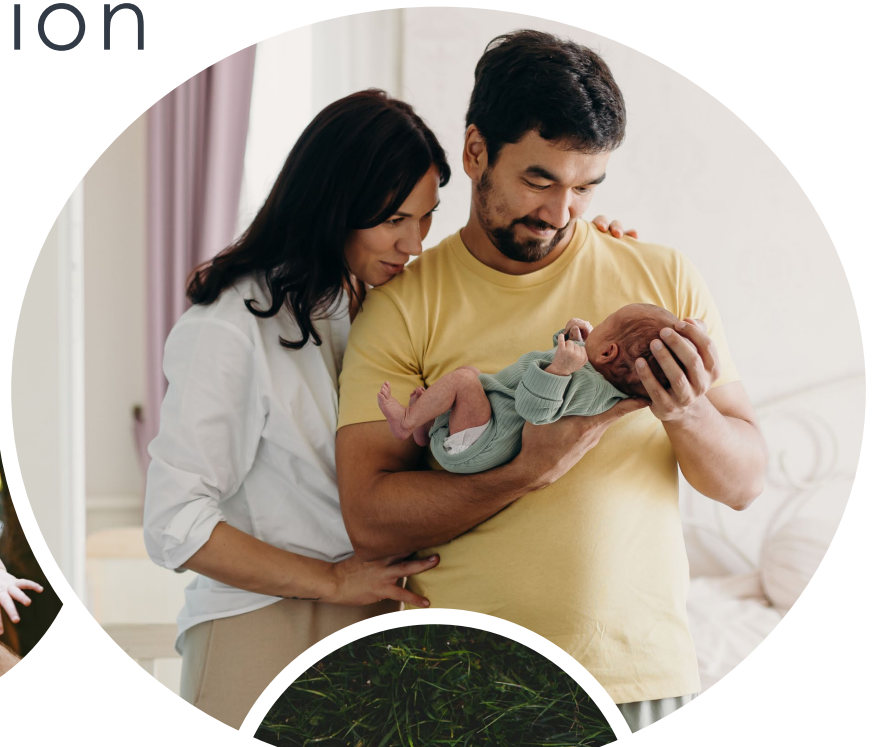
Interagency Coordinating Council (ICC) on Early Intervention

Quarterly Meeting

November 6, 2026







DDS Department of Developmental Services

HOUSEKEEPING



Interpretación en español: haga clic en el globo blanco en la parte inferior de la pantalla con la etiqueta "Interpretation." Luego haga clic en “Spanish” y seleccione "Mute original audio.”



ASL interpreters have been “Spotlighted” and live closed captioning is active

- Raise hand, say first name and **speak slowly**



This meeting is being recorded



Materials are available at: https://www.dds.ca.gov/services/early-start/state-icc-on-early-intervention-overview/



Submit written comment via email to: earlystart@dds.ca.gov

HOUSEKEEPING-INTERPRETATION SERVICES

ASL INTERPRETERS

- ASL interpreters will be spotlighted during the meeting.

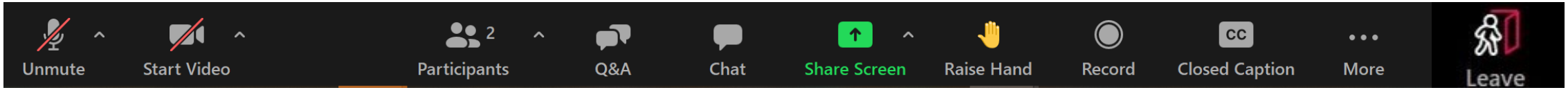
WHEN SPEAKING

- Please introduce yourself by stating your full name and who you represent.

PLEASE SPEAK SLOWLY

- To support our interpreters with accurately interpreting the information discussed during the meeting, please speak slowly.

ZOOM TIPS



Unmute mic only when it's your turn to speak



Turn your webcam on/off

Chat is available for all attendees; send chats to "Everyone"

During public comment, please use the raise hand feature

Leave the webinar at the end of the meeting



- Features will vary based on the version of Zoom and device you are using
- Some Zoom features are not available for telephone-only participants

ROLL CALL



AGENDA



- Welcome, Housekeeping Items, and Roll Call
- Review Agenda
- Review ICC Mission and Purpose
- Introduction of Meeting Theme: **Child Finds & Families**
- Committee Reports
  - Review and vote on Committee Recommendations for 2027 ICC Meeting dates by Governor Appointees
- Public Input
- Break
- Medical Home
- Early Childhood Home Visiting Collaborative (ECHVC)
- Recap and Closing remarks

ICC MISSION AND PURPOSE



To promote and strengthen a coordinated system of services and supports for infants and toddlers, birth to three years old, who have or are at risk for a disability and their families. We are committed to a relationship-based, family-centered approach that fosters meaningful partnerships between families and professionals and encourages effective interagency collaboration.

