



Broward County Children with Special Needs

Business Plan Report

Broward Regional Health Planning Council, Inc.

The creation of this document is 100% funded by a Children's Services Council of Broward County grant received by the Broward Regional Health Planning Council, Inc.

This document and more information about this project is available at

<http://www.brhpc.org/specialneeds>

TABLE OF CONTENTS

1.	Introduction	3
2.	Systems Model Recommendations	6
3.	Issues Affecting Implementing the Medical Home Model in Broward County	7
4.	Estimated Costs to Fund Unmet Need	11
5.	Recommendations	14
6.	References	20
	Appendix 1 – “Project Team”	24
	Appendix 2 – “A Lesson In Collaboration – The Evolution of the Study”	30
	Appendix 3 – “National Best Practice Models”	34
	Appendix 4 – “System Model Recommendations”	44
	Acknowledgements	56

1. INTRODUCTION

This report synthesizes the components and reports of the Special Needs Project commissioned by the Children's Services Council, and presents the major findings and recommendations resulting from the study. The findings and recommendations to the Children's Services Council are organized and styled as a business plan for the use of the provider community, funders, consumers, policy makers and the public.

The Parent/Caregiver and Service Provider Perceptions Report (Linda Bliss Ph.D.) and the Parent and Caregiver Survey Report (Len Bliss Ph.D.) detail the findings of a comprehensive series of activities including parent/caregiver interviews, focus groups, and survey as well as provider interviews and focus groups. Those activities identified parent/ caregiver and provider perceived needs, barriers to care and related experiential information essential to the compilation of these findings and recommendations. The information emerging from this effort gives context to what had previously been anecdotal.

In arriving at these recommendations, the team relied not only on the findings of the Bliss reports but also on a review of national Best Practices conducted by David Wood M.D. and Michael Brady Ph.D. Their efforts concentrated on reviewing the current service delivery components in light of national best practices and the specific findings outlined in the Bliss and Bliss reports. From this, Drs. Wood and Brady developed a best practice service delivery strategy which can be implemented in Broward County to enhance the scope of service delivery and move it toward a more comprehensive continuum of care approach. Specifically, while acknowledging the many outstanding efforts currently being undertaken to assist these children and their families, certain gaps in service delivery areas were identified when comparing Broward's current system of care to that of leading communities nationally. Their recommendations include: a comprehensive information and referral system; the adoption of a "no wrong door" approach; a case management mechanism that offers coordinated and intensive services which connects the family from the medical system to the social services system; and the use of a medical home model that offers family centered, comprehensive, continuous, coordinated, and easily accessible care.

What emerges from the surveys, focus groups and interviews are a series of insights that indicate Broward County enjoys certain successes in meeting the demands of children with special needs even though it experiences certain challenges that call for improvement in the service delivery system essential to the success of many of the children and families served. It also indicates that there is a significant parent and caregiver reported perception of children who are not receiving the full array of services that their diagnosis indicates as required. It further illustrates that significant numbers of parents are currently unaware of the full array of services available. Parents, and caregivers of these children, struggle to identify the needs of their children and hunt to find appropriate care with varying degrees of success. Frustrated, many of these parents stated that they could not find services for their children, or that the services they could find were not accessible either because of eligibility (age, diagnosis, income,

and medical insurance restrictions), lack of transportation and geographic proximity barriers.

A mother of a young boy with severe vision impairment recounted her reaction to the services her son was now receiving. In addition to being pleased, she seemed somewhat surprised at what her son was learning. She smiled as she said, "I would have to say, the difference in my son happened within days of when he started his developmental pre-school. I swear his vocabulary increased three-fold in a week. How much more social he was, how much more interested he was in food....it's been fantastic. It's really great. They treat everyone with such dignity and respect [there] and the kids [respond]. It's integrated, so some of the kids have zero problems, there are Down syndrome kids, dwarfism, amputee kids, and then kids with, you know, no other problems whatsoever. Those kids have such tolerance. I can't get over it."

An attorney voiced the concern of many middle class parents when he said, "It's a challenge for us financially" to pay for the services needed for his child. The middle class mother of 11 year old twin boys with an undiagnosed syndrome/autism reported that finances are the biggest hurdle for the family. She said that private insurance plus Medicaid "make our life livable and affordable" and that without this help they could no longer own their own home and get the boys the services they need. At the late September date of the interview, finances for the current school year were still being worked out with the school the boys attended. Reflecting the reality families with children with special needs face, one formerly middle class family has gone bankrupt; several others now depend on the financial support of extended families. Several parents reported being on the Med Waiver list for up to 5 years without receiving it. Finding and maintaining services is an ongoing pursuit for families of children with special needs.

Concerning the coming transition to adult services, the mother of a 19 year old with Down syndrome was typical, "I almost have a panic attack when I think about her future."

While parents indicated that service providers are talented and dedicated professionals, they are frustrated that the services that their children need cannot be accessed more simply, more effectively, more precisely and with dispatch. The most poignant examples include the many families that told surveyors how happy they were with the service delivery they were receiving prior to their child's fourth birthday. From ages birth to three years, many of these families were being served by the Children's Diagnostic & Treatment Center, where diagnosis, care, and follow-up were provided in a manner that resembles the medial home model. That model and other similar programs available locally, such as the Joe DiMaggio Children's Hospital, offer a comprehensive continuum of services located at one facility and accessed at various locations through linkage agreements and/or subcontracts. Consistently, parents indicate a need and preference for comprehensive service delivery near their home with a full array of services to meet the needs of their children. In the absence of these services, families experience great stress. Not only do their children tend not to receive all of the services they need, but the challenge of parents dealing with their multiple responsibilities of work, spouses and other children are disrupted causing stress not just on the child and parents individually but on families as a whole.

Throughout the activities conducted for the study, repeatedly expressed themes included:

- Parents/caregivers are frustrated because they do not know how to meet their child's needs;
- Parents/caregivers do not understand what is wrong with their child;
- Parents/caregivers do not know where to go for help;
- Some pediatricians are good at diagnosing problems, others are not;
- Some pediatricians refer children to appropriate service providers while others are unaware of the system of care that is available;
- The school board does a commendable job for school aged kids; however they are overburdened and under funded;
- The system of care as it currently exists now is comprised of individual providers doing the best that they can without the benefit of the connecting tissue that a continuum of care or system of care would provide;
- There is limited advocacy, case management, information and referral services available in the County to assist parents;
- Many of the cases require intensive case management, which would take children from their early years of diagnosis to adulthood; however, no such system of care is in place. Children's Medical Services (CMS) care coordination provides that system for children with special needs from birth to age 21. Assisting with transition to adult services is a component of that care coordination.
- Although there are many school based after school programs for special needs elementary children, there are very limited programs for middle and high school students.

Some effort is necessary to take the pieces that exist in the community and bring them together, adding components that are essential to the success that these children and families are missing and coordinate overall service delivery for this population.

Study results indicate that children from birth to three are the most comprehensively served group segment of the special needs population as identified by parents. There is a high level of satisfaction indicated by parents of children in this age group. Among the reasons for this is that there is a sense of one stop comprehensive service delivery that parents miss once their children "age out" and enter the school system. After the child passes the age of three, parents feel that they are left to fend for themselves without the guidance and assistance that a coordinated system model employing intensive case management ordinarily provides with varying degree of success to access the services that their children need.

The contrast for those children and families receiving comprehensive care before and after the child's fourth birthday is striking. When the child enters school or preschool age, the service delivery methodology seems to shift toward focusing on the child's educational ability rather than on their social, emotional and behavioral needs. Special education programs in the school system do exist, even if strained to meet the

increasing demand for services. However school-based programs tend to focus more on how well a child reads and how to remediate educational deficits, and less so on the overall or holistic needs that the child presents. This finding ought not to be interpreted as a complaint about the value of special educational services provided. Rather, it is an observation that the social, behavioral and emotional needs of children certainly do not end at age four and that the need to fill this particular gap in service is indicated. Understandably, the function of schools is to educate even if the needs of the students are much more complex. Notwithstanding, schools are the single most common and important provider of services that these children receive and those services are valuable. The survey and focus group results all support the conclusion that the children need both educational and social service supports to achieve their fullest potential. It is the conclusion of Drs. Wood and Brady that a partnership of greater substance is needed between the educational community and the social services community if the full and holistic needs of these many children are to be more effectively met.

What follows describes the detailed recommendations converted into a Business Plan format which support the findings and aim toward the creation of a continuum of care approach for the provision of services to children with special needs, as defined within the report, in Broward County, Florida.

2. SYSTEM MODEL RECOMMENDATIONS:

A review of best practice models was performed and is available in its entirety in the report entitled, "Systems Model Recommendations" and can be downloaded from www.brhpc.org/specialneeds/System%20Model%20Recommendations.pdf The system model summaries can also be reviewed in their entirety in Appendix Three of this report. An exhaustive list of references is included on pages 20-24.

The models that these recommendations are based on include, but are not limited to:

- The medical home model, American Academy of Pediatrics (2004)
- Healthy Steps, *Archives of Pediatric and Adolescent Medicine* (2001)
- Denver System for Assessment and Referral, Commonwealth Fund (Halfon, 2003)
- Childserve: Citywide Coordination and Enhanced Connectivity Commonwealth Fund (Halfon, 2003)
- Williamsburg, Virginia: All children are connected to a consistent source of health care, a medical home, Commonwealth Fund (Halfon, 2003)
- Palm Beach County's Health Care District (providing continuous, comprehensive health insurance), http://www.hcdpbc.org/childrens_health_programs/index.html
- Palm Beach County Children's Services Council (providing a "funding bank" that specifically targets gaps in insurance coverage), www.cscpbc.org

The recommendations from Drs. Brady and Wood are presented below in summary to provide a contextual framework for the business plan which follows.

A. Timely and Accurate Entry into the System of Care: Getting a Diagnosis and Locating Service

Improve the Capacity of Pediatric Practices to Deliver Developmental Services
Establish a “No Wrong Door” Entry into the Broward County System of Care

B. Staying in Care and Getting Needed Services over the Life Course of the Child

Increase the Availability of Services
Encourage Practice Level Change
Encourage System Level Change
Provide Coordination between Health Care System and the School Board of Broward County
Create a Services Coordinator
Increase Options for Accessible Transportation throughout Broward County
Increase Services that offer Functional Supports (Audiology, Hearing and Cognitive Therapies, etc.)
Increase Availability of Direct Service Personnel, On-Going Training and Promote Retention of Personnel
Increase Availability of Respite Services

C. Continuous Access to Insurance and Resources for Health Care Coverage

Improve Access to and Prevent Loss of Medicaid and KidCare Insurance
Improve Coverage and Reimbursement Policies by Managed Care Companies for Specific Services Needed by Children with Special Needs.
Host a Summit on Health Insurance Coverage for Families of Children with Special Needs
Provide a Structure for Ongoing Dissemination of Information on Health Insurance for Children with Special Needs

D. Tracking, Monitoring and Improving the Status of the System

Monitor, Track and Report the Developmental Functioning of All Children and the Developmental Health Services They Receive
Improve Quality Measurement and Accountability to Enhance Incentives for Optimal Performance.

3. ISSUES AFFECTING IMPLEMENTING THE MEDICAL HOME MODEL IN BROWARD COUNTY:

A. Medical Home Model

While the Medical Home Model is without question the “best practice model” for children with chronic and complex health care needs, it is not a “one size fits all” option for all special needs children in Broward County. Because it seems unlikely that, at this time, a large number of pediatricians would have an interest in and successfully manage a Medical Home model program, even if they value and support the model in theory, a medical model is not being recommended for immediate implementation.

Most system redesign trends support consumer directed care where by families choose the services needed and in many cases, hire the paid support workers to provide the service. Of course there is great value in the role of pediatric practices and child care providers specifically with regard to the screening and early identification of conditions such as autism.

Children with disabilities and their families expressed the desire to be taught to choose how they spend their time and how they live their lives. Services and supports should be tailored to the child and family's preferences in how their needs are met, while ensuring that health and safety are maintained. This approach builds on what the child can already do and likes to do, thus increasing skills, abilities and independence. The focus is on self-development -- acquiring new skills that help the child do the things he/she wants to do.

It is important to acknowledge that children with special needs and their families need a fundamentally different approach to eligibility, service coordination (interchangeable with case management in this text) and service delivery compared to children with other unique needs (e.g. foster care, etc) for some of the following reasons:

- Children will be more likely to thrive in a family-centered system of support that acknowledges the central role of parents as planners and managers of all needed services;
- Children with special needs often have conditions that develop in sequences differently, requiring longer involvement or greater overlap of some systems and services;
- Staff are needed with expertise regarding children with special needs and their families;
- Children with special needs participate in multiple programs and different funding streams than adults;
- Families are concerned about their special needs child's needs being met in a managed care medical model because of previous poor experiences with managed care.

Clear and common characteristics of successful redesign include:

- Shared, well-articulated values and a sense of mission.
- diverse group of stakeholders
- Continuity of leadership - not just at the top but also throughout the system and at the provider level.
- Rigorous family support programs that have grown and improved over time. They have solid quality assurance and improvement efforts that are systematic and comprehensive.
- Relatively low case management ratios (between 30 and 35 individuals per case manager)
- Diversity and choice in case management

- A commitment to person-centered planning and continual training in person-centered approaches.
- The systems were supportive of self-advocacy efforts, including enlisting self advocates in system level advisory capacities.

