

SAN GABRIEL/POMONA REGIONAL CENTER

Prevention Plan Program Design

I. Purpose

The purpose of the prevention plan is to provide intake, assessment, and case management services along with referrals to generic community resources and parent training to infants and toddlers who are:

1. High risk infants, who have not yet manifested a delay, but who meet two or more of the risk factors identified in DDS Prevention Program Policies and Procedures or;
2. Infants and toddlers who have a parent with an identified developmental disability or,;
3. Toddlers ages 24 to 36 months who have a 33% to 49% delay in one of the following areas of development:
 - a. Social /emotional development
 - b. Self Help/adaptive skills development
 - c. Physical and motor skills development
 - d. Communication development
 - e. Cognitive development

II. Intake Assessment Procedures:

The San Gabriel/Pomona Regional Center Prevention Program will have a single point of entry intake procedure to determine eligibility. All children will be assessed for eligibility within 45 days of referral. A determination will be made if the child is eligible for Early Start or the Prevention Program. The intake process will include a social assessment conducted by an Intake Service Coordinator, a request and review of relevant birth and medical records, and if warranted an evaluation in the 5 areas of development.

For those children who are being discharged from a Neonatal Intensive Care Unit (NICU) a review of their discharge summary will be conducted by the SG/PRC medical consultant and a Registered Nurse to assist in determining what additional assessments/evaluations may be needed. The Registered Nurse will also conduct a social nursing assessment for medically fragile infants.

Eligibility for the Prevention Program will be determined by an interdisciplinary team consisting of the SG/PRC Medical consultant, Occupational Therapy consultant, and Speech Pathology Consultant. This team will also make recommendations for the frequency of ongoing screenings, developmental follow-up, and potential referrals to community resources.

Appeal process for eligibility:

Eligibility is the only action or decision of the Prevention Program for which a parent may submit an appeal. If a child is denied eligibility the parent will be sent written notification of the denial along with information about the appeal process. The parent must submit a

written request for the appeal explaining the reasons for their disagreement. Upon receipt of the appeal, a review panel will be convened to review the information and provide a written decision within 30 days of the receipt of the request. Members of the panel will include an SG/PRC clinician, an SG/PRC staff member, and an external member. All members of the panel will have no prior involvement with the original eligibility decision.

Ongoing developmental screenings will be done by the case management staff including the Ages and Stages Questionnaire to look at the child's developmental progress and the MCHAT to screen for risk for autism. Should the results of these screenings show a need for further assessment the child will be referred for a formal developmental evaluation. Frequency of screenings may be conducted quarterly, or semiannually depending on the child's needs and their access to existing community Neonatal follow up clinics. The determined frequency of screenings will be documented in the child's Prevention Program Plan (PPP). An initial MCHAT will be conducted for all children between 16 and 18 months of age. This screening tool may be used again based on the child's needs as identified by the family and the Service Coordinator.

For those children who are identified as high risk and who are not able to participate in a high risk Neonatal Follow Up Clinic, formal developmental assessments will be conducted between the adjusted ages of 4 to 6 months and then again between the adjusted age of 9 to 12 months.

III. Case Management Staffing Model

SG/PRC will be utilizing mixed caseloads of Early Start and Prevention to provide case management to those children who are eligible for the Prevention Program. Eleven Service Coordinators who currently provide services to children in the Early Start program have been identified to also provide case management services to children in the Prevention Program. In the event that a child in the Prevention Program manifests a delay that makes them eligible for Early Start services, the child and their family will maintain consistent services through the same Service Coordinator. Those Service Coordinators who provide case management services to infants and toddlers in the Prevention Program will continue to be directly supervised by the Client Service Managers of the Early Intervention Case Management Units. SG/PRC will have a goal to have these mixed Prevention Program/Early Start caseloads at a ratio of 1:62.

Those children who have a parent with a development disability will continue to receive services and case management from Service Coordinators who have specialized case loads made up of SG/PRC adult clients and their children. Those Service Coordinators have extensive experience in meeting the special developmental needs of young children whose parent(s) have a developmental disability. These Service Coordinators will continue to be directly supervised by the Client Services Manger of the Adult Services unit.