ICC MISSION AND PURPOSE



As an advisory body to the California Department of Developmental Services (DDS), the Interagency Coordinating Council (ICC) seeks input and guidance from a diverse group of stakeholders. By incorporating a wide range of lived experiences and perspectives, we aim to ensure that our recommendations are inclusive, culturally responsive, accessible, and reflective of the needs of all communities we serve.

MEETING THEME

Child Find & Families



ICC COMMITTEE REPORTS

and presenting for approval items not related to the 2027 ICC Schedule

- Improving State Systems
- Communications and Outreach



2027 ICC Meeting Dates





Communications Committee Recommendation:

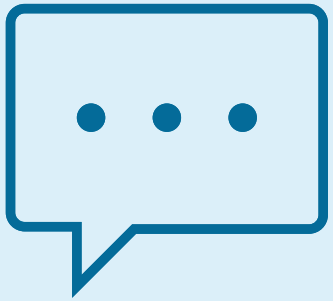
Wednesday 10:00 a.m. to 4:00 p.m.

Thursday 9:00 a.m. to 3:00 p.m.

Improving State Systems Committee Recommendation:

Thursday 10:00 a.m. to 4:00 p.m.;

Friday 9:00 a.m. to 2:00 p.m.



PUBLIC INPUT

Public Input Guidelines

Comments Can be in Writing or Spoken

All comments are published as part of the public record and posted on the ICC website in the form of meeting minutes

Commenting on Behalf of Others

One person is welcome to share input from others, please just be mindful of time, summarize key points and turn in any written statements

Each Person has 2 Minutes to Comment

We want to make sure there's time to hear from everyone.

Please Be Specific

A clear statement including specific suggestions for addressing any concerns you may have is most helpful

Want to share a PowerPoint or Video as Part of Your Public Comment at a Future Meeting?

Email EarlyStart@dds.ca.gov at least 14 days in advance with any audio/visual needs

Housekeeping-Interpretation Services

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PLEASE SPEAK SLOWLY

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BREAK
Return by 10:00 am



MEDICAL HOME

Anjelica Montano and Nora Mays



CDPH
California Department of Public Health

Medical Home

A Presentation for the
State Interagency Coordinating Council
on Early Intervention

November 6, 2026

Table of Contents

1 Welcome & Introductions

2 What is Medical Home?

3 Why Medical Home?

4 Medical Home for MCAH and You

5 Q&A

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Meet the CAH Domain Leads

Child



Jaclyn Pasko, MD

Child and Adolescent Public Health Medical Officer

CYSHCN



Anjelica Montano

CYSHCN Coordinator

Adolescent



Nora Mays

Adolescent Health & Youth Engagement Coordinator

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What is Medical Home?

Definition & Components

Poll: Are you familiar with the AAP Medical Home model of care?

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Medical Home Definition



"A medical home is an approach to providing comprehensive and high-quality primary care."

~American Academy of Pediatrics

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Is Medical Home a Place?

- **No, the medical home approach is not a physical location or a practice.** Medical home is an approach to providing comprehensive and high-quality care, partnering with families.
- **Not just clinical** – can be implemented at a system and policy level
- Even if you have not used the term "medical home" in the past – **you are probably already doing work to advance this approach to care!**