Enhanced coordination between the Health Care system, the School Board of Broward County, the Florida Diagnostic and Learning Resources System (FDLRS), and various other agencies including but not limited to the Agency for Persons with Disabilities, the Department of Education/Division of Vocational Rehabilitation {for the children transitioning out of school based programs}, the Department of Children and Families/Economic Services and Children’s Medical Services is vital. FDLRS is a network of nine centers and four specialized centers in Florida to assist in “the enhancement of learner outcomes for students through provision of information, training and technical assistance to persons involved with students with exceptionalities”. It should be noted that in accordance with Florida Statute 393, the Agency for Persons with Disabilities (APD) is the entity legally mandated to develop and provide services for children (over age 3) and adults with developmental disabilities. The APD is responsible for determining eligibility; funding and providing prevention and home and community based support services; managing the intake and application process; conducting family or individual support planning; providing support coordination/case management services; collaborating with the educational system; and developing transition plans for children entering or exiting the school system. Early intervention services, which are the responsibility of the Division of Children's Medical Services, for children ages birth to 3 years who are eligible for services under this chapter or under Part C of the Individuals with Disabilities Education Act, shall not be provided through the developmental services program unless funding is specifically appropriated to the developmental services program for this purpose.

B. Systems Level Change and Integration of Local Entities:

Medicaid (including the Home and Community Based Medicaid Waiver Program), is the primary and essential funder for health care and other “medically necessary” services, excluding educational services. As has been highly publicized, Medicaid Reform is a hot topic due to uncontrollable spending growth and its impact on both the Federal and State’s budgets. As a result, services for children with disabilities are being caught up in the unfolding budget crisis. Family support programs funded at the Federal and State levels have all but been eliminated. Efforts to reduce the waiting list in Florida have ground to a halt, except for 360 crisis placements annually, and the waiting list is spiraling upward again (nearly 16,000 children and adults statewide). Provider payments have been reduced and as a result, provider agencies have laid off staff and some have even eliminated critical services.

All of this while service demand is increasing and the pressures on the long-term support system in this State is anticipated to grow. It is feared by many that the community of children and families increasingly will be divided between the “haves”

and the “have nots”. Florida is not alone and stakeholders in every state are confronting some of the most difficult challenges that this field has ever faced. In virtually every state, the hard won gains in supporting children and adults with disabilities and their families that have been won over the past decade are in jeopardy due to the enormous state budget shortfalls.

The role of the Title V agency (Children’s Medical Services (CMS)) must be defined. CMS screens for eligibility for the CMS Network, which includes medical, development and behavioral needs of children with special needs, and has the network capacity and referral resources to assist families in meeting their supportive and education needs as well as health related needs.

In addition, the role of the Florida Diagnostic and Learning Resources System (FDLRS) must also be defined. “The FDLRS is funded through IDEA, Part B; Part B, Title II (Preschool); and State General Revenue Funds to provide services for Florida's exceptional student education programs”. The FDLRS network center activities focus on “enhancement of learner outcomes, partnerships between families and professionals, early childhood identification and evaluation, inservice training, instructional technology, interagency services, and implementation of state educational goals and priorities. Services are available to district, agency, community and other personnel working with students with disabilities and their families”.

Coordination of funding, programs and services to ensure transition from the children’s system of care continuum to the adult system of care continuum is also needed. A lack of information and linkages to the adult continuum exists. Further study of these issues is recommended. The United Way of Broward County and Community Foundation of Broward County conducted a study on the challenges of and potential solutions for emancipated foster care youth in Broward County and published a report “Transitional Independent Living Strategic Plan”. A similar study should be commissioned to explore the issues and potential solutions for transition from the children with special needs continuum to the adult continuum.

C. Workforce Recruitment, Retention and Development Issues:

Workforce issues currently pose a major constraint to service delivery, expansion and quality. Human/Social Services, except childcare, ranks among the fastest growing industries, 42% vs. 15% average for all other industries. “Human Service Worker” is the ninth fastest growing occupation in the nation (source: BLS Occupational Outlook Handbook).

There are several challenges that the industry faces including but not limited to:

- Filling 1.2 million new jobs nationally by 2010 as recruitment is the # 1 human service employer problem in America

- Clarifying obscure career paths for front line professionals/human service workers
- Maintaining/sustaining quality over time – what do staff need to know and do?
- Marketing for the human service industry and careers as there is currently no positive perception that the role direct support professionals play in supporting children and their families
- Taking responsibility for wage structures that devalue the work of direct support professionals. Most human service workers are living in the margins of poverty.
- Managing the trend that providers are going out of business due to stagnating rates and increasing costs for health care, overtime, worker's compensation, etc.
- Wasting precious resources on excessive recruitment and training costs due to turnover (\$2,000 - \$5,000 per new hire).

D. Part C Early Intervention Program for Infants and Toddlers:

Part C Early Intervention services provided to infants and toddlers from birth through 3 years of age are primarily delivered by dozens of dedicated early intervention providers and professionals throughout this community. It should be understood that while CDTC is the lead agency for the Part C program in this community and is the contract holder with CMS, it provides initial diagnoses (when deemed necessary) and on-going service coordination. An extensive array of available services (e.g. occupational, speech and physical therapy, transportation, developmental preschool, in home behavioral intervention, etc) are available by referral to children and their families. CDTC has been successful because it has taken the time to work with the community and leverage fiscal assistance with other funders (e.g. the School Board of Broward County), Medicaid and private insurance companies and through significant in kind and fiscal support from it's subcontracted agencies the burden of which has fallen on the shoulders of this community's largest agencies serving this population namely ARC Broward, UCP, Broward Children's Center and the Ann Storck Center.

4. ESTIMATED COSTS TO FUND UNMET NEED:

National surveys estimate that children with special needs constitute about 12-13% of the entire population. Children with developmental delays and developmental disabilities are estimated to make up less than half of this special needs population. The total number of children in the Broward County School system is reported to be 272,691 by the Broward County School Board's website. Therefore, this study estimates that there are 10,907 special needs children (developmentally delayed, developmentally disabled, hearing impaired, visually impaired, and physically impaired) in the public school system. An additional 5,136 children are being served by Children's Diagnostic & Treatment Center not yet in school for a total of approximately 16,000 total special needs children. This is a conservative estimate given the fact that there are additional

children in this category that are neither in the public school system nor receiving services at the Children's Diagnostic and Treatment Center.

Utilizing the results from the 1,010 parent/caregiver surveys, service categories identified by corresponding taxonomy codes were listed. Estimated unmet need was then calculated by multiplying the total number of respondents times the number of respondents who needed but were not able to access a service. This unmet need percentage was then multiplied by total special needs children (16,000) to estimate the number of additional clients needing each service.

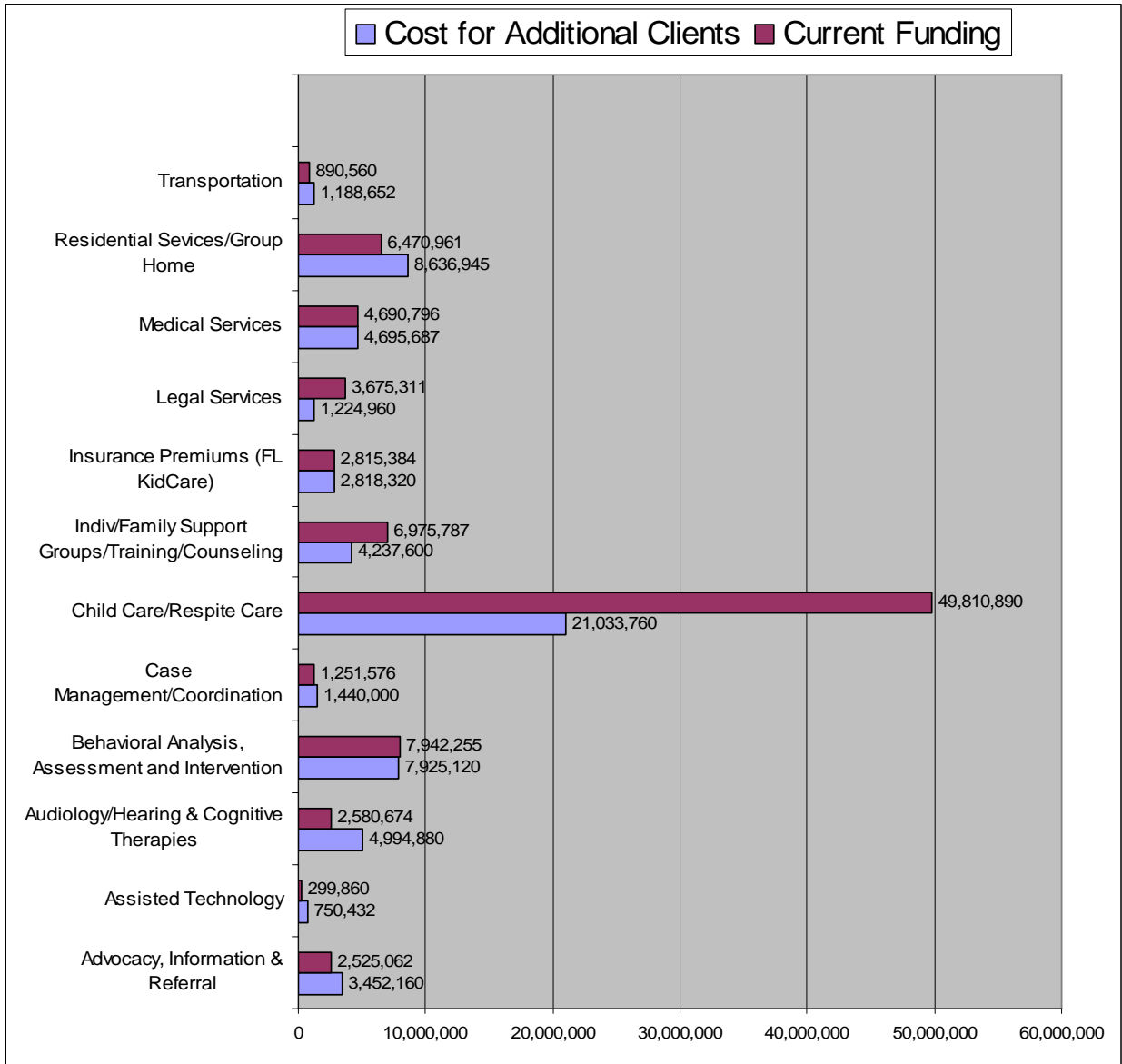
The Children's Service Council (CSC) and the Children's Service Administration Division (CSAD) contracts were the only funding sources that reported funding by number of clients to be served, unit cost and total dollar amount. For those services funded by the CSC and CSAD, the average cost per service was calculated by dividing the number of clients served by total funding for the corresponding category. For all other services, the average number of total clients accessing services, reported in the On-Line Resource Directory database, divided by current funding as an average cost per client. *(As spelled out in the year one recommendations, all funders of special need services should develop uniform taxonomy codes, unbundle funding formulas, and work to develop average costs per client based on diagnosis, client severity, and age,.)*

The average cost for each service was multiplied by the number of estimated additional clients to determine the cost to serve them. This sum was then added to the current funding to estimate the total cost to meet estimated need. The following chart provides the application of this formula for each service category.

Projected Unmet Need and Associated Costs by Service Category

Service	% unmet need	# of additional Clients	Avg Cost Per Client	Cost for Additional Clients	Current Funding	Total Cost
Advocacy	16%	2,560	696	1,781,760	260,000	2,041,760
Assisted Technology	15%	2,400	313	750,432	299,860	1,050,292
Audiology/Hearing Therapy	8%	1,280	1,419	1,816,320	225,191	2,041,511
Behavioral Assessment	14%	2,240	429	960,960	779,348	1,740,308
Behavioral Health Services	6%	960	3,909	3,752,640	1,101,242	4,853,882
Behavioral Analysis Early Intevention	20%	3,200	772	2,470,400	4,678,059	7,148,459
Case Management/Care Coordination	10%	1,600	900	1,440,000	1,251,576	2,691,576
Child Care (After School/Vac Day)	16%	2,560	2,729	6,986,240	6,906,859	13,893,099
Child Day Care/Head Start	8%	1,280	2,094	2,680,320	36,994,153	39,674,473
Child Care (Recreational/Sports)	16%	2,560	2,730	6,988,800	4,717,136	11,705,936
Cognitive Therapy	14%	2,240	1,419	3,178,560	2,355,483	5,534,043
Early Intervention	6%	960	772	741,120	1,383,606	2,124,726
Family Support Services and Training	17%	2,720	415	1,128,800	6,901,757	8,030,557
Individual Counseling	16%	2,560	670	1,715,200	38,750	1,753,950
Information & Referral	15%	2,400	696	1,670,400	2,265,062	3,935,462
Insurance Premiums (FL KidCare)	6%	960	2,936	2,818,320	2,815,384	5,633,704
Legal Services	11%	1,760	696	1,224,960	3,675,311	4,900,271
Medical Services	6%	960	4,891	4,695,687	4,690,796	9,386,483
Residential Sevices/Group Home	8%	1,280	6,748	8,636,945	6,470,961	15,107,906
Respite Care/In-Home Relief for Parent	13%	2,080	2,105	4,378,400	1,192,742	5,571,142
Support Groups	13%	2,080	670	1,393,600	35,280	1,428,880
Transportation	8%	1,280	929	1,188,652	890,560	2,079,212
TOTALS				62,398,515	89,929,116	152,327,631

The following figure compares current funding versus additional funded estimated based on unmet need and presented utilizing the same category groupings as those used in the Visual Presentation of Funding Report.