Service Coordinators will provide the following case management supports to the families and children in the Prevention Program:

- Identification of and referral to appropriate generic community resources: The Service Coordinators will help increase parent knowledge of local resources and how to obtain those resources.

- **Building Advocacy and Problem Solving Skills:** The Service Coordinator will act as an advocate for the family in obtaining community resources and will help the parents to build their skills as advocates for their children and families. The Service Coordinator will use a cooperative relationship to help the family to build their problem solving skills.
- **Identifying Family Strengths:** The Service Coordinators will help the families in the Prevention Program to identify their unique strengths and help them to recognize the natural supports in the family's life.
- **Parent Education:** The Service Coordinator will provide the families with information on their child's current level of development and on the general milestones of child development. The Service Coordinator will provide the parents with information about enhancing their child's development in a manner that is focused on the family's strengths and that is sensitive to the family's needs and cultural preferences. This information will help the parents to identify potential concerns about their child's development.
- **Exit Planning:** At the time of discharge from the Prevention Program, the Service Coordinator will help the family with identifying appropriate programs such as Early Head Start/Head Start, First 5 programs, school district programs, or other community preschool services. With parental permission, the Service Coordinator will also provide a formal written referral to the child's local school district when the child reaches 3 years of age.

A Registered Nurse (RN) will be assigned to the Prevention Program to provide support as needed, especially for those premature infants who have been recently discharged from the NICU. Currently the RN assigned to the Prevention Program has a dual MSW degree and experience working in a NICU. The RN will also be available to provide chart reviews and to go on home visits with the Service Coordinators, especially for visits with those families who have medically fragile infants.

The SG/PRC clinical team will also be available as a source of support for the Service Coordinators providing services to the children and families in the Prevention Program.

A Program Manager has been employed to provide leadership to the Prevention Program to develop and over see the quality and effectiveness of resources for families and children in the Prevention Program. The Program Manger will coordinate and provide training to parents and staff and will act as a liaison to the community.

IV. Knowledge, Skills, and Abilities for Prevention Program Case Mangers

All Service Coordinators who provide case management services to the children in the Prevention Program will have an educational or experiential background in child development that equips them to conduct ongoing developmental screenings. They will also possess the abilities to accurately assess and monitor the child's needs, determine the needs of the family system, provide developmental information to families to help them guide their child's development, assess the family's strengths and cultural preferences, and help the family to build their own advocacy and problem solving skills.

All Service Coordinators must have a minimum of a bachelor's degree and a minimum of one's years experience providing direct service to families who have children with special needs. Currently the Service Coordinators providing case management services to children in the Prevention Program have the following backgrounds: Child Life Specialist, preschool teachers, infant educators, and Early Head Start teachers.

The Service Coordinators must also possess a good knowledge of appropriate community resources to which they can refer their families and the ability to help families access those resources. All Service Coordinators working with the children and families in the Prevention Program will receive information on local resources and resource agencies. They will also have access to support from the Family Resource Center's informational lists about community resources.

As all Service Coordinators providing case management services to children and families in the Prevention Plan have also been serving families and children in the Early Start program they have an excellent understanding of the Early Start system. As a part of their training and experiencing in working with the families and children served through Early Start they have extensive knowledge about developmental screenings, assessments, and milestones.

All Service Coordinators who are working with the children in the Prevention Program received formal training on administering the Ages and Stages Questionnaire (ASQ) on 11/16/09. They will also receive training from the SG/PRC psychologist on the administration of the MCHAT.

The Service Coordinators are also overseen and supervised directly by Client Services Managers who have extensive experience in servicing families with infants and toddlers who have special needs. The current Client Services Managers have from ten to twenty years of experience overseeing the case management of the children and families in the Early Start Program.

