Referrals

Target population: Children (birth-1st grade) with SED or at imminent-risk of SED

Well Child Visit: Referrals from Medical Home
Child attends well child visit. Primary Care Provider uses results from the PEDS/PSC and social history to identify potential MYCHILD families. Provider connects family to MYCHILD based on screening tools, family account of child's behavior, brief observation of child's behavior, observation of parent/child interaction, assessment of family's exposure to stress.

Family Partner or MH Clinician introduced to Family at end of well visit

Direct Referrals from Shelters, Childcare, Preschools & CSAs
Staff at local child agency or shelter identify a child with concerning behaviors or family with concerns regarding their child's behaviors.

Staff at Child Agency or Shelter discuss behavioral concern with Family Partner or MH Clinician at weekly community MH Consultation sessions.

Family Partner or MH Clinician observe child at community site & discuss MYCHILD with parent in person or via phone.

Engagement & Assessment

"MYCHILD Team" always includes Family, MH Clinician, Family Partner & Primary Care Provider. Team expands as natural supports and community supports are identified.

1st Team Meeting: Establishing Relationship & Determining Eligibility for MYCHILD Health Center/Shelter (Family Partner & MH Clinician)

- Orient Family & Youth to Purpose of Visit
- Review Caregiver's Story ("In their own words") Form
- Initial Exploration of Child & Family’s Strengths
- Offer Parent-Child Learning Tool & Model Interaction
- Elicit Developmental/Behavioral Health History of Child from Caregiver
- Elicit Family Behavioral Health History
- Assess for SED & Imminent Risk of SED using guidance of Abbreviated CANS
  - TESI & PHQ-9 to assist in eliciting Trauma history & Screening for Maternal Depression
- Inquire about Immediate Crisis Concerns (ex: safety issues, basic needs)
- If Eligible (SED or “Imminent Risk” of SED & Family Interested in MYCHILD), discuss Enrollment

Yes, Eligible & Family Interested

- Enroll family in MYCHILD Services (Enrollment box on EMR Intake)
- Address legal/ethical issues (Consent Release Forms, mandatory reporting, family’s rights)
- Provide MYCHILD Program Brochure & Family Log
- Schedule 2nd Team Meeting for Home or Clinic (Family Partner)
- Enter Evaluation Demographic Data in EDIF (MH Clinician)

No Study Participation

2nd Team Meeting: Exploration of Family’s Strengths & Needs Using Wraparound Approach
Home Visit/Shelter Visit or Clinic (Family Partner & MH Clinician)

- Orient Family to MYCHILD & Wraparound Approach
- Further Explore Strengths, Needs, Culture and Vision with Family
- Identify Family Interpersonal, Situational, & Environmental Risk Factors
- Observe Parent-Child interactions in Natural Environment
- Inquire about Immediate Crisis Concerns (ex: safety issues, basic needs)
- If Eligible (SED or “Imminent Risk” of SED & Family Interested in MYCHILD), discuss Enrollment

Yes, Study Participation

- Discuss for SED & Imminent Risk of SED & Family Interested in MYCHILD, discuss Enrollment
- Enroll family in MYCHILD Services (Enrollment box on EMR Intake)
- Address legal/ethical issues (Consent Release Forms, mandatory reporting, family’s rights)
- Provide MYCHILD Program Brochure & Family Log
- Schedule 2nd Team Meeting for Home or Clinic (Family Partner)
- Enter Evaluation Demographic Data in EDIF (MH Clinician)

No Study Participation

National Evaluation Longitudinal Study: 30 Day Window from Program Enrollment

Obtain signed consent form Study Consent Script

Submit participant’s site ID # & Study enrollment date to Evaluation team.

Complete Baseline National Evaluation Interview (2hrs)

Collect TRAC Administrative Data

Complete TRAC Interview. (30 min)

Yes, TRAC Interview

Yes, Study Participation

No TRAC Interview

No Study Participation
Example: MYCHILD Care Plan Services Rooted in Wraparound Principles

**Prevention**
- **Home visits for Family Engagement**
- **Education on Child Development**
- **Nurturing Programs to strengthen Parent-Child relationships**
- **Resources to meet Family’s basic needs** (food, heat, cars etc)
- **Connection to Culturally-Related Family Activities** (community ctrs, recreation)

**Intervention**
- **Linkage to Community-Based Early Childhood programs** (e.g., Early Intervention, Preschools)
- **MH Consultation to Childcare, Preschool, & Shelter staff**
- **Brief Parent-Child Therapy**
- **Linkage to Parent Mental Health Services**

**Family Partners**
- Community based services and Family engagement activities
- MH Clinician and Family Partner will continue to provide consultation to community based agencies serving families
- MH Clinician facilitates Wraparound Meetings and Coordinates Behavioral Health Services and Clinical Plans

**Community Services**
- **Family Voice**
- **Culturally Competent**
- **Individuated**
- **Team-based**
- **Strengths-based**
- **Collaboration**
- **Natural Supports**
- **Outcome-based**

**Ongoing Care Team Meetings**
- *Reassessment & Care Plan Revision*
  - Care Plan is revised monthly by MYCHILD Care Team to meet family's dynamic needs based on continuous Family Input, Medical Home Input, & Community Agency Input regarding progress in meeting goals.
  - To monitor progress, CANS is repeated every 3 months for all families receiving clinical services.