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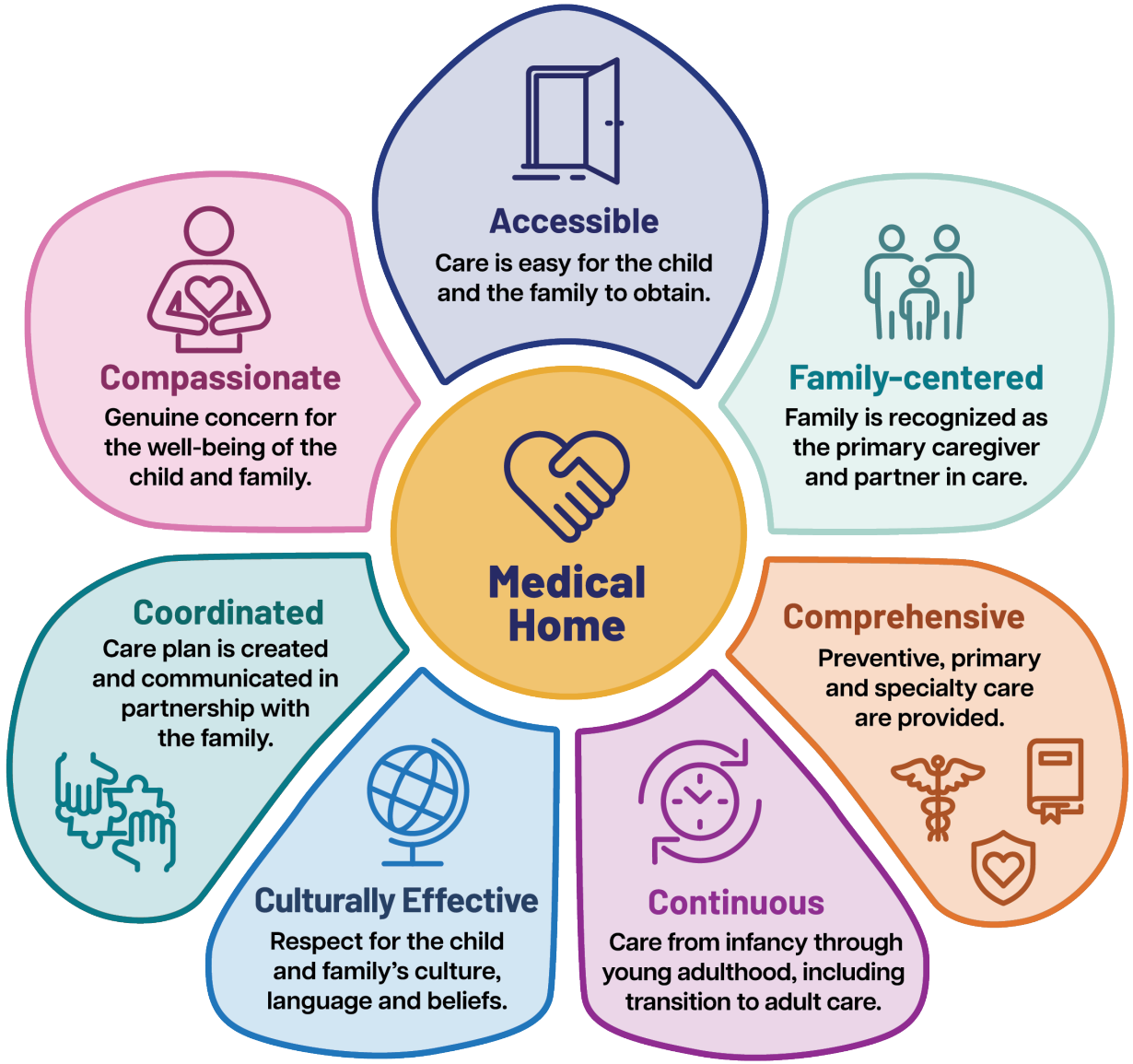
Medical Home Components

American Academy of Pediatrics



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AAP Medical Home Components Defined

- **Accessible**: Care is easy for the child and family to obtain, including geographic access and insurance accommodation.
- **Family-centered**: The family is recognized and acknowledged as the primary caregiver and support for the child, ensuring that all medical decisions are made in true partnership with the family.
- **Continuous**: The same primary care clinician cares for the child from infancy through young adulthood, providing assistance and support to transition to adult care.
- **Comprehensive**: Preventive, primary and specialty care are provided to the child and family.
- **Coordinated**: A care plan is created in partnership with the family and communicated with all health care clinicians and necessary community agencies and organizations.
- **Compassionate**: Genuine concern for the well-being of a child and family are emphasized and addressed.
- **Culturally Effective**: The family and child's culture, language, beliefs and traditions are recognized, valued and respected

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AAP vs NCQA Medical Home Definitions

AAP/NSCH Medical Home

- Not a formal certification
- Supported by National and CA AAP
- Well recognized by pediatric providers
- Uplifts patient and family voice
- Pediatrics forward
- Partially measured by National Survey of Children's Health (NSCH)
  - Focus of Title V – NSCH Medical Home

NCQA Patient Centered Medical Home

- Formal NCQA certification
- Costly to obtain
- Not currently used widely across CA
- Not regulated by CDPH
- Not a factor that DHCS reviews
- More of a business model
- Required evaluation measures
- Not pediatric specific

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Why Medical Home?