V. Prevention Program Plan

Once a child is determined eligible for the Prevention Program, the Service Coordinator will arrange a collaborative meeting with the child's parents/legal guardian, family, and any other individuals the family chooses to invite to complete the Prevention Program Plan (PPP). This meeting will take place within 60 days of the initial referral. The PPP will include the following information:

- The child's eligibility criteria
- The date of the PPP meeting and all participants in the meeting.
- The Service Coordinator's name
- How frequently the service coordinator will be in contact with the family
- Basic information on the family composition and parent-child relationship
- Identification of the family's concerns and priorities
- The child's current developmental and health status

- Resource of which the family is need or which have been provided
- Referrals to be made to community resources
- Frequency and type of developmental monitoring/screening
- Frequency and type of assessment
- Other services the child and family may receive

The Service Coordinator will review the PPP with the family within 90 days of the development of the initial PPP and at least every 6 months thereafter. The Service Coordinator will also complete an Early Start Report (ESR) following the initial visit and then annually thereafter.

A copy of the SG/PRC PPP form is attached.

VI. Proposed Liaison Activities

SG/PRC will maintain a number of agreements with local community resources to which families in the Prevention Program will be referred. Additionally the SG/PRC Program Manager of Prevention Services will build additional relationships and resources with community service providers. The following liaison activities will be a part of the SG/PRC Prevention Program:

- ~~Local Hospital NICU and High Risk Follow Up Clinics~~—The current Early Start Program Manager currently serves as a liaison to the local Hospital NICU programs and attends bi-monthly discharge team meetings with those professionals. She will continue to serve as a liaison for the Prevention Program as well. Additionally an SG/PRC RN will be participating in these meetings. Educational information about the Prevention Program will be provided to the local NICUs through these relationships.
- SG/PRC hosts an established and well attended monthly Local Interagency Coordinating Agencies (LICA) meeting. Local School districts, service providers, the Family Resource Center, representatives from LA County Department of Mental Health, and LA County Department of Children and Family Services participate in these events. Issues surrounding the collaborative efforts necessary for the Prevention Program will be discussed during these monthly meetings.
- SG/PRC is exploring resource options available through First 5 through their early identification policy.
- SG/PRC currently has MOUs in place with the local Early Head Start programs. SG/PRC will continue to work with and additionally build relationships with the local Early Head Start and Head Start program services for which some Prevention Program families may be eligible.
- SG/PRC has completed a service agreement for the Prevention Program family support services with the Local Family Resource Center, The Parent's Place to provide educational services and information about local community resources to the families in the Prevention Program. The Prevention Program Manager will work closely as a liaison to the Family

Resource Center to collaborate on the services they will provide and educate the Service Coordinators about the services the Family Resource Center can offer the families and children in the Prevention Program.

- SG/PRC currently has interagency agreements with the SELPAs that serve the geographical area where clients reside. SG/PRC will continue to use the established relationships with the SELPAs to refer those children in the Prevention Program to an appropriate school district program at the age of 36 months.
- SG/PRC currently has a liaison with LA County Department of Children and Family Services, Dr. Jeff Dorsey, who will be contacted for collaborative efforts with this agency if needed.
- SG/PRC currently has a liaison with the LA County Department of Mental Health, Irma Castaneda, who can be contacted as needed to help in the referral of community mental health resources for families with children in the Prevention Program.
- The Prevention Program Manager will research and explore other models of service and service agencies and organization in the community and will serve as a liaison from the Prevention Program do outreach and education about the Prevention Program to those agencies and organizations.
- SG/PRC currently works with liaisons from LA Care and Health Net to assist families in accessing those services they may be able to obtain through MediCal Managed Care Plans. The Service Coordinators will continue to utilize these individuals to help families navigate their MediCal Managed Care Plan services.

VII. Proposed Initiative to Develop, Enhance, or Obtain Additional Services for Prevention Program Children

The Prevention Program Manager will be working with the existing service providers in the community to assist in evaluating and promoting the quality and effectiveness of the services children and families in the Prevention Program are receiving. Additionally the Prevention Program Manger will work with the SG/PRC Community Resources department to develop the following resources for children and families in the Prevention Program:

- **Parent Training** – Resources for Parent Training will be developed through agencies that have expertise in serving children ages 0-3. Parent training will focus on different areas such as: building parenting skills for new parents, building language skills for those children over 24 months of age with a single delay in communication, Hanen Training, and building awareness of infant mental health and the importance of the parent-child relationship. Possible development partners include Casa Colina Hospital, Justine Sherman and Associates Speech Therapy Services, Mis Suenos Speech Therapy Clinic, and Corazon de la Familia a program associated with USC's University Center for Excellence in Developmental Disabilities. All Parent Trainings will be reviewed by the Prevention Program Manager to ensure they have a valid curriculum and that trained and qualified professionals are providing the trainings.