**Evaluation-Informed Service Systems**
- **Wraparound Fidelity Assessment**: Lead Family Partner to administer 'Team Observation Measure' & 'Document Review Measure' every 6 months.
- **National Evaluation** every 6 months for families participating in study through 24 months.
- **TRAC interview or TRAC Administrative Data** every 6 months for families until after Transition.
- **Medical Home Assessment (NSCCHN & Medical Home Index- organizational component)** repeated every 6 months and at Transition.

**Transition**
- Goal: Transition from MYCHILD with Sustained Involvement in Medical Home & Community Agencies
  - Cesation of Formal MYCHILD services with creation of Transition Plan vs Care Plan Goals are met
  - Caregiver will assume increased care coordination
  - Clinical sessions will become less frequent with MH clinician or external behavioral health provider
  - Family will continue participation in ongoing early childhood community services
  - Primary care provider will continue to follow transitioning families and communicate with MH clinician and Family Partner regarding need for further services.
  - Creation of "Commencement" by documenting family’s work and goal achievement
  - MH clinician and Family Partner will continue to provide consultation to community based agencies serving MYCHILD families, and thus will be aware of new concerning behaviors or risk factors arise
  - Administer Medical Home Assessment Tools at Transition & TRAC interview 6 months after Transition.
Family Partner
- Coordinates referrals from Well Visits, Childcare, Preschools, Shelters
- Ensures Family Voice is Represented in Wraparound
- Serves as first-line contact for MYCHILD families
- Provides Care Coordination among Community services & family engagement activities
- Home Visits for Family Engagement
- Assists Family in recording & monitoring goals & activities in Family Log
- Provides MH Consultation Provides MH Consultation & Trainings to Child Agencies/Shelters
- Conducts & Records Study Interviews

MH Clinician
- Facilitates Wraparound Approach to meetings
- Performs CANs at intake & Every 3 months; determines eligibility for MYCHILD services
- On-site therapy with Child or Parent-Child Dyad
- Refers families to external behavioral health services as needed & coordinates care with partnering providers
- Provides MH Consultation & Trainings to Child Agencies/Shelters
- Documents all Team Meetings & Care Plans in EMR Systems
- Obtains & Inputs EMR Demographic Data in EDIF for Cross Sectional Study
- Facilitates Wraparound Approach to meetings
- Performs CANS at Intake & Every 3 months; determines eligibility for MYCHILD services
- On-site therapy with Child or Parent-Child Dyad
- Refers families to external behavioral health services as needed & coordinates care with partnering providers
- Provides MH Consultation & Trainings to Child Agencies/Shelters
- Documents all Team Meetings & Care Plans in EMR Systems
- Obtains & Inputs EMR Demographic Data in EDIF for Cross Sectional Study

Primary Care Provider
- Screens and Identifies Families for MYCHILD
- Integrates medical care needs with MYCHILD Wraparound
- Provides health anticipatory guidance and long-term medical care
- Communicates with MYCHILD team regularly to ensure coordination
- Champions Early Childhood Mental Health promotion in primary care

Family
- Communicates dynamic strengths & needs of Child & Family in Team Meetings
- Engages in Care Plan Services & Discusses Perceptions of services
- Engages Natural Supports in Care Plan
- Maintains Records of Care Plan activities & goals via Family Log
- Takes an increasing role in Care Coordination of Child’s services
- May choose to participate in Study

MH Clinician & FP communicate Organizational & Structural support needed to Site Administrator

Site Administrator
- Enables Medical Home practice through organizational change
- Facilitates planning process for MYCHILD programs
- Ensures IT & EMR systems for medical home communication & program evaluation
- Supports MYCHILD staff in professional development
- Participates in grant & budget reporting

MYCHILD Team Communication Across Program Sites
- Cross Site Family Partner Meetings: Lead Family Partner facilitates cross-site discussion among family partners & addresses barriers to implementation of MYCHILD services (every 1-2 months)
- Cross Site MH Clinician Meetings: Lead Family Partner facilitates cross-site discussion of family partners & addresses barriers to implementation of MYCHILD services (every 1-2 months)
- Learning Collaborative: Cross-Site Medical Home Discussion & Development