Child & CYSHCN HRSA Requirements

Medical Home for MCAH

- Key component of Title V Strategic 5-year plan for 2025-2030
- HRSA has required all Title V funded programs to focus on promoting, uplifting, and increasing connections to Medical Home for the following population health domains for the 5-year period 2025-2030:
  - Child
  - Children and Youth with Special Healthcare Needs
- In addition, HRSA requires Title V funded programs to focus on the Postpartum medical visit for the Maternal/Women domain
- CDPH/MCAH has chosen to focus on the Adolescent Preventive Health visit for the Adolescent domain

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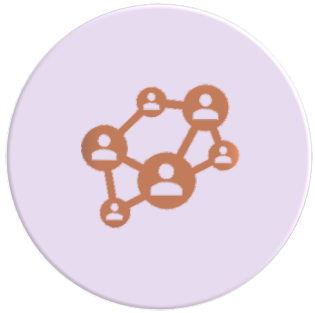
MCAH Medical Home Promotion



DEFINE WHAT IS MEDICAL HOME (AND WHAT IS IT NOT)



INCREASE TRANSPARENCY AND USE OF MEDICAL HOME TERMINOLOGY



PROMOTE THE IMPORTANCE AND EFFECTIVENESS OF MEDICAL HOME



ENCOURAGE ADOPTION OF THE MEDICAL HOME MODEL

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Why is Medical Home Important?

- The gold standard of care for all children, including children and youth with special health care needs (CYSHCN).[1]
- Children with stable and continuous health care are more likely to receive preventive care, less likely to be hospitalized, more likely to be diagnosed early for chronic or disabling conditions.[2]
- The medical home approach to care has been shown to save money due to reduced hospital and emergency department visits and improved patient outcomes.[3]



[1] American Academy of Pediatrics. Medical Home Model Overview.
[2] National Survey of Children's Health (NSCH) – Medical Home Measure Framework.
[3] Medical Home Evidence Accelerator. MCH Evidence. https://www.mchevidence.org/documents/accelerators/Medical-Home-Evidence-Accelerator.pdf

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Measuring Medical Home

- National Survey of Children's Health
  - Children 0-17
  - CYSHCN 0-17
  - Some additional subgroups available via online data inquiry
  - Medical home
    - Overall
    - Personal doctor
    - Usual source of sick care
    - Family centered care
    - Referrals
    - Care coordination

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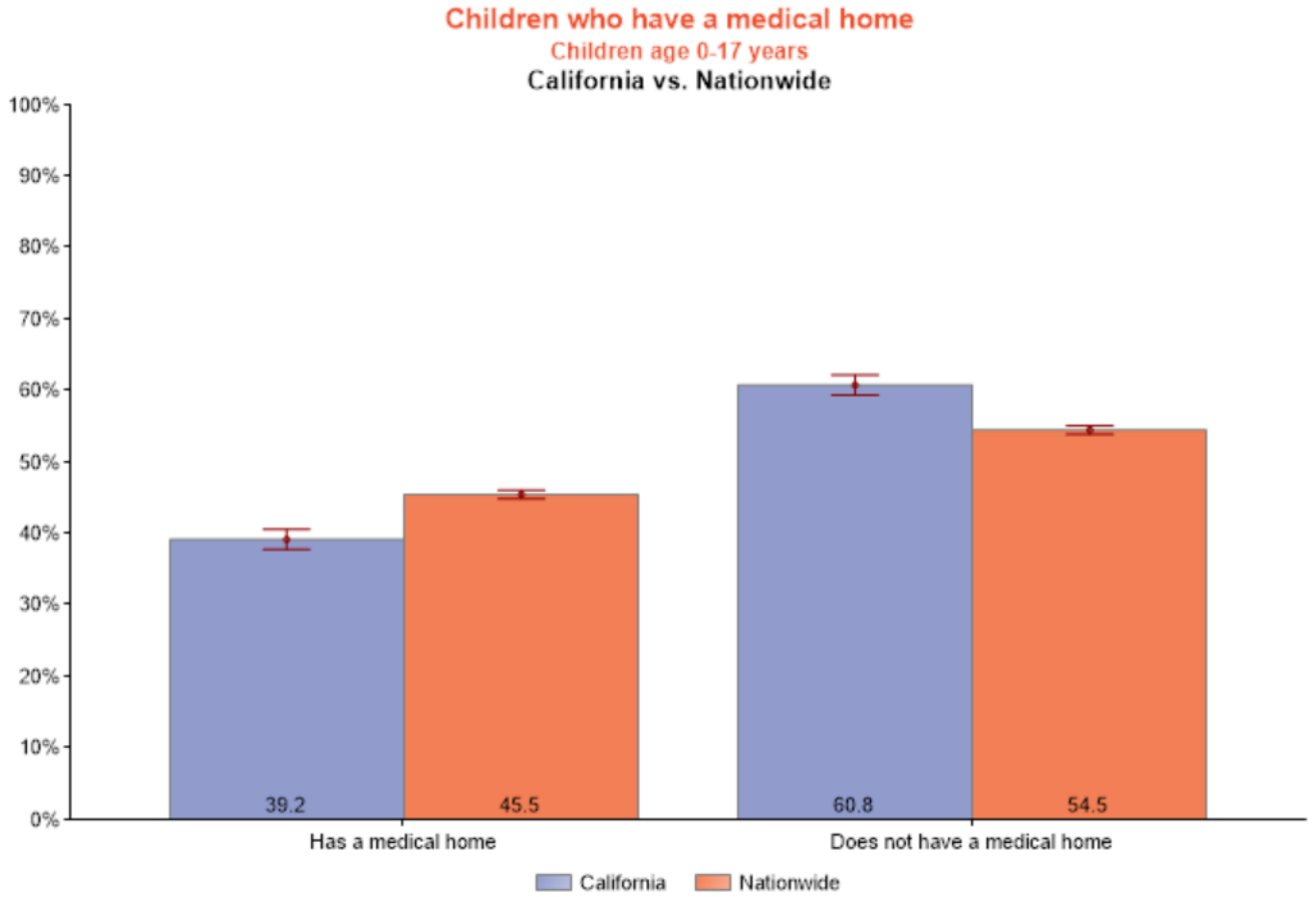
Measuring Medical Home - CHILD