- **Parent-child Workshops** – Specialized trainings will be developed and hosted by SG/PRC where parents will bring their infants and toddlers for a “hands on” workshop with one of SG/PRC’s clinical consultants to learn important skills to enhance their child’s development. Possible workshops might include feeding skills, sensory integration techniques, building fine or gross motor skills, and enhancing play skills.
- **Internet Resources** – SG/PRC will develop and maintain a specialized website for families in the Prevention Program. The website will include features such as: information on upcoming trainings and workshops, links to community resources including the Family Resource Center, tips and techniques parents can use to enhance their child’s development, comments and feedback from other parents, and information on developmental milestones.
- **Brochures and Informational packets** – SG/PRC is developing a family friendly brochure that describes the services and supports that families will receive through the Prevention Program.

The Service Coordinators who provide case management services for the children and families in the Prevention Program will also help families to obtain the following additional services:

- SG/PRC Service Coordinators will continue to work with families to help them to access the services they may have available to them through publicly funded agencies such as California Children Services and their insurance options.
- SG/PRC Service Coordinators will encourage parents to participate in the High Risk Neonatal follow up clinics at Pomona Valley Hospital Medical Center and Huntington Memorial Hospital.

VIII. Purchase of Direct Services

The following direct services may be purchased for children and families in the Prevention Program:

- **Infant Development Programs** – For those children whose parents have a developmental disability, SG/PRC will continue to fund for Infant Development Programs to provide in home services to meet the unique parenting needs of these families.
- **Group Speech Therapy Services** – May be provided for those children over the age of 24 months with a sole delay in communication, if all other service options have been exhausted.
- **Group Parent Trainings** – May be provided to families to increase their skills and abilities to meet the unique developmental needs of their child when other training and educational opportunities are not available to the family. Trainings will be provided in a small group setting, have an identified curriculum, and a defined length.

IX. Early Start Program Transfers

In the event that a child in the Prevention Program starts to display a significant delay the parent and the Service Coordinator will review the developmental information and any

concerns and a referral for a formal developmental assessment will be made. The assessment will be reviewed to determine if the child may be eligible for the SG/PRC Early Start Program. Should the child be found eligible for the Early Start Program they will retain the same Service Coordinator to ensure a consistency and continuity of services for the family.

X. Transfer of Case to Another Regional Center

In the event that a child in the Prevention Program moves from SG/PRC's service area to another service area, SG/PRC will make arrangements transfer the case to the receiving regional center that oversees the area where the child is currently residing. The transfer information will include contact information and all available records including all evaluations, assessments, and a copy of the PPP.



CONFIDENTIAL CLIENT INFORMATION
 DO NOT RELEASE WITHOUT PRIOR WRITTEN PERMISSION
 SEE CALIFORNIA WELFARE & INSTITUTIONS CODE SECTION 4514

Prevention Program Plan (PPP)

IDENTIFYING INFORMATION

Child's Name:		Sex: () Male () Female	
UCI#		Date of Birth:	
Primary language spoken in your home:			
Home Address:			
City:		Zip:	Home Phone:
Name(s) of: () Parent () Legal Guardian () Foster Parent () Other (Specify):			
#1		#2	
#1 Work Phone:		#2 Work Phone:	
#1 Mobile/Message Phone:		#2 Mobile/Message Phone:	
#1 E-Mail Address:		#2 E-Mail Address:	
Prevention Program Service Coordinator:		Phone and E-mail Address:	

PPP PARTICIPANTS

The following individuals/agencies participated in the development of the PPP by either attending the meeting or giving input.