Funding estimated “unmet need” is impractical for many reasons and will not address the multitude of issues raised in the preceding reports.

5. RECOMMENDATIONS:

The Goals from the “System Model Recommendations” applied to Broward County and based on the above, were grouped into categories based on a logical and achievable approach to move towards changing the Special Needs Services Continuum from a fragmented system into a Coordinated System of Care. Towards this end, the following overall system narrative recommendations are:

- A. Funders are encouraged to coordinate efforts with community stakeholders to drive systems level change including ongoing efforts to establish the initial and ongoing plan for the structure of the resource center/case management organization(s); identify service gaps; monitor quality assurance functions and monitor and evaluate levels and ease of participation with children with special needs and their families.
- B. Funders are encouraged to play an active role in cultivating change with regard to workforce issues including:
 - Assisting providers to strengthen the status of direct support roles and improving the industry’s image through the creative marketing of career plans and opportunities.
 - Promoting systems change, in collaboration with key stakeholders, with regard to improving the living wage; linking wage enhancement to skill development; promoting voluntary credentialing of human service/direct support professionals; tracking workforce indicators; transforming human service recruitment, retention and staff development practices; and developing public policies that support the transformation of the workforce.
 - Fiscally supporting activities, as defined above, so that a stable, well trained workforce is available to meet the ever growing capacity needs of children with special needs and their families.
- C. Funders are encouraged to continue efforts that support and promote family involvement at all levels of the process. It should explore various models of self-direction, including those targeted to children and their families who need help in self-direction. Further, the use of an autonomous Advisory Council comprised of families that specifically provides consultation on system redesign and family support issues should be considered.
- D. It is suggested that the funders work in collaboration with the Agency for Persons with Disabilities and other key funding partners to establish and clarify distinct roles and responsibilities so that a case management system is not created that duplicates efforts that are the responsibility of the Agency or others and further confuses families who may also have support coordinators, school social workers, Vocational Rehabilitation counselors, etc. It is suggested that case management/care coordination include the following:

- 1) A new "one stop shop" web based, on-line screening process that could be created and used by the case management entity and other funding entities. The new process could be streamlined and used to establish eligibility for programs such as the Agency for Persons with Disabilities (APD) waivers and a variety of other social service programs. The use of this screening tool would help families get to the programs that will help support their child without the family having to find each one separately. The system could help to reduce or even eliminate the lengthy and cumbersome paper application process related to both functional and financial eligibility for various programs. Terminals/kiosks could be situated in various locations throughout the community that are accessible to potential users. The system would need to be designed for ease-of-use and an informational brochure about the services and supports that are currently available. The system would also need to be accessed by people with visual, hearing, physical and other disabilities and would need to be culturally sensitive to non-English speaking individuals.
- 2) Within the context of a "no wrong door approach", comprehensive information and assistance should be available through the network of case management entities including staff that could be considered "first responders". These professionals (or even parent resource specialists) could help answer questions and problem-solve with families 24 hours per day, 365 days per year.

- D. The new model should pre-suppose that there are self-directed mechanisms for which children and their families provide direction on a number of levels. Service planning should be driven by family choice, desired outcomes and a selection of program supports to achieve family outcomes.
- E. Quality management activities should be established to determine the efficiency, effectiveness, accessibility and satisfaction of the model. Person centered outcomes could focus on issues such as health, developmental, social and community inclusion outcomes.

The following specific recommendations are provided to begin to implement a coordinated system of care by:

- 1) Establishing a planning/coordination mechanism to:
 - establish/continue an autonomous planning initiative
 - standardize terminology/ "glossary" of terms/taxonomy codes/for special needs services
 - working with Broward Information Network, First Call for Help and Special Needs Directory personnel to develop single source information and referral database
 - identify/continue/encourage/strengthen collaboration opportunities/efforts
 - identify potential grant opportunities

- conduct a needs assessment/analysis of children with special needs on the Medicaid Waiver waiting list
- 2) Funding identified immediate service needs including:
 - additional case management dollars to strengthen linkages between the special needs system and other systems of care—not to create a new “case management system” or “case management model”;
 - additional funding for respite services including after school care for Middle and High school aged students
 - additional funding for functional supports (e.g. Audiology/Hearing & Cognitive Therapies)
 - additional funding for increased transportation options
 - additional funding for Legal Advocacy services (like Guardian ad Litem); and,
 - 3) Funding approximately 10% of estimated unmet need based on estimates identified on page 12, based on the availability of funding and funding priorities established by the CSC.

These recommendations are based on an additional commitment of funds from the CSC and/or other funders with the assumption that current funding levels identified earlier in this report are maintained.

<u>Recommendations</u>							
Systems Planning Recommendations				<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>
A. Establish an autonomous planning body for systems planning recommendations and oversight for overall business plan implementation							
1		Create a Services Coordinator to:		200,000	200,000	200,000	200,000
	a	Develop standardized "glossary" of terms for special needs services provided throughout Broward County		*			
	b	Identify/encourage/strengthen opportunities for collaboration across agencies		*	*	*	*
	c	Identify disincentives/barriers for collaboration across agencies and solutions		*	*	*	*
	d	Develop specific recommended changes to funding streams to promote or require coordination		*	*	*	*
	e	Identify potential grant opportunities to fund "System Model Recommendations"		*	*	*	*
	f	Migrate the Children's Services Council Strategic Plan for Special Needs Services with this Business Plan		*			
	g	Begin development of Quality Assurance Activities to Monitor, Track and Report the Developmental function of all Children and the Developmental Health Services they receive					*
	h	Begin Development of Quality Measurement and Accountability Activities to Enhance Incentives for Optimal Performance.					*
	i	Re-Assess/Evaluate System and Service Level Change				200,000	
2		Through the direction of the planning body and services coordinator:		<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>
	a	Develop a Single-Source Information and Referral Database		40,000			
	b	Establish a "No Wrong Door" Entry Into the Broward County System of Care by funding the on-going maintenance of the Single-Source Information and Referral Database including a hotline phone number with dedicated staff assigned to this responsibility and trained to make referrals to eligibility specialists and case coordinators			20,000	20,000	20,000
	c	Fund centrally-located eligibility specialists to assist in identifying resources and services for parents/caregivers and service providers.			50,000	50,000	50,000

d	Fund legal advocacy services (like Guardian ad Litem) to provide coordination between Health Care System (e.g. service providers), the School Board of Broward County and parents/caregivers of special needs children.	40,000	40,000	40,000	40,000
e	Conduct a needs assessment/analysis of children with special needs on the Medicaid Waiver waiting list	50,000			
f	Work with pediatric practices and Children's Medical Services to encourage practice level changes which utilize the services of funded trained case managers/care coordinators to negotiate the special needs system for them and their clients which ultimately will improve the Capacity of Pediatric Practices to Deliver Developmental Services		25,000	25,000	25,000
g	Develop legislative strategy to promote services and funding for SNC		50,000	50,000	50,000
h	Develop a social marketing mechanism to inform and education parents/caregivers and providers about changes and activities that affect the service delivery system for children with special needs.		75,000	75,000	75,000
i	Increase the availability and promote retention of direct service personnel, identify specific on-going training needs and resources to fund them.		75,000	75,000	75,000
j	Assist in providing continuous access to insurance and resource to pay for services by:		50,000	50,000	50,000
	1) Improving Access to and Prevent Loss of Medicaid and Kid Care Insurance		*	*	*
	2) Working with Managed Care Companies to improve coverage and reimbursement policies for specific services needed		*	*	*
	3) Hosting a summit on Health Insurance Coverage for Families/caregivers of children with special needs		*	*	*
	4) Providing a structure for ongoing dissemination of health insurance info		*	*	*
TOTAL SYSTEMS PLANNING ESTIMATES		330,000	585,000	785,000	585,000

Service Delivery Recommendations							
B. SERVICE DELIVERY EXPANSION RECOMMENDATIONS				<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>
1			Increase funding for Respite Services including After School care for Middle and High School aged students, and encourage development of networking of caregivers to provide respite for each other. The "pool" of caregivers could be included in the "Single-Source Information and Referral Database".	800,000	800,000	800,000	800,000
2			Increase funding for Case Management/Care Coordination	500,000	1,500,000	1,500,000	1,500,000
3			Increase funding for services that offer Functional Supports (e.g. Audiology/Hearing & Cognitive Therapies)	1,000,000	1,000,000	1,000,000	1,000,000
4			Increase funding/options for accessible transportation throughout the County	500,000	500,000	500,000	500,000
Total Service Delivery Recommendations				2,800,000	3,800,000	3,800,000	3,800,000
C. OTHER FUNDING RECOMMENDATIONS							
1			Fund approximately 10% of estimated unmet need/service/planning priorities	6,000,000	6,000,000	6,000,000	6,000,000
TOTAL FUNDING ESTIMATES				9,130,000	10,385,000	10,585,000	10,385,000

Grey shading indicates items that do require any activity.

Same color shading represents all activities included for each dollar amount listed

The Total Increase for Services indicates an additional commitment of dollars from the CSC and/or other funders. Explanation of Item 25 "Fund approximately 10% of estimated unmet need" = an additional commitment of dollars from the CSC and/or other funders. The "estimated unmet need" dollars should be prioritized based on meeting estimated unmet service needs and the funding needs based on planning activities.

References

American Academy of Pediatrics. (2004). The Medical Home Policy Statement. *Pediatrics*, 113; 1545-1547.

Antonelli, R. C. & Antonelli, D. M. (2004). Providing a medical home: The cost of care coordination services in a community-based, general pediatric practice. *Pediatrics*, 113, 1522-1528.

Bethell, C., et al. (2001a). "Medicaid Parents' Experience with the Health Care System: Summary of Findings from a Survey of Parents of Young Children Enrolled in Medicaid in Three ABCD States." Prepared for The Commonwealth Fund by FACCT. Portland, OR: FACCT, Inc.

Bethell, C., et al. (2001b). "Assessing Health System Provision of Well-Child Care: The Promoting Healthy Development Survey." *Pediatrics* 107, 1084-93.

Brooks-Gunn, J. & Duncan, G. J. (1997). The effect of poverty on children. *Future of Children*, 7, 55-71.

Carey, J. W., Morgan M., & Oxtoby, M. J. (1996). Inter-coder agreement in analysis of responses to open-ended interview questions: Examples from tuberculosis research. *Cultural Anthropology Methods*, 8(3), 1-5.

Carey, J. W., Wenzel, P. H., Reilly C., Sheridan J., & Steinberg J. M. (1998). CDC EZ-Text: Software for management and analysis of semi-structured qualitative data sets. *Cultural Anthropology Methods*, 10(1), 14-20.

Christakis, D. A., Wright, J. A., Zimmerman, F. J., Bassett, A. L., & Connell, F. A. (2003). Continuity of care is associated with well-coordinated care. *Ambulatory Pediatrics*, 3, 82-86.

Cooley, W. C., McAllister, J. W., Sherrieb, K., & Clark, R. E. (2003). The medical home index: Development and validation of a new practice-level measure of implementation of the medical home model. *Ambulatory Pediatrics*, 3, 173-180.

Cooley, W. C., & McAllister, J. W. (2004). Building medical homes: improvement strategies in primary care for children with special health care needs. *Pediatrics*. 113, 1499-1506.

Cooley, W.C. & McAllister, J.W. (2001). Medical Home Improvement Kit. Center for Medical Home Improvement.

Davidson, E. J., Silva, T. J., Sofis, L. A., Ganz, M. L., & Palfrey, J. S. (2002). The doctor's dilemma: Challenges for the primary care physician caring for the child with special health care needs. *Ambulatory Pediatrics*, 2, 218-223.

Doggett, L. , & Bronheim, S. (2004). *Communities of Excellence: 2002*, Georgetown University Center for Child and Human Development, Washington, D.C.

Falik, M., Needleman, J., Wells, B.L., & Korb. (2001). Ambulatory care sensitive hospitalizations and emergency visits: experiences of Medicaid patients using federally qualified health centers. *MedCare*, 39 (6): 551-561.

Forrest, C. B., Glade G. B., Baker A.E., Bocian A. B., Kang M., & Starfield B. (1999). The pediatric primary-specialty care interface: How pediatricians refer children and adolescents to specialty care. *Archives of Pediatric and Adolescent Medicine*, 153, 705-14.

Geertz, C. (1973). *The interpretation of culture*. New York: Basic.

Guba, E., & Lincoln Y. (1989). *Fourth Generation Evaluation*. Newbury Park, CA: Sage.

Gupta, V. B., O'Connor, K. G., & Quezada-Gomez, C. (2004). Care coordination services in pediatric practices. *Pediatrics*, 113(5), 1517-1521.

Halfon N, Regalado M, McLearn KT, Kuo AA, & Wright K. (2003). *Building a bridge from birth to school: Improving developmental and behavioral health services for young children*. Commonwealth Fund.