Data Source: National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau. https://mchb.hrsa.gov/data/national-surveys

Citation: Child and Adolescent Health Measurement Initiative. 2023-2024 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [mm/dd/yy] from [www.childhealthdata.org].

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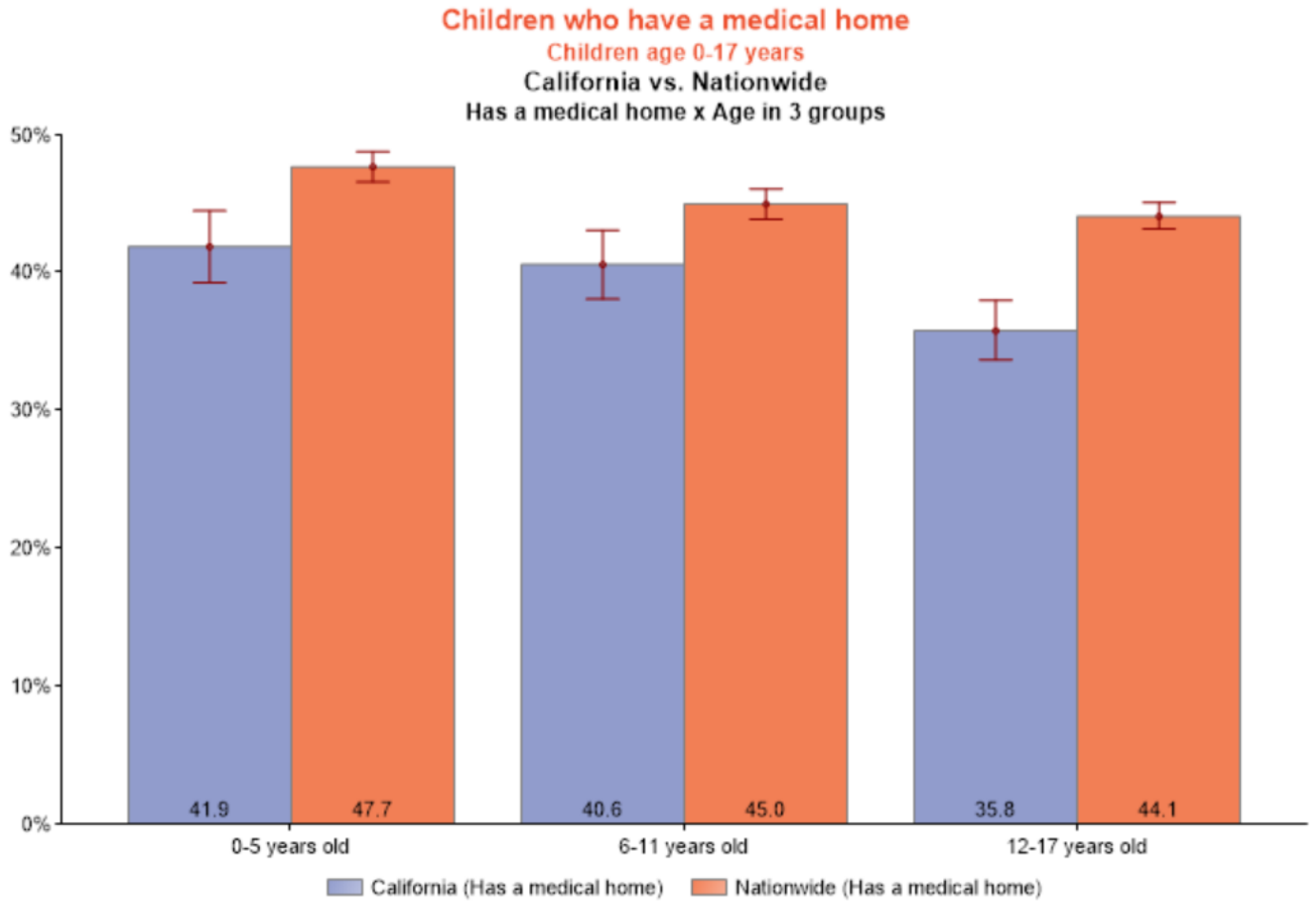
Measuring Medical Home – CHILD by age