Name/Title	Agency/Phone	Present	Consultation	Report
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ELIGIBILITY CRITERIA

- Developmental Delay (33% - 49% delay in one domain for children 24 - 35 months old):
- Adaptive/Self Help Communication Cognitive Physical Social/Emotional
- High Risk Condition: Specify _____

FREQUENCY OF VISITS

PPP is to be completed within 60 days of initial referral, 90 days after development of initial PPP and every six months thereafter

	Date:		Date:		Date:
Initial Mtg.:		Review Mtg.:		Review Mtg.:	
90 Mtg.:		Review Mtg.:		Review Mtg.:	
Review Mtg.:		Review Mtg.:		Review Mtg.:	
Review Mtg.:		Review Mtg.:		Review Mtg.:	

FAMILY INFORMATION

CHILD/FAMILY (Briefly state family composition, child description, and parent-child relationship):

FAMILY CONCERNS AND PRIORITIES

FAMILY RESOURCES AND SUPPORT (check all that apply)

Financial Support Parent (s) Employment <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Public Assistance <input type="checkbox"/> Cash Benefits: <input type="checkbox"/> Food Stamps: <input type="checkbox"/> Housing/Section 8 <input type="checkbox"/> Social Security Income: Family Support System <input type="checkbox"/> Immediate Family Members <input type="checkbox"/> Extended Family Members <input type="checkbox"/> Friends <input type="checkbox"/> Mental Health Services <input type="checkbox"/> Religious Organizations Other: _____	Child Care Support <input type="checkbox"/> Parents <input type="checkbox"/> Relative <input type="checkbox"/> Friend(s) <input type="checkbox"/> Licensed Child Care <input type="checkbox"/> Nurse(s) <input type="checkbox"/> IHSS <input type="checkbox"/> Other: _____ Educational/Community Support <input type="checkbox"/> Parent Support Group(s) <input type="checkbox"/> Parent Education Group(s) <input type="checkbox"/> Parents' Place Family Resource Center <input type="checkbox"/> Local Library <input type="checkbox"/> Internet Access Mode of Transportation <input type="checkbox"/> Own Car <input type="checkbox"/> Bus <input type="checkbox"/> Friend (s) <input type="checkbox"/> Relative(s) <input type="checkbox"/> Taxi <input type="checkbox"/> Other: _____	Health Services <input type="checkbox"/> Private Health Insurance: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Healthy Families <input type="checkbox"/> Medi/Cal # _____ <input type="checkbox"/> Regular <input type="checkbox"/> HMO <input type="checkbox"/> SSI <input type="checkbox"/> CCS # _____ <input type="checkbox"/> Medical <input type="checkbox"/> MTU <input type="checkbox"/> WIC <input type="checkbox"/> Other: _____
---	--	--

CHILD'S DEVELOPMENTAL STATUS

Monitoring/Assessment completed on: _____ Tool used (Enter name of Assessment/Screening Tool): _____

Child's Chronological Age: _____ Child's Adjusted Age: _____

Information Summary

- | | |
|-------------------------------|--|
| Physical - Gross & Fine motor | <input type="checkbox"/> Child's development appears to be on schedule
<input type="checkbox"/> Child's score is close to the cut-off, provide learning activities and monitor
<input type="checkbox"/> Child's total score is below the cut-off, further assessment may be needed |
| Cognitive | <input type="checkbox"/> Child's development appears to be on schedule
<input type="checkbox"/> Child's score is close to the cut-off, provide learning activities and monitor
<input type="checkbox"/> Child's total score is below the cut-off, further assessment may be needed |
| Communication | <input type="checkbox"/> Child's development appears to be on schedule
<input type="checkbox"/> Child's score is close to the cut-off, provide learning activities and monitor
<input type="checkbox"/> Child's total score is below the cut-off, further assessment may be needed |
| Social Emotional | <input type="checkbox"/> Child's development appears to be on schedule
<input type="checkbox"/> Child's score is close to the cut-off, provide learning activities and monitor
<input type="checkbox"/> Child's total score is below the cut-off, further assessment may be needed |
| Adaptive Self-Help | <input type="checkbox"/> Child's development appears to be on schedule
<input type="checkbox"/> Child's score is close to the cut-off, provide learning activities and monitor
<input type="checkbox"/> Child's total score is below the cut-off, further assessment may be needed |