Homer, C.J., Kleinman, L.C., & Goldman, D.A. (1998). Improving the quality of care for children in health systems. *Health Services Reserve*, 33: 1091-1099.

Institute of Medicine. (1990). *Medicare: A strategy for quality assurance*. Washington, D.C.: National Academy Press.

Ireys, H. T., & Perry, J. J. (1999). Development and evaluation of a satisfaction scale for parents of children with special health care needs. *Pediatrics*, 104, 1182-1191.

Ireys, H. T., Anderson, G. F., Shaffer, T. J., & Neff, J. M. (1997). Expenditures for care of children with chronic illnesses enrolled in the Washington State Medicaid program, fiscal year 1993. *Pediatrics*, 100, 197-204.

Kellogg Foundation. (2001). *Using logic models to bring together planning, evaluation, and action: Logic model development guide*. Retrieved August 10 from <http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf>

Krauss, M. W., Gulley, S., Leiter, V., Minihan, P., & Sciegaj, M. (2000). *The family partners project: Report on a national survey of the health care experiences of families of children with special health care needs*. Waltham, MA: The Heller School, Brandeis University.

Krauss, M.W., Wells, N., Gulley, S., & Anderson, B. (2001). Navigating systems of care: results from a national survey of families of children with special health care needs. In: *Children's Services: Social Policy, Research and Practice*. Mahwah, NJ: Lawrence Erlbaum Associates; 165-187.

Krueger, R.A. (1994). *Focus group interviews: A practical guide for applied research*, (2nd ed). Thousand Oaks, CA: Sage Publications.

Kruger, B. J. (2002). *Care coordination and children with special health care needs: An integrative review*. Unpublished manuscript.

Kruger, B. J. (2004). Care Coordination. In P. Jackson Allen & J. A. Vessey (eds.), *Primary care of the child with a chronic condition*, (4th ed., pp. 102-119). St. Louis, MO: Mosby.

Liptak, G. S., Burns, C. M., Davidson, P. W., & McAnarney, E. R. (1998). Effects of providing comprehensive ambulatory services to children with chronic conditions. *Archives of Pediatric and Adolescent Medicine*, 152(10), 1003-8.

Liptak, G.S., & Revell, G.M. (1989). Community physician's role in case management of children with chronic illnesses. *Pediatrics*, 84, 465-471.

Luce, B.R., Manning, W. G., Siegel, J. E., & Lipscomb, J. (1996). Estimating costs in cost-effectiveness analysis. In M.R. Gold, J.E. Siegel, L.B. Russell, and M.C. Weinstein, Eds., *Cost-Effectiveness in Health And Medicine*, pp. 176-213). New York: Oxford University Press, 1996):

MacQueen K. M, McLellan E., Milstein K.K., & Milstein B. (1998). Codebook development for team-based qualitative analysis. *Cultural Anthropology Methods*, 10(2), 31-36.

Maxwell, J. A. (1996). *Qualitative research design*. Thousand Oaks, CA: Sage Publications.

McGlynn, E. A., Halfon, N., Leibowitz, A. (1995). Assessing the quality of care for children: Prospects under health reform. *Archives of Pediatric Adolescent Medicine* 149: 359-368.

Miles, M. B., & Huberman A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. Thousand Oaks, CA: Sage Publications.

Minkovitz et al. and the Healthy Steps evaluation team, "The Early Effects of the Healthy Steps for Young Children Program," *Archives of Pediatric and Adolescent Medicine* 155 (2001): 470-79.

Moore, B., & Tonniges, T. F. (2004). The "every child deserves a medical home" training program: more than a traditional continuing medical education course. *Pediatrics*, 113, 1479-1484.

National Center for Health Statistics. (2004). *The National Survey of Children with Special Health Care Needs*. Retrieved 8/6/04 from <http://www.cdc.gov/nchs/slait.htm>.

National Science Foundation. (1997). *User-friendly handbook for mixed method evaluations*. Retrieved Aug. 6 from <http://www.ehr.nsf.gov/EHR/REC/pubs/NSF97-153/start.htm>. Division of Research, Evaluation and Communication.

Newacheck, P. W., & Halfon, N. (1998). Prevalence and impact of disabling chronic conditions in childhood. *American Journal of Public Health*, 88, 610-7.

Newacheck, P. W., & Stoddard, J. J. (1994). Prevalence and impact of multiple childhood chronic illnesses. *Journal of Pediatrics*, 124, 40-48.

Newacheck, P. W., Strickland, B., Shonkoff, J. P., Perrin, J. M., McPherson, M., & McManus, M. et al. (1998). An epidemiologic profile of children with special health care needs. *Pediatrics*, 102, 117-123.

Omnibus Budget Reconciliation Act (OBRA). (1989). *The Maternal and child health services block grant*. Public Law [PL] 101-239, Sec. 501. Amendment, Social Security Act, 1935.

Palfrey, J. S., Levy, J.C., & Gilbert, K.L. (1980). Use of primary care facilities by patients attending specialty clinics. *Pediatrics*, 65, 567-572.

Palfry, J. S., Sofis, L. A. Davidson, E. J., Liu, J., Freeman, L., & Ganz, M. L. (2004). The pediatric alliance for coordinated care: Evaluation of a medical home model. *Pediatrics*, 113, 1507-1516.

Patton, M. Q. (1997). *Utilization focused evaluation*. Thousand Oakes: Sage Publications.

Patton, M. Q. (2002). *Qualitative research & evaluation methods*. Thousand Oaks, CA: Sage Publications.

Perrin, E. C., Lewkowicz, C., & Young, M. H. (2000). Shared vision: Concordance among fathers, mothers, and pediatricians about unmet needs of children with chronic health conditions. *Pediatrics*, 105, 277-285.

Raddish, M. Goldmann, D. A., Kaplan, L. C., & Perrin, J. M. (1993). The immunization status of children with spina bifida. *American Journal of the Disabled Child*, 147(8), 849-53.

Schaffer, V., & Shenkman, E. (2004). *Children's Medical Services Enrollee Satisfaction Report*. Institute for Child Health Policy, University of Florida: Gainesville, FL.

Scholle, S. H., & Kelleher, K. J. (1995). Children with chronic medical conditions: looking for a medical home. *Ambulatory Child Health*, 1, 130-138.

Shonkoff, J. P., Hauser-Cram, P., Krauss, M. W. & Upshur, C. C. (1992). Development of infants with disabilities and their families. *Monographs of the Society for Research in Child Development*, 57 (6, Serial no. 230).

Spilker, B. *Quality of Life and pharmacoeconomics in clinical trials*. Philadelphia: Lippincott-Raven.

Spradley, J.P. (1980). *Participant observation*. Fort Worth, TX: Harcourt Brace.

Starfield, B., & Shi, L. (2004). The medical home, access to care, and insurance: A review of the evidence. *Pediatrics*, 113, 1493-1498.

- Stein, R. E., & Jessop, D. J. (1982). A noncategorical approach to chronic childhood illness. *Public Health Reports*, 97, 354-62.
- Stein, R. E., & Silver, E. J. (1999). Operationalizing a conceptually-based noncategorical definition: A first look at the U. S. children with chronic conditions. *Archives of Pediatric and Adolescent Medicine*, 153, 68-74.
- Stille, C., Korobov, N., & Primack, W. A. (2003). Generalist-subspecialist communication about children with chronic conditions: An analysis of physician focus groups. *Ambulatory Pediatrics*, 3, 147-153.
- Strickland, B., McPherson, M., Weissman, G., van Dyck, P., Huang, Z. J., & Newacheck, P. (2004). Access to the medical home: Results of the national survey of children with special health care needs. *Pediatrics*, 113, 1485-1492.
- Szilagyi, P. G., & Rodewald, L. E. (1992). Missed opportunities for influenza vaccination among children with asthma. *Pediatric Infectious Disease Journal*, 11, 705-8.
- US Department of Health & Human Services. (2004). *Healthy People 2010*. Retrieved Aug. 6 from <http://www.healthypeople.gov/document/html/objectives/16-22.htm>
- van den Brink, M., van den Hout, W. B., Stiggelbout, A. M., van de Velde, C. J., & Kievit, J. (2004). Cost measurement in economic evaluations of health care: Whom to ask?" *Medical Care*, 42(8), 740-746.
- Varni, J. W., Burwinkle, T. M., Seid, M., & Skarr, D. (2003). The PedsQL 4.0 as a pediatric population health measure: feasibility, reliability, and validity. *Ambulatory Pediatrics*, 3(6), 329-41.
- Varni, J. W., Seid, M., & Kurtin, P. S. (2001). PedsQL 4.0: reliability and validity of the Pediatric Quality of Life Inventory version 4.0 generic core scales in healthy and patient populations. *Medical Care*, 39, 800-12.
- Wood, D. (2003). Effect of child and family poverty on child health in the United States. *Pediatrics*, 112, 707-11.
- Yin, R. K. (1994). *Case study research: Design and methods*. Thousand Oaks, CA: Sage Publications.
- Ziring, P. R., Brazdziunas, D., Cooley W.C., Kastner, T.A., Kummer, M.E., & Gonzalez de Pijem, L. et al. (1999). Care coordination: integrating health and related systems of care for children with special health care needs. American Academy of Pediatrics, Committee on Children With Disabilities. *Pediatrics*, 104, 978-81.

Appendix 1

Project Team

Project Team

BRHPC analyzed the requirements of the project and determined that in order to provide the best possible end product, its experienced in-house health systems planning experts would be complimented by assembling a team with expertise in specific areas.

The **Broward Regional Health Planning Council, Inc. (BRHPC)**, is a private, not-for profit, 501(c)(3) organization established in 1982 under Florida Statutes as the legislatively designated health planning entity for District 10 (Broward County, Florida) and is a County Certified agency. One of its responsibilities is to prepare a district-wide Health Plan to be utilized by various local health care resources, including State of Florida agencies, for planning and service development purposes. As the primary public health planning entity for District 10, BRHPC has ongoing projects, including the collection of countywide service utilization data, distribution of health care information, provision of input on various community committees, and special studies on specific health areas. The Ryan White Title I Grantee sub-contracts with BRHPC to provide both Program Support and Planning Council Support to the local HIV Health Services Planning Council. BRHPC also provides health care planning services to other state and federal programs, including: 1) Broward Healthy Start Coalition, Inc. – A State funded initiative that provides health and supportive services to pregnant women and infants under the age of two; 2) DCF Alcohol, Drug Abuse and Mental Health Program; 3) Healthy Families Program which provides intensive in-home services to families within targeted zip codes in the county; 4) Broward County's Children's Services Division to develop a strategic plan for children's services, including a culturally competent teen pregnancy prevention and intervention model; 5) Agency for Healthcare Administration Pediatric Emergency Room Diversion Project; 6) Broward County Trauma Management Plan; 7) Ryan White Title II Health Insurance Continuation Provider funded by the Broward County Health Department; 8) Chair the Health Care Access Committee of the Coordinating Council of Broward County,; and, 9) Financial Monitoring for the Children's Service Council's funded providers.

The in-house BRHPC team:

John H. Werner JD, CEO/General Counsel for the Broward Regional Health Planning Council, Inc., a private not-for-profit Florida Corporation which is responsible for the development of an area wide health plan for all of Broward County, and the implementation of that plan as it relates to the health care delivery system in Broward County, Florida. Responsibilities include the hiring and supervision of all staff; coordinating and directing all Board and Committee activities; the development of an annual budget and work plan and overseeing the conduct of all public hearings related to the Certificate of Need Program. As

General Counsel, responsibilities include the review and negotiation of all contracts of the corporation and providing legal opinions and other legal services as they related to the functions of the corporation. As General Counsel, consulted by the Department of Health, the Statewide Health Council, and other health planning agencies and health facilities in the State of Florida.

Michael De Lucca, MHM, is the Deputy Director of Broward Regional Health Planning Council. Michael provided oversight of all fiscal and administrative activities for the Children with Special Needs study. He served as Interim Division Director of Mental Health Services at Jackson Memorial Medical Center as well as Director of various Human Service Divisions of Broward County Board of County Commissioners. Michael has served as the Project Director for numerous federal, state and local projects including the HRSA Healthy Community Access Program (HCAP); the AHCA Pediatric Diversion Project; and the Health Foundation of South Florida Healthy Directions Evaluation. Michael has recently consulted on numerous federal projects throughout the United States including participating on federal grant reviews, providing technical assistance to grantees, and speaking on the topics of healthcare evaluation, sustainability, and cost effectiveness.

Michele Rosiere, MSW, is a doctoral candidate in Adult Education and Human Resource Development. Michele has five years experience conducting and coordinating research projects in the fields of health and education. As project coordinator, she ensured that all project activities were in line with the project timeline. She worked with all team members to troubleshoot data and access issues. She served as the day to day project coordinator and liaison between all project consultants.

Terri Sudden, AS, has over twenty years experience in data analysis and health planning. She has produced and/or updated various health related resource inventories, developed and implemented numerous surveying tools, and written qualitative and quantitative health plan components, reports, briefs and successful grant proposals. The HIV/AIDS Comprehensive Health Plan and Needs Assessment are utilized as best practice models locally, statewide and nationally. Terri assisted in the expansion and update of the on-line resource directory. She authored the “**Advocacy Report**” and the “**Visual Presentation of Funding Streams for Children with Special Needs**” and assisted in the preparation of the “**Business Plan**”.