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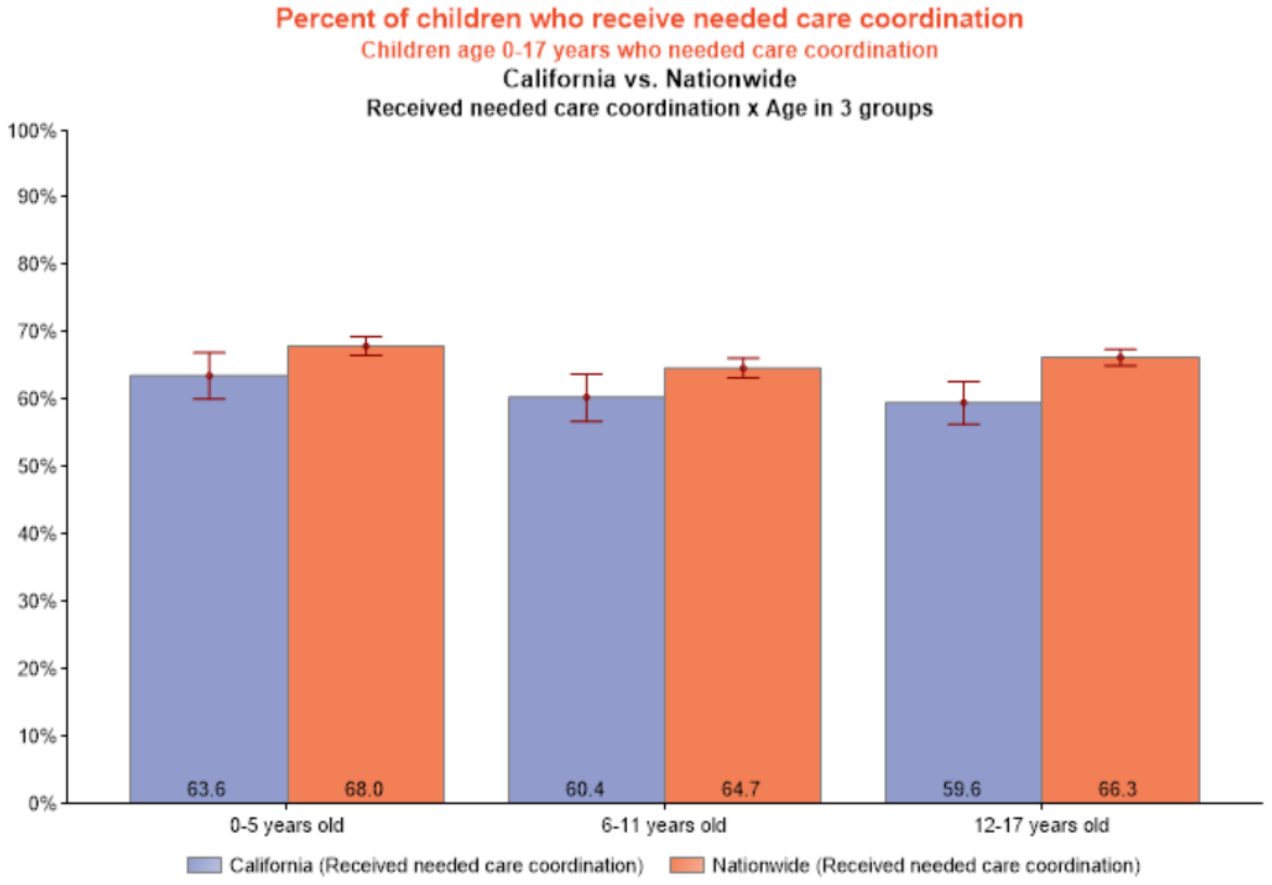
Measuring Medical Home – CHILD Care Coordination by Age



