Community Care Network (Partnership for Health Management, or P4HM), a private, nonprofit funded through Medicaid to increase patients' access to care, as well as cost containment. Through P4HM, GCH has worked towards improving developmental screening and case management for all children. They are also currently participating, with P4HM, in a Mental Health/PCP Integration Initiative, designed to improve mental health services in the county.

**Setting and Population Served:** GCH currently sees approximately 30,000 patients, with the largest percentage being African-American (45 percent), followed by Latino (35 percent), Caucasian (15 percent), and a group of refugee/immigrants from many countries (5 percent). Because Greensboro is a refugee resettlement area, approximately 30 percent of the patients don't speak English or Spanish (and represent multiple ethnicities, including Bosnian, Vietnamese, Hmong, and African).

They operate two large sites and one small site, with 15 physicians and five nurse practitioners spread across those three sites. They are open from 8:30 A.M. to 5:30 P.M. Monday through Friday, as well as Saturday mornings.

**Staffing and Staff Development:** With 15 doctors, GCH has long functioned by consensus, with doctors agreeing upon protocols for practice-wide implementation. This means that the providers are used to the fact that they are not 15 people practicing 15 different ways. Protocols typically develop because one or two physicians have an interest and will take the initiative to change the way something is done. Staff at each site meets one Wednesday a month, when they close the practice for the morning. They report that this amount of time is never adequate, especially if they are going to be training provider staff on a new protocol. In those cases, whoever is presenting the training will do a formal presentation at each of the three sites during lunches. On a more individualized basis, the teams that take care of children with chronic health care needs try to meet together after each team-directed care clinic to discuss the children they have just seen. The social workers meet weekly as well.

*Guilford Child  
Health, Inc. Continued*

**Financing:** GCH is mandated to care for all children in the county at or below 200 percent of the federal poverty line. Approximately 86 percent of their patients receive Medicaid, 6 percent have Health Choice (the North Carolina Children’s Health Insurance Program, or CHIP<sup>2</sup>), and the rest is a growing population of uninsured children, made up almost entirely of undocumented immigrants. They are not allowed to close the practice to new patients, and currently they use county funds, approved by the county commissioners, to pay for the child health clinic to supplement what Medicaid doesn’t cover and to allow them to care for uninsured patients. As with other private practices, they will bill when they administer developmental assessments (code 96110). They cannot do this with screenings administered as part of regular check-ups, because in North Carolina payment is bundled for all aspects of the well-child visit provided as part of Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program<sup>3</sup>. However, if a social worker administers a secondary screen or assessment, it can be billed using a therapy code. For example, if a child has an at-risk score on the Ages and Stages Questionnaires in the Personal-Social domain or if the parent or caregiver has a concern in that area or there are risk factors such as maternal depression, domestic violence, or substance abuse issues, then the Ages and Stages Questionnaires Social-Emotional is administered. GCH has on staff a finance director, an accountant, two certified coders, and two people doing charge entries. GCH is the recipient of a Health Resources and Services Administration (HRSA) grant for development of a community web-based system for the community care network of which they are part (this includes multiple practices and agencies, not just GCH).

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<sup>2</sup> CHIP is a federal program designed to provide funding to states to deliver health insurance to children in families with incomes too high to qualify for Medicaid but too low to afford private health insurance.

<sup>3</sup> EPSDT is Medicaid’s child health program for children ages 0-21. Under EPSDT, all children must receive screening services, which include a comprehensive health and developmental history.

## Hagan and Rinehart Pediatricians

*Burlington, VT*

HAGAN & RINEHART (AT-A-GLANCE)		
Site Description	Staffing/Staff Development	Financing
<p>Large, suburban pediatric practice committed to providing comprehensive and compassionate care for children and families that is family-centered, culturally competent, and readily accessible.</p> <hr/> <p>3,000 patients Majority Caucasian Small influx of Bosnian and Russian immigrants 20% with special health care needs</p>	<p>2 Pediatricians 2 Nurse practitioners 16 Staff (part-time nursing and administrative)</p> <hr/> <p>Monthly staff meetings Bi-weekly Medical Home Updates, care conferences to discuss special needs for care Annual conferences on family-centered care and parent-to-parent training</p>	<p>Private insurance (70%) Medicaid (20%) Self-pay (10%)</p>

**History and Mission:** In 1991, Dr. Joe Hagan left a larger practice to start a small pediatric practice with one office manager and one nurse. The practice expanded with the addition of another pediatrician Dr. Jill Rinehart in 1999 to form Hagan and Rinehart Pediatricians. The pediatricians, nurse practitioners, nurses and staff of Hagan and Rinehart Pediatricians, PLLC, are committed to comprehensive and compassionate care for their patients and families. They feel this will be achieved with care that is family-centered, culturally competent, and readily accessible to the families of the Burlington community.