Myles Henderson has six years of experience as the Systems Administrator for BRHPC with overall responsibility for all Management Information System (MIS). Myles has five years of experience developing Geographical Information System (GIS) mapping for various projects within BRHPC. He developed the “**GIS Mapping**” for this project. In addition, Myles provided MIS support including the development of the Special Needs Website, Interactive On-Line Surveying tools

as well as multiple database systems and associated reporting tools required throughout the life of the project.

The experts recruited for the project:

Angelo Castillo, Vice-Mayor and Commissioner for the City of Pembroke Pines holds a MBA in finance from Wagner College, a law degree from New York Law School, and completed the Senior Executives in Government Program at Harvard University's Kennedy School of Government. From 1985 to 1996, Angelo served as a senior government executive in the Koch, Dinkins, Giuliani, Cuomo, and Pataki administrations in New York City. Offices held included Chief of Staff of the NYC Department of Consumer Affairs, Deputy Commissioner of the NYC Department of Social Services, and Auditor General of the NYC School Construction Authority. Angelo moved to South Florida in 1996 to become founding director of the US Department of Housing and Urban Development's, Florida State Office of Community Planning and Development under the Clinton Administration. He was later appointed Director of Human Services for Broward County where he oversaw a \$250 million government agency employing over 1,200 staff. In 2001, Angelo returned to federal service as Deputy State Coordinator at US HUD's Miami Office, and in 2003 was named President and CEO of Broward House, Inc., a well-respected Fort Lauderdale non-profit with a \$7 million dollar budget and over 100 employees. From 1998 until his election as Pembroke Pines City Commissioner in March 2004, Angelo served as Adjunct Professor of Business Ethics at St. Thomas University's Graduate School of Management. Angelo Castillo orchestrated all financially related study analysis, projections and recommendations and developed the "**Business Plan**".

David Lee Wood, MD, MPH (B.A., Harvard, 1977, M.D., M.P.H. combined degree, UCLA, 1982) After completing residencies in Pediatrics and Preventive Medicine, Dr. Wood completed a federally funded research fellowship at RAND in health systems and quality of care research. As a faculty member of the UCLA School of Medicine and member of the Ahmanson Department of Pediatrics, Cedars-Sinai Medical Center in Los Angeles and a Senior Social Scientist at RAND, he conducted health policy research on the quality of health services for high risk, disadvantaged and disabled children. David Wood, MD, MPH, then served as Associate Medical Director for Clinical Outcomes Management for the 22 Shriners Hospitals for Children in North America, during which time he developed a clinical research program with an annual budget of \$2 million and conducted innovative outcomes measurement driven quality improvement systems for children with cerebral palsy, Spina Bifida and other conditions. In 2002, he joined the faculty of the University of Florida, as Chief, Division of Community Pediatrics, Associate Professor of Department of Pediatrics, Jacksonville Campus. He is currently the recipient of grants to study the care of children with special health care needs using a Medical Home model, access to health services of children and adults with developmental disabilities. Dr. Wood provided consultation services for the project on all survey activities to

ensure that the results are valid and reliable assessments of the population and services in Broward County. Additionally, he co-authored the “**System Model Recommendations**” with Dr. Brady.

Michael P. Brady, Ph.D., is a professor and chair of the Department of Exceptional Student Education at Florida Atlantic University. He received the doctorate from George Peabody College at Vanderbilt University. Dr. Brady has been active in developing teacher education programs for students with moderate to severe disabilities, and has worked with numerous school districts to improve services for students with autism and other severe disabilities. He serves as consulting editor on several professional journals including *Education and Training in Developmental Disabilities*, and *Focus on Autism & Developmental Disorders*. His professional interests focus on translating and adapting research findings into practice. Recent applications of this involve building training and support teams to implement functional behavioral assessment in local school districts, and the use of family friendly prompting and generalization strategies for school aged children. He is co-author of *Mental Retardation: Historical Perspectives, Current Practices, and Future Directions* (Allyn & Bacon), *JOBS: the Job Observation and Behavior Scale, A Work Performance Evaluation for Supported and Entry Level Employees* (Stoelting), as well as *Students with Autism: Characteristics and Instructional Programming* (Singular / Wadsworth). Dr. Brady co-authored the “**System Model Recommendations**” with Dr. Wood.

Linda Bliss, Ph.D. is presently the principal investigator for two professional development program evaluation projects in Broward County. She has been conducting qualitative (semi-structured) interviews and focus groups of public school personnel for both projects. She also serves as a qualitative research consultant for Florida International University, has taught Foundations of Qualitative Research, and has served on qualitative research dissertation committees there. She has made numerous presentations in the United States on her interview based research and has contributed to professional journals and to the Handbook of Mixed Methods in Social and Behavioral Research. Linda Bliss authored the “**Parent/Caregiver And Service Provider Perceptions**” Report.

Leonard B. Bliss, Ph.D. received the Ph.D. in educational research methodology from Syracuse University in 1975. He has served on the faculty of the State University of New York at Potsdam, the University of Maine at Farmington, the College of the Virgin Islands, and Appalachian State University in North Carolina as well as doing a stint with National Teacher Corps in the areas of program development and evaluation. He presently works as Professor of Educational Research in the Department of Educational and Psychological Studies at the College of Education of Florida International University in Miami, Florida. Dr. Bliss served as statistical and data analysis consultant for the National Study of Developmental Education carried out by the National Center for

Developmental Education under a grant from the Kellogg Foundation. His present research program involves the identification and measurement of study behaviors of students in secondary and higher education. He is one of the authors of the *Study Behavior Inventory* an instrument used in over 300 institutions of higher education in the United States and abroad. It has been published by and is available through Andragogy Associates. Dr. Bliss has also developed *Instrumento de Comportamiento de Estudio*, the Spanish language version of the *Study Behavior Inventory*. The validation of the high school version of the *SBI* was completed in December of 2004. Dr. Bliss is currently under contract to Guilford Publishers for a textbook for the teaching on statistics to university graduate students in the behavioral sciences which is scheduled for publication in the spring of 2006. Dr. Bliss has been a guest professor and lecturer in Israel, Canada, Mexico, Costa Rica and Taiwan in the areas of educational research and statistics. Dr. Len Bliss authored the “**Parent and Caregiver Survey Report**”.

Sharon F. Slutsky, Ph.D. has been directly involved with the needs assessments of children for over twenty-six years. As a teacher, she observed, evaluated, and recorded educational and behavioral data that assisted in determining the services necessary for students. As a teacher and administrator, she interfaced with parents, counselors, Exceptional Students Education professionals, psychologists, placement specialists, and special needs schools in order to best meet the needs of children. In both roles, she participated in Child Study Team meetings and staffing, utilizing background information from the parents, teacher assessments, protocols administered by school psychologists and their findings and recommendations to meet each child’s special needs. She has been directly involved with establishing and evaluating Individual Educational Plans (IEPs) for students, including her own children. Sharon assisted in the development of the parent and provider surveying instruments and interview process.

Randy Green, MS, served as the parent expert on this project. Randy has a son who is affected by Fragile X Syndrome, the most frequently inherited cause of mental retardation. She assisted in the development of parent and provider surveys as well as participated in the interview process.

Appendix 2

**“A LESSON IN COLLABORATION -
THE EVOLUTION OF THE STUDY”**

“A LESSON IN COLLABORATION-THE EVOLUTION OF THE STUDY”

Meetings were held regularly with members of the BRHPC Special Needs project team and with a CSC board member and staff, special needs providers, community members, school board staff, school board member, and a member of the state legislature to provide insight and direction at each stage of the project. Data gathering methods and materials were continually reviewed, refined, and revised to better meet the needs of CSC and the community. Research progress reports were presented at each of these meetings with input and suggestions provided by the CSC Special Needs Committee.

The unique, refreshing and collaborative relationship forged between all parties involved in this project, should serve as a “best practice model” for any future community planning initiatives. The willingness of all parties to allow each phase of the project to inform the next phase of the project and to make learned adjustments from strict contractual terms to more applicable and appropriate expectations, afforded a fluid process that engaged the community and created solid investment in the eventual outcome of the project.

The service category of “special needs” as is used and defined for the purposes of this report included children aged 0-22 that are visually, physically, hearing impaired, with developmental disabilities including but not limited to autism, mentally handicapped, cerebral palsy, Down syndrome, Asperger’s, spina bifida, etc.; and individuals aged 0-6 with developmental delays.

A. Website and Resource Directory Development

An initial resource directory was created for the project by consulting the following data bases: Florida Diagnostic and Learning Resources System (FDLRS) at <http://www.fdlrs.com/>, Family Network on Disabilities of Florida, Inc (FND) at <http://www.fndfl.org>, and the Community Resource Inventory. Once obtained, all providers were contacted via telephone to verify the accuracy of the information in the directory. During this process, additional providers were identified, contacted and added to the directory. In September, 2004, the need to develop a “Special Needs Website” linked to the CSC and BRHPC websites was identified. The site would contain information about the project and post the resource directory information collected. In October, 2004, the Special Needs website was presented to the CSC. The website included information about the project (including project description, special needs action plan, team members, participating agencies, and meeting minutes) and the resource directory in a printable form. A “visual presentation of funding” report was another contract requirement. Utilizing the data collected in the initial resource directory, an online resource directory was created which incorporated the capability of attaching funding information to programs. Funding information collected from the CMS, CSC, CSAD, United Way, etc. was entered into the online directory to supplement the basic agency profiles. In addition, an on-line version of the

parent survey was presented that could be completed by parents in English, Spanish, and Creole.

At the October, 2004 meeting, the CSC requested that the resource directory incorporate data from the “2-1-1 First Call for Help” (FCFH) database. This request resulted in a myriad of challenges and consequences.

- Once the data was downloaded and migrated into the database. It became apparent that in many cases, the data was not as current/up-to-date as what was previously presented in the original on-line directory.
- All the data had to be re-verified for accuracy.
- All providers in the original directory were not in the FCFH database.

BRHPC developed a letter to the providers identified in the resource directory requesting that they review and update the information presented. The CSC sent this letter on October 11, 2004. A second letter was sent on December 9, 2004 to those agencies that had not updated their data.

When preparing the “Visual Presentation of Funding Streams” report, it became apparent when comparing directory generated funding reports to contract funding allocation information from funders that even with the two requests for update, funding information was not accurate. Identified funding information was then utilized to update information provided in the directory.

B. “Parent/Caregiver and Service Provider Perceptions”, Linda Bliss, Ph. D.

This report contains information gathered from both parents and service providers by BRHPC researchers concerning the current service delivery situation experienced by Broward County children with special needs and their families and/or caregivers. Data were gathered from parent interviews and focus groups and from service provider interviews and focus groups; all conducted between July 2004 and November 2004. Both the parent/caregivers and service providers are included in this report because their complementary experiences are best understood together.

Parents were recruited for the study through flyers distributed electronically (via the Special Needs Website) and physically throughout Broward County. CSC special needs advisory members were given copies of the flyer and assisted in its distribution. Parents also assisted in recruiting other parents. Forty parents were individually interviewed. In addition, three geographically distributed parent/caregiver focus groups were held. Almost 80 service providers were identified through data bases (First Call for Help, Florida Diagnostic and Learning Resources System, Family Network on Disabilities of Florida, and Community Resource Inventory) and through the media and phonebook. Twenty five service providers were individually interviewed and three geographically distributed service provider focus groups were held.

C. “Parent and Caregiver Survey Report”, Leonard B. Bliss, Ph.D.

Parent surveys were mailed to or hand delivered to all CSC and Broward County CSA funded providers of services for children with special needs, the Broward County School Board, and the Department of Children and Families. Service providers distributed these to their clients. The survey packets included both a provider and parent cover letter outlining the purpose of the study. The surveys were provided both by mail and on-line in three languages: English, Spanish and Creole. Completed surveys were mailed to BRHPC or completed on-line. A total of 1,010 surveys were returned. Since information concerning the number of questionnaires that were actually distributed is not available, the response rate cannot be determined. An analysis of the responses obtained from this convenience sample is provided in this document. Results are reported for (a) the entire sample, (b) for the sample divided into the children’s special needs, (c) for the sample divided by geographic region of children’s residences, and (d) by the age of the children with special needs.

D. “Advocacy Report”, Terri Sudden

This report was prepared utilizing the Interactive Resource Directory interface developed in September, 2004 for this project and specific questions regarding advocacy, information and referral, and linkages that had been incorporated into the funded activities of the project including: Provider surveys, Key informant interviews, Parent/Caregiver surveys, and/or focus groups. Overall findings from these activities were reviewed with pertinent information extracted for this report. In early 2005, a follow-up questionnaire was conducted with Advocacy providers and key informants.

E. “Visual Presentation of Funding Streams for Children with Special Needs”, Terri Sudden

In Broward County, health and social services for children with special needs and their caregivers are funded through multiple Federal, State, local and private resources. Utilizing the Resource Directory interface developed for this project, entities that provide funding for Special Needs Services were contacted to provide/verify information for their agency/programs to include service descriptions, number of clients to be served, units of service to be provided and total funding for each contract. This information was compared to data collected from funders (CSC, CSA, United Way, Medicaid, DOH/C&F, CMS, etc.).