Additional Information: _____

CHILD'S HEALTH STATUS

Current Medical Condition/Diagnosis:	CCS Eligible Condition Yes <input type="checkbox"/> No <input type="checkbox"/>	
Physicians/Specialists (name, phone):	High Risk Infant Unit (name, address, phone):	
Medications (name, dosage, reason prescribed):	Ongoing Procedures/Technical Devices	
	<input type="checkbox"/> Oxygen Tank	<input type="checkbox"/> Apnea Monitor
	<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Feeding Pump
	<input type="checkbox"/> Suctioning Machine	<input type="checkbox"/> Other: _____
	Nutrition/Oral Health: _____ _____	
	Height: _____	Weight: _____
Immunization Status	Hearing Status	Vision
<input type="checkbox"/> All immunizations current	<input type="checkbox"/> Newborn Hearing Screening	<input type="checkbox"/> Normal Limits
<input type="checkbox"/> Follow-up Needed: _____	Date: _____ <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A	<input type="checkbox"/> F/U Needed: _____
	<input type="checkbox"/> F/U Needed: _____	

Infant & Family Direct Service Plan

CASE MANAGEMENT ACTIVITIES

Date copy of PPP provided to parent: _____

PARENT EDUCATION

- Ages & Stages Learning Activities, Section: _____
- Ages & Stages Learning Activities – Communication Section and <http://www.asha.org/public/speech/development/chart.htm>
- First Five – Kit for New Parents
- Warm Line – “Bananas Baby Briefs” Handouts 0-24 months (E+S)
- Zero to Three – “Your Child’s Development” Handouts 9-12 Months (E+S)
- Zero to Three – “Healthy Minds” Handouts (E+S)

Comments: _____

HEALTH/MEDICAL ACTION PLAN

Next Pediatric Visit: _____ Next Specialist Visit: _____ N/A

American Academy of Pediatrics – <http://www.aap.org/healthtopics/stages.cfm>

Health Plan Coverage for Medical Services/Name of Insurance: _____

Parent will request access to health insurance benefit to provide medically required service:

Occupational Therapy Physical Therapy Speech Therapy Hearing Test

Next High Risk Follow-Up Clinic Visit: _____ N/A

NEW REFERRAL NEEDED: (see box's below)

REFERRALS TO GENERIC RESOURCES

<input type="checkbox"/> CCS	<input type="checkbox"/> EPSDT	<input type="checkbox"/> Early Head Start Program	<input type="checkbox"/> Healthy Families	<input type="checkbox"/> _____
<input type="checkbox"/> CHDP	<input type="checkbox"/> LACMH	<input type="checkbox"/> Employment Development Dept.	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> DPSS	<input type="checkbox"/> SSA/SSI/IHSS	<input type="checkbox"/> Family Resource Center	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> LADHS	<input type="checkbox"/> WIC	<input type="checkbox"/> Head Start Program	<input type="checkbox"/> _____	<input type="checkbox"/> _____

OTHER EDUCATIONAL/COMMUNITY RESOURCES PROVIDED

<input type="checkbox"/> Adult Education	<input type="checkbox"/> First Five	<input type="checkbox"/> Public Transportation	<input type="checkbox"/> Internet/Website:
<input type="checkbox"/> Child Care Resources	<input type="checkbox"/> Legal Services	<input type="checkbox"/> 211	Bright Futures www.brightfutures.org
<input type="checkbox"/> Charitable Organization	<input type="checkbox"/> Mommy and Me Community Program	<input type="checkbox"/> _____	CDC Learn the Signs. Act Early: http://www.cdc.gov/ncbddd/actearly/milestones/index.html
<input type="checkbox"/> Foster Parent Training	<input type="checkbox"/> Local Library Program	<input type="checkbox"/> _____	First Signs www.firstsigns.org
			Zero to Three www.zerotothree.org

EXIT PLANNING

Based on PPP Team, Exit Planning will include referral to:

- None at this time, continue monitoring visits as appropriate.
- Early Start Program
- Begin transition planning to local education agency to complete assessment and eligibility for Part B services by age 3.
- Begin transition planning to local community preschool/day care program by age 3.
- Evaluate for Lanterman Eligibility by age 3.

OTHER SERVICES