The practice is committed to the medical home model. Dr. Rinehart was on the American Academy of Pediatrics' original Medical Home Committee and helped write the original policy statement in support of medical homes. Their practice addresses the standard AAP definition directly, providing care coordinators and "24/7" accessibility for their patients and their families.

Hagan and Rinehart have also developed a unique relationship with the Lund Family Center, a residential substance abuse treatment program for women and young children, located "just up the hill" from the practice. Many women come to Lund pregnant, and it may be the first time they are receiving prenatal care. Their children up to age five can be served residentially at Lund with their mothers. Since there is a pediatrician on-site at Lund only every other week, Drs. Hagan and Rinehart become many of the children's primary care providers. This relationship is

*Hagan and Rinehart  
Pediatricians Continued*

long-standing, and so the nursing staff at Lund coordinates with the staff at Hagan and Rinehart to determine what services a child needs and what basic information the Lund mothers need to know before they call a doctor. The staff at Lund truly views Drs. Hagan and Rinehart as an extension of their team. When issues arise at Lund such as the recent case of a residential toddler who was sexually abused and having multiple acting-out issues, staff at Lund will often invite one of the pediatricians to meet with the residential mothers to discuss appropriate behavior as well as strategies for supporting the mother and child dyad.

**Setting and Population Served:** The practice currently has approximately 3,000 patients; the vast majority is Caucasian and a small percentage are immigrants from Bosnia and Russia. Approximately 20 percent of the patients have been identified with some form of special health care needs.

**Staffing and Staff Development:** Hagan and Rinehart now has a total of 16 staff members, including the two doctors and two nurse practitioners. They are open from 8:30 A.M. to 5:00 P.M., Monday through Friday, with one of the two doctors on call every night, in keeping with a medical home model. While there are no well visits scheduled for weekends, the doctors will see sick patients in the office on weekends.

Staff development is conducted during monthly staff meetings, as well as through care conferences on Monday and Wednesday. At the monthly meetings, there is always a medical home update to talk about children with special health care needs that are new to the practice. The care conferences are designed for families with children with special needs who are served by multiple providers, and they function as occasions for updates and problem solving. Family members and providers attend the care conferences. Staff members also attend annual family-centered care and parent-to-parent conferences.

**Financing:** The majority of the patients at the practice pay with private insurance, with less than 20 percent on Medicaid and approximately 10 percent pay-as-you-go.

**Healthy Steps**  
Fresno, CA

HEALTHY STEPS FRESNO (AT-A-GLANCE)		
Site Description	Staffing/Staff Development	Financing
<p>Large, urban hospital medical center draws from surrounding suburban and rural areas “to provide the best clinical services” and train pediatric residents, using Healthy Steps program to support training and provide developmental services.</p> <hr/> <p>9,000 patient capacity at Children’s Health Center 220 client capacity for Healthy Steps program 97% Medicaid or no insurance 80% Latino (50% monolingual Spanish)</p>	<p>1 Mental health professional 1 Child development specialist 30 Pediatric residents in training</p> <hr/> <p><b>Pediatric Residency Training Program:</b> Weekly didactic training Daily experiential activities including home visits, tandem visits with pediatric resident and Healthy Steps specialist, and individual coaching and consultation</p>	<p>Medical Center Services: Medicaid (97%) Self pay (very few) California Children’s Services for indigent families</p> <p><b>Healthy Steps Services:</b> First 5 Fresno Grant, Children &amp; Families Commission of Fresno County</p>