F. “GIS Maps”, Myles Henderson

The School Board of Broward County and Children’s Diagnostic and Treatment Center provided the number of clients they serve by zip code. This data was combined, color coded, and stratified into the same six service categories used in the “Visual Presentation of Funding Streams” report. This stratification was then used as the basis for the Geographical Information System (GIS) maps produced for the project. Utilizing the resource directory, the locations of the agencies providing services were plotted on top of the client stratification again, utilizing the same service groupings that were used in the “Visual Presentation of

Funding Streams” report. The maps display service locations in relation to the distribution of clients.

G. “Broward County Children with Special Needs System Model Recommendations”, Michael Brady, Ph.D., David Wood, M.D.

Drs. Wood and Brady performed a literature review to research “Best Practice” models and identified several models that address Broward County’s needs in response to issues identified in project activities to date. A “Medical Home Model” was identified as the best practice model for children with special needs with recommendations on how to apply and implement this model in Broward County. In addition, several other models were identified and included as tools to assist Broward County to redefine and reshape the service delivery system for children with special needs.

H. “Business Plan”, Angelo Castillo

The goal of the Business Plan is to synthesize the findings (lessons learned) from all of the activities described above and report them in a manageable way that will allow the Children’s Services Council, the provider community, funders, consumers, policy makers and the public at large to have a clear road map/strategy to make informed decisions about how services for children with special needs and their families are provided in Broward County.

Appendix 3 – National Best Practice Models

**“NATIONAL BEST
PRACTICE MODELS”**

The Medical Home Model of Care (also known as a Medical Home) is a systems care model that can help families navigate the various systems of primary care. Studies have shown that a Medical Home increases family satisfaction, continuity of care, and child outcomes (Christakis, Wright, Zimmerman, Bassett and Connell, 2003). A Medical Home provides much more than just immunizations and regular well child visits. The Medical Home is a new, comprehensive approach for primary care that helps families get screened comprehensively and early, provides accurate information responsively, provides help with referrals to appropriate services to promote the development of their child and helps them navigate the maze of services that address families' and children's social, developmental, preventive, chronic and acute health needs. The medical home model has been described by the American Academy of Pediatrics as a health care provider that is:

- Accessible: physically and economically accessible to all patients in the practice
- Family centered: mutual responsibility and trust exist between the parent/child and the provider and families and youth share in their health care management
- Continuous: care is provided to the family across outpatient and inpatient care. Over time, one provider gets to know and is trusted by the family.
- Comprehensive: care is available 24/7 by the practice, preventive, primary and tertiary care issues are addressed and the child and family's medical, educational, developmental, psychosocial and other service needs are identified and addressed
- Coordinated: all needed care, including special services for children with disabilities, is facilitated and coordinated through the Medical Home
- Compassionate: care is provided to the family and child with empathy and concern.
- Culturally effective: care that recognizes values and respects the family's culture, beliefs, rituals and customs. (Sia CJ, et. al., 2002)

The medical home should be a place that supports the optimal development and health of both the child and the family. As such, the medical home should work with all other agencies or services that are offering services or supports to the family.

A model service and financing system should have the following characteristics:

- Children are screened early and comprehensively for developmental or other special needs by primary care providers.
- Once a concern is identified the parent must be able to gain access to the system of care appropriate for their child from any provider—the pediatrician, schools, day care or specialty providers.
- A single point of entry should be established that allows parents and providers easy access to information on the services their child or patient qualifies for as well as referrals to those services.
- Services should be of high quality, adequate intensity and convenient both with regard to time of the day/week and geographical accessibility.

- Funding for services should allow access to an adequate quality and quantity of services and should be continuous, without interruption, as long as the child and family need the services.
- Providers and families should be able to exchange information easily and should have access to the most current information on services available and the evidence that services are effective.
- The system should be monitored regularly for barriers to entry and/or problems with access once a child and family are in the system. Regular measurement of child and family process and outcomes measures, easily understood by families and providers, should occur. Ongoing system improvement should occur to address gaps in service and improve services and outcomes for children and families.

The Medical Home Model is an example of a coordinated system of care that has these characteristics. Based on input from the CSC, the original graphic representation of the Medical Home Model presented in System Model Recommendations Report was revised to incorporate feedback received for clarification.

American Academy of Pediatrics Ad Hoc Task Force on Definition of the Medical Home. The medical home. *Pediatrics*.1992; 90 :774

Timely and Accurate Entry Into the System Of Care: Getting a Diagnosis and Locating Services – Best Practice Models

Two examples of best practice models are Healthy Steps and the Denver System for Assessment and Referral.

HEALTHY STEPS: A PRACTICE-BASED MODEL. Several recent reports, including the Institute of Medicine's *Crossing the Quality Chasm: A New Health System for the 21st Century*, have highlighted the value of physicians working in teams with non-physician professionals to deliver care more effectively (IOM, 2001). One of the best models for this approach is the Healthy Steps Program, which leverages the skills of a child development specialist with the medical skills of the physician (McLearn et al., 1998). The Healthy Steps team approach demonstrates the value of a nurse or social worker in the office who can navigate the various community systems, perform developmental assessments, address the needs of both parents and their children, make community referrals, and provide education, anticipatory guidance, and counseling. In December 1994, the Commonwealth Fund launched the Healthy Steps for Young Children Program. With a panel of experts and multidisciplinary teams, the program formed partnerships with nearly 70 funding sources and 24 pediatric and family practice sites across the country to reorganize pediatric primary care. The goal was to promote the physical, emotional, and intellectual development of young children by enhancing the knowledge, skills, and confidence of parents in their child-rearing abilities. The program included:

- A team approach to care, including pediatric clinicians and Healthy Steps specialists.
- Enhanced well-child visits by teams and a sequence of home visits by Healthy Steps specialists.
- Written materials for parents emphasizing health promotion and healthy development.
- Periodic child development screening and family health assessment.
- A child development telephone information line.
- Parent groups and linkages to community resources.

The program accomplishes its objectives through a training institute and curriculum to enhance the knowledge and skills of pediatric clinicians participating in the Healthy Steps program. Early findings suggest that the Healthy Steps model provides better care for behavioral and developmental services. The model also better meets the needs of parents and improves parental safety practices. (Minkovitz, 2001)

Reshaping Primary Care: The Healthy Steps Initiative." Lawrence, P., et al., *Journal of Pediatric Health Care*, March/April 2000, Vol. 15, pp. 58-62.

DENVER SYSTEM FOR ASSESSMENT AND REFERRAL. The Denver General Hospital and Clinics system for assessing and referring children with developmental disabilities for treatment has three tiers. Primary care pediatric clinics are linked to a second tier, which has more centralized developmental assessment and coordination. This center is in turn linked to the Individuals with Disabilities Education Act (IDEA) system for treatment of children with developmental disabilities. In the Denver model, children are routinely screened in the pediatrician's office or Medical Home using the PEDS Developmental Surveillance Instrument at nine and 18 months. Children with problems are referred to a central assessment team that conducts additional assessments and refers children to diagnostic and treatment providers in other community locations. This unit also coordinates care and serves as the entry point to the IDEA system. Funding for the initial screenings comes from Medicaid-related health service delivery dollars. Funding for the assessment and coordination into the IDEA system comes from IDEA funds and Title V funds, in addition to Medicaid funds. This model results in developmental surveillance for all children, and uses a multi-tier process to assess those children identified as most at risk. Innovation also occurs along a pathway that links the primary care, developmental screening, and developmental treatment systems to facilitate movement of children and families to the appropriate level of care. (Halfon et. al., 2003).

Staying in Care and Getting Needed Services over the Life Course of the Child

Among many examples around the country we offer two best practice models; ChildServ in Hartford, CT and a group of programs in Williamsburg, VA.

ChildServ: Citywide Coordination and Enhanced Connectivity. (Excerpted from Halfon, 2003). The ChildServ program was developed in Hartford, Connecticut, in response to the need for a coordinated, citywide system of developmental surveillance to serve the large number of Hartford children with developmental and behavioral problems. ChildServ has been collecting data on an ongoing basis to evaluate the program's effectiveness. The program has already made improvements in meeting the developmental and behavioral needs of Hartford's children and families. The program emphasizes, moreover, that its success is largely due to the collaborative relationships formed among the program's providers and community agencies. Major components of the program include:

- Training local child health care providers in effective developmental surveillance and monitoring.
- A computerized inventory of regional services for developmental needs.
- A triage, referral, and case management system that help children and families access services.
- Gathering systematic data on the developmental status and needs of local children in local communities.
- Educational programs for parent groups and child care providers that offer information about early detection of developmental concerns and promote increased communication with child health care providers.

Williamsburg, VA: All children are connected to a consistent source of health care, a medical home. (Following excerpted from Doggett, & Bronheim, 2004.) Two initiatives collaboratively ensure that all children are connected to a medical home. Low-income children who do not have a private physician are served through the private, non-profit Olde Towne Medical Center. The medical center provides health services, including prescriptions, and serves as the children's medical home. The second initiative, the Comprehensive Health Investment Program (CHIP), uses a combination of public and private, state and local funds to provide home visits to low-income families of children age's birth to six.

Establishing a single phone number to call for Information and Referral to programs and services for children with special needs and their families in Williamsburg, VA was an important early step that helped build strong interagency working relationships and the trust necessary for future collaboration among agencies serving infants and toddlers. The phone number (566-TOTS) links parents of young children to services based on their needs and interests. Originally funded through a grant, the TOTS line is now supported through a combination of public and private funds, including local tax dollars. Families are linked to publicly funded early childhood programs and other community resources for a variety of services such as:

- "Welcome baby" home visits for new parents;
- Information and answers to questions about child growth and development;

- A formal screening for developmental delays to determine if the child might need other services;
- Referrals to community resources; and,
- Temporary service coordination until the linkage to other services is complete.

The TOTS line receives approximately 500 calls annually. Follow-up surveys have found that 100% of the callers received the assistance needed. Approximately 25% of the calls resulted in referrals to early childhood special education or to early intervention (Part C) services for infants and toddlers with disabilities. Recommendations for Improving Availability of Services and the Coordination of Care:

Continuous Access to Insurance and Resources for Health Care Coverage

Best Practice Models for Improving Continuous Access to Insurance and Resources for Health Care Coverage: A best practice model is one in which the financing of health care is understandable to both providers and recipients. Such a model typically provides an services coordinator or advocate for families to assist them to move through the system. Information is available in understandable language, and frequent opportunities for decision making exist. Palm Beach County utilizes two complimentary best practice models to address these issues. The first model provides continuous, comprehensive health insurance and the second provides a “funding bank” that specifically targets gaps in coverage.

Palm Beach County’s Health Care District. The Health Care District of Palm Beach County is a self governing, special taxing district established in 1988 to maximize the health and well being of Palm Beach County residents. The Health Care District provides a source of funding for low-income residents to gain access to health care coverage and maintains a comprehensive trauma system in Palm Beach County. Children in Palm Beach County have particularly benefited from the services provided by the Health Care District and its collaborating organizations. The major services touching children include a) Health insurance for more than 89,000 children, b) Health care services provided by a registered nurse to more than 165,000 children in every public school in the county, c) specialists in behavioral health in schools provides prevention, early assessment, and early intervention services to more than 25,000 children in kindergarten through third grade. The Health Care District has blended local, state, and federal dollars to expand access to health insurance for all children in families below 200 percent of the poverty level. Low-income children who are not eligible for Medicaid or KidCare have access to health insurance through Coordinated Care, a local program created to fill the gaps not filled by the state/federal programs. Coordinated Care provides primary care, specialty and emergency care, hospitalization, and prescription drugs to Palm Beach County children and adults who meet basic income and asset requirements. No co-payments are assessed.

A funding bank to meet individual needs. Even with well-planned systems, gaps occur. The Palm Beach County Children’s Services Council planned for these gaps by creating special funding “banks,” which receive funds from multiple organizations and is funded through an independent special taxing district that helps fund integrated, comprehensive service delivery systems. The Children’s Services Council uses those revenues to provide ongoing activities to plan, coordinate, fund, and evaluate services for children. The county also raises funds through a similar taxing scheme to administer and fund local health programs for the needy through the Health Care District of Palm Beach County. The banks ensure that families and children receive all the services they require through a system in which “the money follows the child.” For example, if a child needs several services, some of which the family’s insurance will cover and others which it won’t, the child is ensured of receiving all the services through access to the “bank.”

COMPARISON OF BROWARD COUNTY SYSTEM OF CARE TO A MEDICAL HOME MODEL OF CARE/COORDINATED SYSTEM OF CARE

As described above, the service system for special needs children in Broward County is like most communities in the United States. It is composed of a complex and baffling array of services, providers, and funding sources. Getting a diagnosis and accessing the system is difficult and confusing for parents. Once a diagnosis is made providers often do not know, given the changes in the system and the complex eligibility requirements for insurance and services, where to refer for appropriate services. For families, getting the care needed by their child is an ongoing challenge for a number of reasons. First, each program and each insurance or funding program has different and changing eligibility criteria, which are very difficult to keep straight. Information is constantly changing, as are the individuals within provider organizations or service systems. Second, there is no one source of information for the types and sources of services for children with special needs. Third, as the child ages, the service system, insurance coverage and eligibility criteria change requiring providers and parents to know multiple systems of care over the life course of the child.