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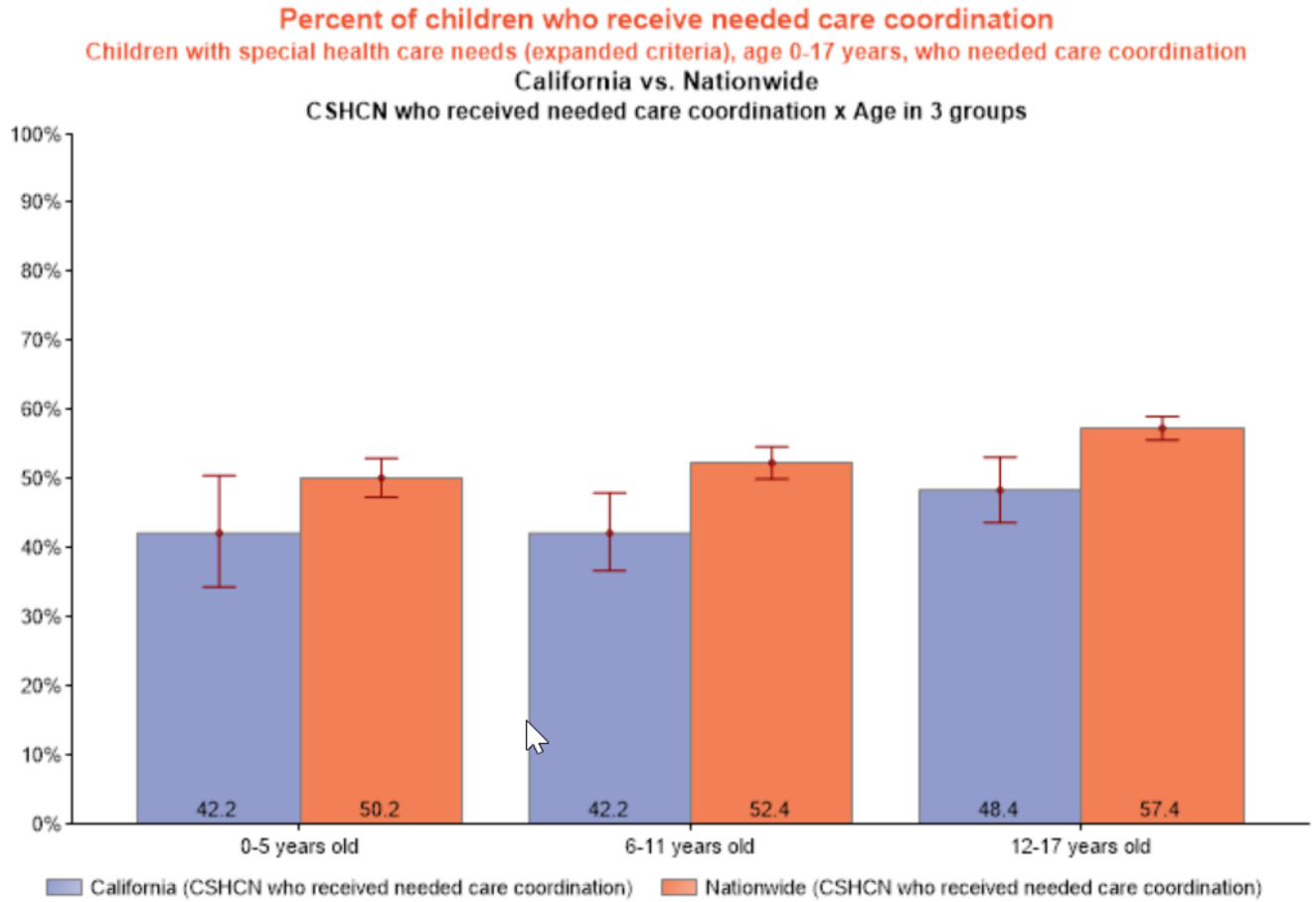
Measuring Medical Home – CYSHCN Care Coordination by Age



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Poll: Are you familiar with the definition of Children/Youth with Special Healthcare Needs?

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How Does CDPH/MCAH Define Special Health Care Needs?

- CYSHCN are individuals from birth through age 21 who have, or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions that require health care, educational services, and other related supports beyond those needed by the general pediatric population.
- Chronic conditions are defined as those lasting one year or longer and require ongoing medical care, limit activities of daily living, or both.
- Currently developing CYSHCN Definition and Identification Flowchart to be added to CYSHCN Webpage



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Measuring Medical Home

- MCAH is also currently evaluating whether there are other additional surveys that may help provide information about Medical Home and it's components in CA