**History and Mission:** Healthy Steps in Fresno, California, is based in the Children’s Health Center at University Medical Center, which is affiliated with the University of California San Francisco (UCSF) School of Medicine Fresno Pediatric Residency Training Program. Residents are post-graduate doctors learning the specialty of pediatrics. Fresno Healthy Steps is in its third year of operation as a replication site for the national Healthy Steps for Young Children program, which was originally designed to address gaps in developmental and behavioral care for children ages birth to three. The results of the three-year national study by the Commonwealth Fund inspired and guided the implementation of the program within the Fresno Pediatric Residency Training. The intent of the Fresno model is to deliver high quality care to families and children and at the same time train pediatric residents in a behavioral and developmental approach to early childhood health care. The Healthy Steps specialist provides direct services by working with the pediatric resident during well-child care visits, making home visits, completing developmental assessments, providing telephone support, offering written materials aimed at prevention and promotion to families, offering parent groups, linking families to community resources, and implementing Reach Out and Read. The Healthy Steps specialist has expertise in prenatal care, child development, parenting, and prevention and provides didactic and experiential training to the pediatric residents.

*Healthy Steps  
Continued*

**Setting and Population Served:** Healthy Steps in Fresno is part of the Children’s Health Center at the University Medical Center. The Children’s Health Center serves approximately 9,000 patients per year from the city of Fresno, the city’s suburbs, and the surrounding county, which is rural and agricultural. The community includes a large number of Latino and Mexican Spanish-speaking families. Healthy Steps currently serves about 150 first-time mothers and families, prenatally and until the children reach four years old. The program expects to reach its total capacity of 220 in spring 2006. The guidelines for enrollment in Healthy Steps are:

- Families who have or plan to have pediatric care at the Children’s Health Center;
- Priority to babies born to first-time mothers and/or first-time fathers;
- Enrollment on or after 35-weeks gestation; and/or
- Enrollment at the newborn exam or after, as space allows.

Referrals to the program are received through three program partners: Comprehensive Perinatal Services Program, the Fresno Community Hospital labor and delivery service, and newborn exams at the Children’s Health Center.

**Staffing and Staff Development:** The program is staffed by a clinical social worker who is the Coordinator of Developmental and Behavioral Pediatrics with UCSF Fresno Pediatric Residency Program and Co-primary Investigator of the Healthy Steps grant; the Healthy Steps specialist with the Children’s Health Center, University Medical Center; and an evaluator. The Healthy Steps specialist and the pediatric residents deliver the majority of the services. Roughly 30 residents participate in the three-year Residency Training Program. Residents operate in Continuity Teams, which include seven or eight residents, a nurse practitioner, and an attending faculty in charge. Residents are assigned a panel of patients, and each resident has between eight and ten Healthy Steps patients/families that they follow as part of that program. Residents act as a child’s primary pediatric care provider for the duration of their training.

Within the larger scope of the pediatric residency program, training for pediatric residents includes didactic and hands-on training under the guidance of the Healthy Steps specialist. Specifically, one morning a week is dedicated to lectures on child development,

videos, and observations of children at the Huggins Child Development Center in the Department of Education at Fresno State University. Residents also accompany the Healthy Steps specialist on prenatal home visits and operate as a team for all well-child care visits.

**Financing:** Healthy Steps is grant funded through First 5 Fresno, the early childhood health, education, and support services initiative within the Children and Families Commission of Fresno County, California (<http://www.first5fresno.org/contactus.htm>). The program is entering its third year of operation. The total grant funding is \$151,163 per year for a total of three years. None of the Healthy Steps services is currently billed to any insurance plan.

**High Point Medical and Dental Clinic**  
*Seattle, WA*

HIGH POINT MEDICAL AND DENTAL CLINIC (AT-A-GLANCE)		
Site Description	Staffing/Staff Development	Financing
<p>Large, urban family practice community health clinic dedicated to “partnership with families” and “100 percent access and 0 percent disparities.”</p> <hr/> <p>8,000 patient capacity 78% Below poverty line 30% Caucasian 21% African American 2% Am. Indian/Alaska Native 21% Asian/Pacific Islander 17% Latino 9% Other</p>	<p>7 Family practice teams: physician or physician’s assistant; nurse, and medical assistant 6 Dentists 8 Dental hygienists 1 Behavioral health specialist 2 Behavioral health interns 1 Chemical dependency provider (on-call) 1 Health educator 1 Social worker 1 Midwife (with 5 additional on-call) 3 WIC program staff 1 Referral coordinator 1 Health service’s coordinator 3 Interpreters 1 Program manager Other administrative staff</p> <hr/> <p>Existing meetings for training as needed Consultation and coaching Balint Group, peer support and case consultation for physicians Learning conversation, personnel review</p>	<p>Medicaid Community Health Plan (Healthy Options, CHIP, and Basic Health Plan) State DHSA, Alcohol, Drug Treatment Services Act funds Self-pay, sliding scale Foundation funds (supplement unreimbursed health care) Kids Get Care, Community Access Program Grant (HRSA) Public Housing Primary Care Grant (HRSA)</p>