Applying the Medical Home Model of Care to Broward County

The Medical Home model of care makes the primary care provider central to the promotion of child and family developmental health. Academic medical centers or other large service providers, such as the CDTC, should become “centers of excellence” for training in developmental health services, linking community-based providers with specialized developmental services and promoting innovations in developmental care. A marginal investment in infrastructure development could allow academic medical centers or other prominent providers of developmental services to children to play long-term roles in workforce development and quality improvement in developmental health services in Broward County.

Barriers to accessing a Medical Home for Special Needs Children include lack of insurance, sociocultural issues, and poverty (Strickland et al., 2004). Studies have demonstrated that children with chronic conditions frequently do not receive important primary care services such as immunizations or regular well child visits (Raddish, Goldmann, Kaplan, and Perrin, 1993; Szilagyi & Rodewald, 1992) or may not have a primary care provider who implements all of the Medical Home criteria (Palfrey, 1980; Strickland et al., 2004). In the National Survey of Children with Special Health Care Need, while 90% of special needs children had a regular source of primary care, only 52% describe services that meet the criteria for a comprehensive Medical Home (Strickland et al., 2004). In the same survey children who were minority race, poor, or who had a severe medical condition were less likely to have access to a Medical Home. Barriers to access for poor children are compounded by the fact that children living in poverty have more special health care needs and these needs have a greater negative impact on their quality of life and function (Brooks-Gunn & Duncan, 1997; Wood, 2003; Newacheck, 1994). Health insurance and having a source of primary care are common determinants of access to care and increase the chance of having a Medical Home (Starfield & Shi, 2004). Having continuous insurance logically promotes continuity of well and illness care while gaps in insurance erode family-provider relationships and interrupt care.

Barriers to implementing a Medical Home in primary care practices is multiple. First, providing care to complex patients requires extensive knowledge of medical and community resources, is time consuming, and is not adequately reimbursed under current health care financing mechanisms (Antonelli & Antonelli, 2004; Gupta et al, 2004; Palfrey, Sofis, Davidson, Liu, Freeman, and Ganz, 2004). Pediatricians highly committed to providing care to this population report a lack of reimbursed time to care for special needs children, to assist with coordinating school services, and to transition older children to adult care (Davidson et al., 2002). Cooley and McAllister (2004) have worked extensively to implement the Medical Home in a number of practices and they identify a number of practical office-based organizational barriers. These include the lack of an office registry; lack of clear roles of parents and office staff related to care coordination; limited consumer involvement in design and evaluation of care; and practices' lack of understanding of and models for improvement in care.

Barriers also exist within the structure of the pediatric health care system. Often communication *to* and *from* specialists and other health professionals outside the primary care practice is difficult (Forrest, Glade, Baker, Bocian, Kang, and Starfield, 1999; Stille, Korobov, and Primack, 2003). Forrest and colleagues (1999) found that less than half of referring pediatricians schedule an appointment with specialists, leaving that up to the family. Also, they found that just over half were aware if their clients completed or missed the referral visit they had recommended. Furthermore, only about half received feedback from the specialist on the referral visits. The system of care outside the pediatrician's office is incredibly complex and constantly changing. Each insurance program has a different set of providers that will accept that insurance. Families are switching on and off insurances, requiring changes in

the referral patterns for individual children. Furthermore, each child health program or service system has a different set of clinical and income eligibility criteria, which also change frequently. Moreover, system contacts and information sources are hard to develop because agencies serving children have very high staff turnover rates.

APPENDIX 4

**“SYSTEM MODEL
RECOMMENDATIONS”**

A. Timely and Accurate Entry Into the System Of Care: Getting a Diagnosis and Locating Services

The Medical Home model of care makes the primary care provider central to the promotion of child and family developmental health. Academic medical centers or other large service providers, such as the CDTC, should become “centers of excellence” for training in developmental health services, linking community-based providers with specialized developmental services and promoting innovations in developmental care. A marginal investment in infrastructure development could allow academic medical centers or other prominent providers of developmental services to children to play long-term roles in workforce development and quality improvement in developmental health services in Broward County.

- **Improve the Capacity of Pediatric Practices to Deliver Developmental Services.** Pediatricians and family physicians seeing children, using the Medical Home model of care, should be empowered and trained to improve the quality and frequency of developmental screening and surveillance and to increase their knowledge of specific developmental conditions, such as autism. The service coordinator and provider community should collaborate on how best to inform and update pediatricians regarding available social service interventions/services. It is envisioned that by implementing the recommendations for case management including a decentralized case management system, system enhancement and the development of on-going coordination and linkages between the social service system, educational system and primary medical care will occur. Child health practices must improve their capacity to provide developmental health services and dismantle the barriers that impede delivery.
- **Establish a “No Wrong Door” Entry Into the Broward County System Of Care:** A “No Wrong Door”, single source of Information & Referral (I & R) system disseminates I & R to every family and provider in Broward County and increases I & R linkages to other health, education, and social service agencies. A No Wrong Door I & R system is one in which any family who receives a disability diagnosis for a family member, or who moves into Broward County with knowledge of an existing diagnosis, will find the basic information needed on health, education, and social services related to the family member’s disability. I & R is not idiosyncratic to the provider or agency funding streams, but is comprehensive, systemic, and accessible to both families and providers. One way to establish a single entry system would be to fund development and maintenance of a Broward County I & R portal. In addition to basic information on health, education, and social services, links to provider directories and websites would be available. Getting families and providers to the portal will also require activity and information dissemination via billboards, TV spots, radio announcements, information disseminated via churches and temples, more visible Child Find activities, and training for personnel who work in the 211 system.

A single source of information and referral (I & R) should be integrated into a care coordination system provided by county or regional health care providers. This is increasingly important in regions where families have many individual providers to sort through, and where providers have overlapping responsibilities (e.g., Florida Diagnostic and Learning Resource Services (FDLRS), individual hospitals, community agencies). In a *No Wrong Door* I & R system, materials are available in multiple languages and platforms/formats (e.g., increased materials in Spanish, Haitian-Creole, and hearing and visually impaired, and are available in physicians' offices, schools, and other social service agencies. Information is also public and high profile (e.g., radio and billboards). Parent-to-Parent networks are available and supported, and play a critical role in connecting/linking families with a new diagnosis to the I & R system. Providers also play an important role in single source I & R systems, by regularly updating their directory information and by working within provider networks to share information pertinent to professionals and other providers.

B. Staying in Care and Getting Needed Services over the Life Course of the Child

- a. **Increase the availability of services.** A community-wide planning effort should be initiated to identify specific services that are inadequate in number and scope to meet the needs of special needs children in Broward County. The planning effort should prioritize those services most needed by CSHCN and explore ways to increase the availability of these services, through increased funding for specific services and training of potential service providers.

Approaches to increasing the availability of information include:

- Creating and maintaining system-wide directories focused on specific child populations (e.g., autism) or organized in ways that primary care providers could best use them.
 - Creating centralized information and referral centers focused on children's health and CSHCNs (the existing Broward Information Network (BIN) or First Call For Help Information System may provide some assistance in the development of this centralized database).
 - Developing new means for primary care providers to communicate with specialty service providers, make referrals, and provide information on eligibility criteria and referral processes.
- **Promote Practice level change.** At the practice level, a Medical Home Initiative with the local child health provider community to should be initiated:
 - Train pediatric providers in the principles of the Medical Home
 - Provide practical tools to assist practices to access information on services for CSHCN

- Provide guidance to practices on how to incorporate care coordination services into their practices
- Provide incentives for practices to incorporate care coordination services into pediatric practices
- **Promote System level change.** An in-depth assessment on the availability of information to providers and parents regarding services for CSHCN. Based on this assessment, an RFP process to create new initiatives that improve the availability of information on services for CSHCN should be initiated. The roles, responsibilities, linkages, and boundaries for each aspect of care coordination should be specifically defined. For example, the role of the health care provider and the roles of other providers (e.g., Children’s Medical Services or family resource centers) in identifying family needs and referring to appropriate services must be explicit. In many communities, physicians are poorly trained to fulfill those roles and service system redesign must take that into account. To connect the medical home with the full range of developmental, habilitative, social and other services, a community would need to plan and implement a set of appropriate policies and procedures that effectively link a child’s medical home with other community-based resources, such as the United Way, First Call for Help, Women, Infants, and Children program providers, Children’s Medical Services, and other services.

The Children’s Services Council, in partnership with schools, parents, families, and local communities, should undergo a planning process to design a system that allows the Medical Home and all services for CSHCN to be integrated into a centralized care coordination or information and referral center. The plans could foster a closer collaboration among schools, health care providers, regional centers for developmental disabilities, and early intervention programs, Children’s Medical Services, the CDTC and other agencies.

Moreover, studies should be initiated to examine potential cost effectiveness of proactively providing services to CSHCN such as care coordination, improved access to medications and therapies, in order to prevent costly hospitalizations or emergency room visits. The Emergency Room Diversion project with the Pediatric Associates could serve as a model in this area. Best practices in the county could be cited to demonstrate to insurers the broad and substantial benefit to families and employers for supporting case management and other critical services for CSHCN (e.g., fewer days lost from work by parents of CSHCN).

- **Coordination between Health Care System and School Board of Broward County.** The relationship between the health care system and the Broward County Schools should be improved. Funders of programs for Children with Special Needs could initiate programs to create shared care management plans, training for health professionals on services offered in the schools, training for school health professions on indications for health, developmental and support services, centralized assessment and referral centers that work across the health

and education systems, and the education of health professionals and care coordinators on how to advocate for families within the schools. These funding bodies should initiate dialogue between the Broward School system and the health care system to negotiate common eligibility criteria for therapies and other services. Additionally, services which assist in ensuring that families, advocates, and others understand the Broward School system's processes for completing comprehensive assessments and developing IEPs including the timeline and what to do if there are concerns regarding the effectiveness of efficiency of this process should be increased. One approach would be to fund a services coordinator to work with families and health providers as they advocate for assessments and services within the schools.

- **Create a Services Coordinator.** Create an services coordinator position to increase communication and problem solving across providers within the health care, social service, and education systems. Empower ombudsman to work with providers to develop models of case management that cut across agencies, funding streams, and institutional barriers to coordinated care. Broward County is many steps away from a system of coordinated care. Presently, providers have difficulty networking at the most basic levels for information exchange – comprehensive care coordination for actual children and families is simply not in the immediate future. One method of moving toward this goal is to establish an services coordinator responsible for outlining a strategic plan for the development of such a system. With a charge to begin the process of helping the county to such a system, and the budget to do so, a services coordinator will establish a blueprint for a system of coordinated care that includes:
 - Identifying disincentives for collaboration across agencies and solutions to them;
 - Recommending specific changes to funding streams to promote or require coordination;
 - Establishing a series of pilot projects for coordinated case management with attention to the caseworker / child ratios, caseworker job descriptions, and strategies for linking professionals' input on children as outcomes of the pilots; and
 - Establishing a series of provider networking opportunities that would gather professionals from various agencies to explore systems issues, as well as to interact on specific case management issues.

- **Increase options for accessible transportation throughout Broward County** Accessible transportation is frequently reported as an unmet need in the systems literature. Although recognized as a need by both families and providers alike, transportation lacks a visible constituency group and thus “falls below the radar” in many systems. Transportation is available through some providers but like other services, the availability of transportation is idiosyncratic to the agencies' own capacity and goals. To meet families' and providers' needs, an increase in the availability of accessible transportation is needed. Efficient transportation systems

typically involve a network of both private and public providers, provide a host of incentives for agencies to offer services, monitor utilization and destination patterns continuously, and establish an expectation that reliable transportation will be available during both peak and “off hour” periods.

Although it is unlikely that Broward will be able to establish a short-notice, 24/7 transportation system that meets the needs of all families, a coordinated effort is needed that will result in:

- Accessible and reliable transportation on short notice;
- Transportation that allows a limited number of family members to accompany a child; and
- Reliable transportation that is available throughout all the geographic regions in the county.

An initiative on accessible transportation, focusing on changing the transportation system from the current, ad hoc approach to a more comprehensive approach should be implemented. Transportation should not be unique to the individual family and provider who can afford it. Such an initiative can include incentives to providers to increase transportation services/options, an evaluation of the current user patterns and concerns, a review of fiscal restrictions on providers who seek to make transportation more available, and a cost/benefit assessment of public and private alternatives.

- **Increase services that offer functional supports.** Increase focus on services by function rather than traditional service categories (e.g., mobility, recreation, or life skill classes). Increase supports for assistive technology, mobility training, communication devices, employment preparation, and other services, particularly services for older adolescents. Increase incentives for extended day and extended year services for children and families. Increase availability of services to middle and secondary aged students before school, after school, on weekends, during summers. In addition to the traditional services, other needs include social skills groups, sibling support groups, networking opportunities for families, continuing education activities; and community instruction outside the school system. Many of these services should be available outside of school hours, including evenings, weekends, and summers. The best practice literature frequently uses terms such as *wrap-around*, *24-hour*, and *full service*, to describe a comprehensive service model. Although no model can provide every needed service or support, models that excel are those in which children and families have access to services that result in functional (identifiable) improvements in their lives. Although such services are not always universally available, they are available within and outside of the school system, and during extended hours.
- **Personnel Shortages, Training, & Retention:** To solve the continuous need for direct service personnel in Broward, a clear career path is needed that brings new professionals into the field, and better prepares the people who

currently work in the field. A needs assessment should be conducted to estimate (a) the workforce needs during the next decade, and (b) the current opportunities for professional development. Based on the results of that assessment, a comprehensive plan should be developed designed to:

- bring new and better prepared professionals into the field, and
- provide additional professional development opportunities to existing personnel.

