Participants will learn:

- To describe how Public Health and Parent Support Providers can work together to support a family so the family will be successful
- Challenges and possible solutions to integrated healthcare supports
- Practical tools to partner with agencies to develop a Family Driven System of Care
- Strategies for collaboration with agencies and building relationships

This System of Care/SAMSHA Grant initiative is working to develop a sustainable infrastructure of services, supports, procedures and training to deliver best practices in mental health care for very young children and their families. Alamance Alliance works with children 0–5 years old with social/emotional issues, mental health issues or at risk for being removed from the home.

- 800+ children have received direct services funded by the Alliance
- 643 children have been referred for a diagnostic evaluation
- 479 had a diagnostic evaluation
- 368 were eligible for Alliance services
- 335 enrolled in the Alliance
- 288 were assigned a mental health provider
- 254 were assigned a Family Partner

### Children’s Diagnoses

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disruptive Behavior Disorder Not Otherwise Specified (NOS)</td>
<td>53%</td>
</tr>
<tr>
<td>Adjustment Disorder with Mixed Disturbance of Emotions and Conduct</td>
<td>25%</td>
</tr>
<tr>
<td>Adjustment Disorder with Disturbance of Emotions</td>
<td>9%</td>
</tr>
<tr>
<td>Attention Deficit Hyper Active Disorder (ADHD)</td>
<td>6%</td>
</tr>
<tr>
<td>Pica</td>
<td>5%</td>
</tr>
<tr>
<td>Adjustment Disorder with Disturbance of Conduct</td>
<td>4%</td>
</tr>
<tr>
<td>Anxiety Disorder Not Otherwise Specified (NOS)</td>
<td>3%</td>
</tr>
<tr>
<td>Post Traumatic Stress Disorder</td>
<td>3%</td>
</tr>
</tbody>
</table>
Children’s Life Experiences
- 72% have lived with someone who was depressed
- 35% have lived with someone with mental illness
- 35% have lived with someone with substance abuse problems
- 17% of kids in preschool have been suspended, expelled or both

Children’s Life Experiences cont.
- 35% have lived with someone who committed a crime
- 44% have witnessed domestic violence
- 26% witnessed or experienced physical assault
- 10% witnessed or experienced sexual assault

Parent Support Provider
A Parent Support Provider, or Family Partner, is defined as a parent / caregiver of someone who has received services and therefore has firsthand experience within the child and family system, or who has gone through the system themselves.

Role of A Family Partner
- Engage families and help them stay connected to services and supports
- Provide peer/emotional support
- Help families navigate complex service systems
- Link families to appropriate services and supports
- Advocate for families at various levels
- Facilitate Child and Family Team meetings
- Develop a Futures Map with family

Family Partner Activities: Care Coordinators

Family Partners

Caregiver Report of Satisfaction with Family Partner
CC4C (Care Coordination for Children) is an at-risk population management program that serves children from birth – 5 years of age who meet certain risk criteria.

The main goals of the program are to improve health outcomes and reduce costs for enrolled children.

CC4C Target Population

Children birth to 5 years who:
- Are a high cost/high user of services
- Have special health care needs
- Are exposed to toxic stress in early childhood
- Are in the foster care system

A screening tool assists CC4C Care Managers in identifying children with the highest need.

What is Toxic Stress?

- A type of stress that can have long term negative affects on a child’s development.
- Toxic Stress hinders the child’s ability to thrive.

What contributes to toxic stress?

- Extreme poverty in conjunction with continuous family chaos
- Recurrent physical or emotional abuse
- Chronic neglect
- Severe and enduring maternal depression
- Persistent parental substance abuse
- Repeated exposure to violence in the community or within the family

CC4C Services

- Individualized to the client’s (child’s) needs
- Provided in multiple settings
- Based on standardized, evidence-based strategies that will meet desired outcomes
- Documented in CCNC database (Community Care of NC)
What happens when a CC4C referral is made?

- Action of the CC4C Case Manager based on the completed form:
  1. If any of the boxes under reason/requirement for referral is checked, the child is eligible for CC4C and will receive a comprehensive assessment.
  2. If the Medical Home provider checks the "direct referral" box, the child is automatically referred for a comprehensive assessment.

CC4C Outcome Measurements

- Increase in NICU graduates who have their first PCP visit within one month of discharge.
- Reduce the rate of hospital admissions for children enrolled.
- Decrease the rate of readmissions for children enrolled.
- Reduce the rate of ED visits for children enrolled.
- Increase the number of infants < 1 year of age referred to the Early Intervention program.

CC4C Outcome Measurements cont...

- Increase the percent of children with special health care needs who are enrolled in a medical home.
- Increase the percent of children in foster care who are enrolled in a medical home.
- Increase the percent of comprehensive assessments completed for CC4C patients identified as having a priority.
- Increase Life Skills Progression assessments on children receiving care coordination through CC4C on entry into the system and every 6 months after or upon discharge.

CC4C Medical Home Partnership

- Specific CC4C Care Managers linked to specific medical homes.
- Goal – Stable and consistent Medical Home – CC4C relationship.
- Open two-way communication between Medical Home CC4C.
- Relationship defined at local level.
- No matter how the partnership is structured, it will be strong.

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