*High Point Medical  
and Dental Clinic  
Continued*

**History and Mission:** High Point Medical and Dental Clinic is a community health clinic and part of a network of Puget Sound Neighborhood Health Centers (PSNHC), a private, nonprofit organization providing health services in central and west Seattle, Washington. This network includes three school-based Teen Health Centers, two Wellness Centers, and seven community clinics, including High Point. The mission of PSNHC is to provide community-based medical and dental health care services to people of all ages and ethnic backgrounds throughout Seattle and King County. At High Point Medical and Dental Clinic, individuals and families are perceived as partners and part of the health care team, with services guided by the goal of “100% access and 0% disparities.” High Point provides a range of primary care health services in a family practice model, including: prenatal, delivery, and midwifery services; newborn care, well-baby and well-child care; social work services; mental health and substance abuse counseling services; health education programs; pharmacy and laboratory services; and Women, Infants, and Children (WIC) services. High Point’s Dental Clinic serves children under the age of 19 and pregnant women. The adult dental care practice is limited to residents of the community or patients at High Point Medical Clinic.

**Setting and Population Served:** High Point Medical and Dental Clinic is located in West Seattle in a culturally and linguistically diverse community. Residents and High Point patients speak more than 30 languages, and many of them are new immigrants and young families—most of whom are low income and many of whom are indigent. The neighborhood is in transition from an urban center with old public housing high-rises to one of newly constructed mixed housing facilities. High Point Medical and Dental Clinic has recently moved to a new building with modern and welcoming features, including state-of-the-art dental facilities. High Point is next-door to the public library, which is also new, and residential buildings surround both. Public transportation is available, with a bus stop at the curb by the clinic. The clinic hours are 8:00 A.M. to 6:00 P.M. most weekdays and 9:00 A.M. to 2:00 P.M. on Saturdays, with after-hours telephone support available.

**Staffing and Staff Development:** High Point Medical and Dental Clinic is staffed by seven family practice teams; each team includes a physician or physician’s assistant, nurse, and medical assistant. Other staff include one full-time behavioral health specialist

(employed by Highline Mental Health Center but on-site at High Point); a midwife, health educator, and social worker for maternal support services; six dentists and eight dental hygienists; three full-time, certified medical interpreters; a program manager; a referral coordinator; a health services coordinator; and other administrative support staff. A chemical dependency provider, who is located at the Rainier Park Clinic within the PSNHC network, is available and on-call for consultation and intervention.

High Point has had a long-standing agreement with Highline Mental Health Center, a community-based behavioral health services provider. A staff member from Highline has been co-located at High Point for a number of years to provide outpatient services. In 2003, High Point applied for and received a Kids Get Care grant funded by a Health Resources and Services Administration (HRSA) Community Access Program to promote integrated health, dental, and behavioral health for children from birth to five years and their families. With additional funding from the Washington Dental Association, High Point expanded these efforts to focus on oral health and community education. The combination of these grants and carry-over funding enabled High Point to partner with Highline Mental Health Center and engage the current, full-time, on-site behavioral health specialist. For the past year, two marriage and family therapy interns have expanded these services under the supervision of the behavioral health specialist.

Staff development activities include periodic training events; regular staff meetings; physician participation in a Balint group (a facilitated, peer group learning process in which a member of the group presents a patient case situation, and then the group discusses the doctor/patient relationship); consultation and coaching; and support and/or funding for individual professional development. Although no formal staff development plan is in place, specific training related to behavioral health issues have included the King County Health Department's Kids Get Care "Red Flags" Tools training on early child development (including social and emotional aspects) and an in-house de-escalation training focused on how to calm and respond to an individual who is in crisis. The primary mode for staff development related to behavioral health issues is through consultation and coaching.