This effort will involve cataloging the different requirements for employment by providers, and identifying the typical skill sets needed by professionals in a range of roles. Opportunities for pre-service and in-service training should be identified, including opportunities at colleges and universities, as well as by providers themselves. An exploration of new options should be conducted including:

- Increased incentives for professionals pursuing associate, bachelors, or masters degrees;
 - Increased incentives for professionals pursuing specialized certifications (e.g., certification in applied behavioral analysis, Infant Toddler Developmental Specialists, etc.);
 - Increased opportunities for continuing education in developmental disabilities by medical, health care, and other professionals; and
 - Strengthening provider networking and mentoring activities as a continuing education activity.
- **Increase availability of Respite Services:** Funders of respite services and community stakeholders should develop a master plan to coordinate the provision of Respite Services for children with disabilities in Broward County. Currently Respite Services are insufficient in both scope and number. Some providers have invested agency resources into making respite services available to families, but the nature and availability of these services are idiosyncratic to each provider's own focus or target population.

There is ample literature documenting the need for comprehensive services for children with disabilities. The systems of care literature is replete with reports of the need to support families to, in turn, support their children within their own family homes (American Academy of Pediatrics, 2000, 2002; McPherson et al., 1999; McDonnell & Hardman, 1988). While no single model of Respite Service appears as a preferred model, the availability of regular respite is strongly linked to healthy families. Respite also reduces the need for future crisis interventions involving familial stress or dissolution and out-of-home placements. Although each family has and uses its own coping mechanism when dealing with familial stressors, the availability of either a brief respite (1/2 day or overnight) or respite period of several days during family emergencies can enable families to attend to complex life circumstances, or otherwise "re-charge" their energy and to deal with practical family issues (Martin et al., 1998).

To meet families' needs for Respite Services, an overall increase in the availability of these services is needed. In addition, eligibility should be linked to family needs rather than nature or type of disability category. For many providers, this might simply require an expansion of current efforts; for others, Respite Services will be a new direction and require start up time and resources.

Elements of the master plan should include:

- Geographic distribution of Respite Services
- Increased overall availability of services
- Provision of both short term and long term services. Short term respite ranges from 3-4 hours to a single day or overnight; long term respite may be needed for as long as a week or more.
- Availability of both in-home and out-of-home Respite Services
- Enhance the existing case management system and begin development of a mechanism to coordinate case management services across funding streams
- Availability of services for children with a variety of disabilities including complex medical and behavioral challenges
- Availability of services for children of all ages, including infants, toddlers, and school aged youngsters through adolescence
- Expectations for staffing, staff credentials, and continuing professional development
- Incentives that promote staff stability and reduce high turnover

C. Continuous Access to Insurance and Resources for Health Care Coverage

Funders of special needs programs and other stakeholders should take the lead in Broward County to assure optimal access to public assistance and insurance programs and CMS for CSHCN. Funders of special needs programs should establish programs that assist with the application and entry into these programs, promote coordination between them and advocate for increased reimbursement rates for identified services.

- **Improve Access to and Prevent loss of Medicaid and KidCare insurance.** The Children's Services Council should continue to fund a centralized outreach and intake process to engage providers and parents and make them aware of KidCare enrollment periods, assist with applications, assist with ongoing bureaucratic requirements to maintain eligibility and to assist with complaints or grievances. The changes in the Medicaid and KidCare programs will continue and families and providers will need reliable, easily accessible sources of information to enable them to advocate for CSHCN.
- **Improve Coverage and Reimbursement Policies by Managed Care Companies for Specific Services Needed by CSHCN.** Funders of special needs programs and other stakeholders should work with local and state representatives and the Agency for Health Care Administration (AHCA) to

advocate for the inclusion of language in local Medicaid and KidCare managed care contracts to cover four areas: screening and assessment, developmental health promotion, general developmental interventions, and care coordination, including referrals to child service agencies. The George Washington Center has created model contract language to facilitate the adoption of such provisions. Medicaid-eligible children under age 5 are entitled to Early Periodic Diagnostic Screening and Treatment Program (EPDST) services. If a developmental service falls into a statutory or regulatory Medicaid benefit category (such as EPSDT services or physician services), and even if this service category is not covered under a state's Medicaid Plan, federal matching funds are available for those services in that state. Thus, if framed correctly, matching funds can be obtained for some developmental services.

- **Host a Summit on Health Insurance Coverage for Families of Children with Special Needs.** Funders of special needs programs and other stakeholders should initiate a “Summit on Insurance for CSHCN,” inviting all companies that provide public and private insurance for families with CSHCN as well as the major employers and purchasers of family health insurance in Broward County, service providers, families with special needs children, legislators, and insurance industry representatives. The insurance executives should be educated on the needs of CSHCN and the need for better access to specific services.
 - The Summit on Insurance for CSHCN should evolve into a working group or commission that could, consider innovative strategies to improve both coverage and reimbursement for specific services that are not in adequate supply. For example, Broward County could initiate insurance pools that blend local, state and federal funds to provide improved coverage for services not adequately covered by traditional forms of insurance. Programs developed by Palm Beach County and other localities in the US could serve as a model for this effort.
- **Provide a structure for ongoing dissemination of information on health insurance for CSHCN.** The increasingly complex situation involving health care financing requires an active approach to assisting families. Families and providers need a reliable source of information to help solve their on-going problems related to the financing of health care. Funders of special needs programs and other stakeholders could set up periodic Frequently Asked Question (FAQ) periods, staffed by people familiar with case management procedures, who also understand the myriad of insurance networks and services. Physicians, health care providers, and families could call in to ask / answer questions, and find providers with certain services.

D. Tracking, Monitoring, and Improving the Status of the System - In analyzing the data gathered in this project, including the survey of parents and providers, there was no evidence presented that the system of care for CSHCN has a coordinated, systematic method of monitoring, tracking or continuous improvement. Although

each agency has some mechanism for tracking numbers of referrals, wait times for services, requests for additional services, etc., there is no continuous monitoring of the overall system that leads to improvement. This lack of a monitoring system has implications for delivering basic services, making improvements to the system. It also has implication for projecting the manpower needs of the system in the future, and for identifying and improving the professional development needs of employees within the system.

The system of care should be monitored to evaluate the demand for services, time to initial diagnosis, the source and type of referrals made, the time from diagnosis to referral, the type and quantity of services received by CSHCN, the quality of services and the outcomes experienced by CSHCN. A centralized referral and information source could greatly help with the tracking of the issues listed above. In addition, a concerted effort is needed to monitor and improve the knowledge and skills of direct care staff among the various agencies. Currently, there is no on-going system for professional development or any concerted effort for continuous improvement.

- **Monitor, Track, and Report the Developmental Functioning of All Children and the Developmental Health Services They Receive.** At the child/family level, service provider level and city and county levels there is a need for better data about the developmental functioning and needs of young children, the services they receive and their outcomes. From a population health perspective, there is also an urgent need to assess and track the content and quality of services, and to monitor progress in early childhood systems. Any system for continuous improvement also should target the training needs of front-line providers who work in the myriad human service agencies in Broward.

New quality assessment tools, such as the National Survey of Early Childhood Health (NSECH), measure both population and practice-based experience and help to formulate integrated data collection strategies (Bethell et al., 2001a; Halfon et al., 2002a). Just as states now administer the Youth Risk Behavior Surveys on the changing profile of youth risks and the impact of preventive services, Broward County should consider modifying the NSECH to develop a county-level profile of the developmental health needs, risks, and service use of children from birth to age 5. Linking such countywide population-based surveillance with the content and quality of developmental health services would allow Broward to assess the impact of policy, program, and practice-based changes. This initiative would help Broward County begin to develop the strategic vision needed to improve the system of care for CSHCN. This also has the potential to encourage a collaborative process, with public and private partners working to improve the quality of developmental health services.

- **Improve Quality Measurement and Accountability to Enhance Incentives for Optimal Performance.** Quality measurement tools that many state health departments routinely use, such as HEDIS, should be modified to measure developmental health services. This type of administrative change would create a

powerful incentive for change within managed care organizations and physician practices because of the accountability demanded by County and State funded programs. In addition, Broward County could encourage the Florida Medicaid, KidCare and CMS programs, and private insurance companies to consider launching practice improvement initiatives focused on developmental health services. Maine, Washington, Vermont, North Carolina, and several other states have already done so. In these states, the Foundation for Accountability Promoting Healthy Development consumer survey is being used to assess quality of services and improvement efforts.

ACKNOWLEDGEMENTS

Children's Services Council Board

Laurie Sallarulo

Children's Services Council

Cindy Arenberg Seltzer, Esq.

Sandra Bastien-Bernard

Michele Carmel, Ph.D.

Evan Goldman, Esq.

TerryAnn Petticini

Karen Swartzbaugh

Jean Thaw, Ph.D.

Hal Wiggin, Ed.D.

Broward Regional Health Planning Council Research Team

Mike De Lucca	Broward Regional Health Planning Council
Angelo Castillo, Esq.	Broward House
Leonard Bliss, Ph.D.	Florida International University
Linda Bliss, Ph.D.	Bliss Associates
Michael Brady, Ph.D.	Florida Atlantic University
Randy Green	Parent of a Special Needs Child
Myles Henderson	Broward Regional Health Planning Council
Rene Podolsky	Broward Regional Health Planning Council
Michele Rosiere	Broward Regional Health Planning Council
Sharon Slutsky, Ph.D.	Parent of a Special Needs Child
Terri Sudden	Broward Regional Health Planning Council
David Wood, M.D.	Department of Health/ University of Florida

Community Input

DeMaris Baez	SFFC's Inc.
Howard Bakalar , Esq.	Family Central, Inc.
Jon Bandes	Memorial Healthcare System
Thor Barclough	Broward Children's Center
Robin Bartleman	Broward County School Board
Rebecca Bedell	Children Services Bureau of Broward County
Wendy Bellack	Parent to Parent – Family Network on Disabilities
Ellen Breslow	Florida Diagnostic & Learning Resources System
Irene Butcher	YMCA of Broward County
Ana Caleron	Florida Diagnostic & Learning Resources System
Kathy Carroll	Broward Children's Center
Carrie Cohen	Kids in Distress
Janie Cohen	Memorial Healthcare System
Efram Crenshaw	Urban League of Broward County
Christie Cohn	Alliance for Families with Deaf Children
Maria DelMoro	ESE Broward Advisory

Cobi Dunn	YMCA Broward
Dr. Mike Elwell	Children's Services Administration Div., Broward County
Margorie Evans	Broward Children's Center
Kathy Gent	Lighthouse of Broward
Rep. Susan Goldstein	Florida House of Representatives
Shelley Greif	Children's Medical Services
Dr. Mark Gross	Family Central, Inc.
Jeremy Grunford	Children's Resource Center of South Florida
Rhonda Grunther	Florida Service and Training Institute
Christine Gudicello	ASC Preschool
Dennis Haas, Esq.	Achievement and Rehabilitation Centers
Diane Harvey	Children's Resource Center
Jennifer Jones	Alliance for Families with Deaf Children
Michele Kaplan	MSI/ Nova Southeastern University
Leah Kelly	Broward County Public Schools
Martha Keim	Department of Children & Families
Andrea Levy	FAIMH – Children's Psychiatric Center
Nancy Lieberman	School Board of Broward County
Gwen Lipscomb	Florida Diagnostic and Learning Resources System
Jim Lobel	Intermed Health Care
Cathy Lovern	Kids in Distress
Lori Mandke	ASC Preschool
Karmel McCarthy	MHW/MHM
Jim McGuire	Ann Storck Center
Jeanne Miley	North Broward Hospital District - CDTC
Ilene Miller	Florida Diagnostic & Learning Resources System
Audrey Millsaps	Children's Services Board
Paul Napier	Devereux Family Services
Ellyn Okrent	Kids in Distress
Dr. Kevin O'Mara	Children's Services Administration
E. Pierce	North Broward Hospital District
Laura Prado	Parent Activist
Shawn Preston	ARC Broward
Julie Price	ARC Broward
Michelle Rogers	Family Central, Inc.
Eileen Roth	Autism Society & Broward Autism Foundation
Denise Rusnak	Broward County Schools
Tonya Fox Shaw	Joe DiMaggio Children's Hospital
Diane Sherkow	BAEYC
Meryl Sherris	Autism Society of America
Silvia Starin	Behavior Analysis
Haydee Toro	Department of Children & Families - APD
Leni Ulrich	Pediatric Therapy Associates

Medical Home/Systems Model for Community Based Care for CSHCN STRATEGY

CSC Oversight/Advisory

Provide Guidance on Funding, Standards, Policies and Procedures for Integration and Monitoring of the Effectiveness of Services for CSHCN