*High Point Medical  
and Dental Clinic  
Continued*

**Financing:** PSNHC is a recipient of a HRSA Public Housing Primary Care (PHPC) grant support program and services delivery. The PHPC program is a federal grant program created under the Disadvantaged Minority Health Improvement Act of 1990, reauthorized in 1996, to provide accessible comprehensive primary care and supportive services in order to improve the overall health and well-being of the public housing community and to eliminate health disparities. In addition, primary care and dental care services are billed to Medicaid and Community Health Plan coverage (Healthy Options, CHIP, and Basic Health Plan). Patient fees for self-pay patients operate on a sliding scale. Un-reimbursed medical care is supplemented by foundation funds. Patient representatives on staff are available to assist patients and families with eligibility and application for medical coverage as well as housing, transportation, and child care assistance. Medicaid changes at the state level and the need to qualify for special “coupons” have made access to coverage for mental health and substance abuse services challenging. Although historically the co-located services of the Highline Community Mental Health Center staff member, prior to this grant, billed Medicaid for services for those who qualified, behavioral health services are not billed at this time. High Point and PSNHC are developing the administrative and supervisory infrastructure to bill for behavioral health services as well as to continue to make them available to those ineligible for coverage. The Kids Get Care grant awarded in 2003 has paid for the behavioral health specialist’s services, but this funding ended in 2005. Because administration and health care providers at High Point have high value for integrated behavioral health services and its contribution to the quality of primary care services, HRSA grant funds and portions of the primary care and dental health services budgets have been dedicated to maintain the behavioral health specialist’s position as an interim funding mechanism.

## Hope Street Family Center

Los Angeles, CA

HOPE STREET FAMILY CENTER (AT-A-GLANCE)		
Site Description	Staffing/Staff Development	Financing
<p>Large, urban community-based family services center affiliated with Catholic Health Care West's California Hospital Medical Center, offering multiple co-located programs, including Early Head Start (EHS)</p> <hr/> <p>Hope Street Family Center serves more than 2000 clients in all programs Early Head Start program serves 152 pregnant women and children birth to three 95% Latino</p>	<p><b>Early Head Start program staff include:</b> 1 Program director 2 Mental health professionals: social services and mental health coordinator 1 Health coordinator 1 Child development and disabilities services coordinator 12 Home visitors Classroom teachers and aides Elected policy council</p> <hr/> <p>Continuous improvement focus through self-assessment, team approach, case conferences, and monthly documentation reviews Orientation training and departmental training, weekly reflective supervision and staff support</p>	<p><b>Hope Street Family Center funding sources:</b> US DHHS CA DOE LA DCFS LA Prop 10 Commission, USDA, and Crystal Stairs (child care)</p> <p><b>Early Head Start Program:</b> US DHHS direct award In-kind contributions</p> <p><b>Community Health Services Partners:</b> Medicaid Healthy Kids Public Private Partnership County MH and EPSDT</p>

**History and Mission:** Hope Street Family Center was established in October 1992, following the civil unrest that destabilized central Los Angeles. It was intended to create a greater sense of community through the collaborative effort of the California Hospital Medical Center (CHMC), the University of California, Los Angeles, and the residents of central Los Angeles. Hope Street is a multi-service agency dedicated to enhancing the overall development of children, strengthening the economic self-sufficiency and stability of families, and enhancing the community's service delivery system for young children and families. Through its community partnerships, Hope Street provides a comprehensive continuum of on-site educational, medical, developmental, and social services that support children and families from birth through adulthood. The philosophy underlying these efforts is one based on mutual respect, partnership, and an understanding that the community members themselves must guide meaningful community services.













































































































**4** Federal  
Team**Dawn Levinson, MSW***Policy Advisor on Children and Families*

Office of the Administrator, Office of Policy, Planning and Budget  
Substance Abuse and Mental Health Services Administration  
(SAMHSA)

U.S. Department of Health and Human Services

1 Choke Cherry Road, Room 8-1062

Rockville, MD 20857

**Michele M. Basen, MPA***Public Health Analyst*

Division of Knowledge Application and Systems Improvement  
Center for Substance Abuse Prevention, SAMHSA

1 Choke Cherry Road, Room 4-1026

Rockville, MD 20857

**Ruby Neville, MSW, LGSW***Public Health Advisor*

Division of State & Community Assistance

Center for Substance Abuse Treatment, SAMHSA

1 Choke Cherry Road, Room 5-1102

Rockville, MD 20857

**Gail F. Ritchie, MSW***Public Health Advisor*

Center for Mental Health Services

Division of Prevention, Traumatic Stress and  
Special Programs/PIPPDB

1 Choke Cherry Road, Room 6-1111

Rockville, MD 20857