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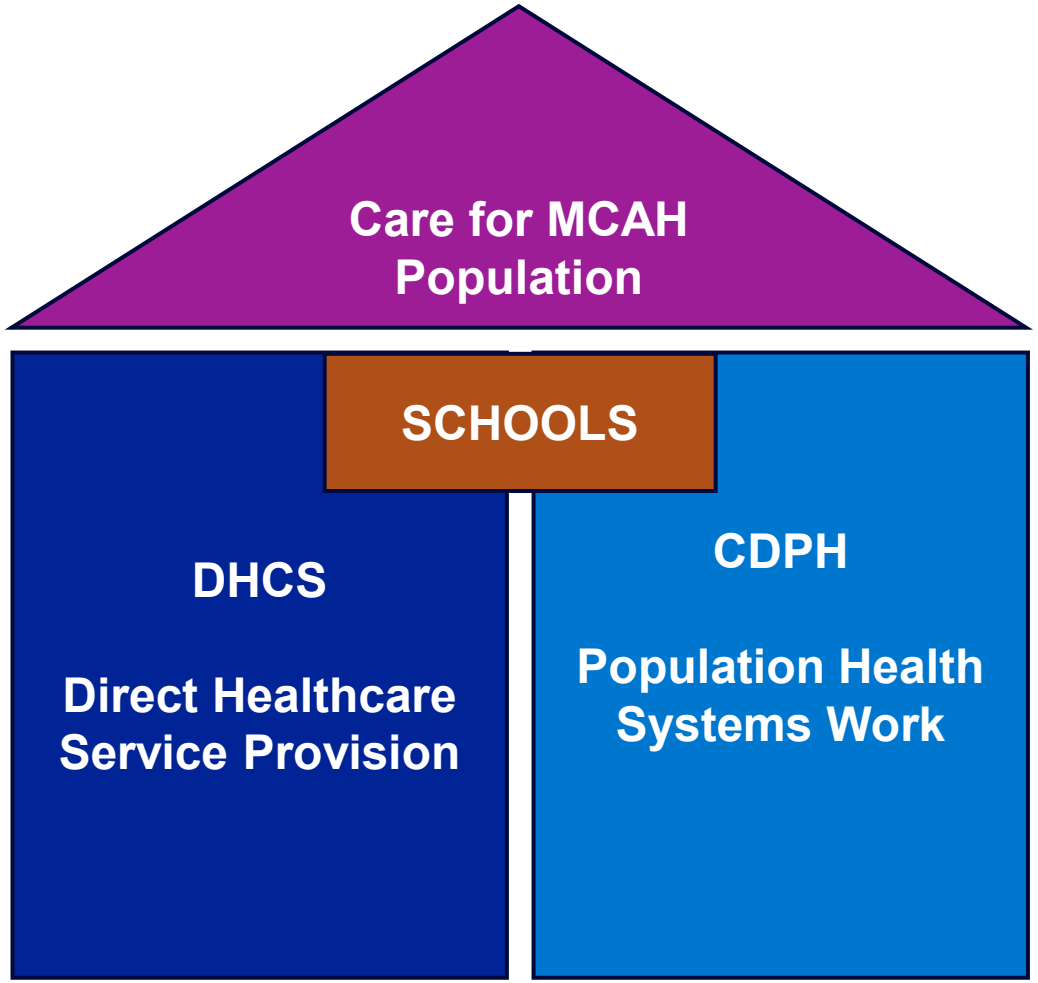
Medical Home for MCAH

Success Through Partnership

Roles/Lanes – “The Duplex”



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CDPH/MCAH Tiers of Work

Population Level Work

- Policy, Systems, and Environmental work
  - Birthing Care Pathways, Black Birth Equity
- Partner Collaboratives
  - Early Child Home Visiting Collaborative, California Perinatal Quality Care Collaborative, Office of School Health

Targeted Work

- Direct Service Programs
  - Black Infant Health, Adolescent Family Life Program, California Home Visiting Program
- Target Population Programs
  - CYSHCN Innovation Grants

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Role of State MCAH

State MCAH Does….

- Promote medical home
- Promote care coordination through home visiting programs as an emerging evidence driver of medical home[1]
- Convene local and state agencies and those groups active in child/youth health space
- Partner with CDPH/OSH to promote school-linked/school-based health centers, especially as methods to increase medical home

State MCAH Does NOT….

- Focus on providing direct medical care to the MCAH population in CA
  - This is the role of Medi-Cal (DHCS) and other healthcare plans/providers
- Directly fund or oversee healthcare facilities (e.g., school-based health centers)
- Oversee schools/school districts

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1. Medical Home Overall | MCH Evidence

Medical Home Coordinating Council

Membership (created 2025):

- CAH domain leads: Nora Mays, Anjelica Montano, Jaclyn Pasko

Mission:

- Advance adoption and implementation of the medical home model through strengthening collaboration and establishing channels of communication and information sharing between state agencies, CBOs, academic institutions, health centers, and other organizational types serving and supporting the health of children and youth in California.

Goal:

- Our goal is that **all children and youth in CA are connected to a regular source of high-quality care** that is: accessible, timely, culturally effective, evidence-informed, family-centered, compassionate, continuous, comprehensive, and coordinated. (the AAP **Medical Home** model of care).

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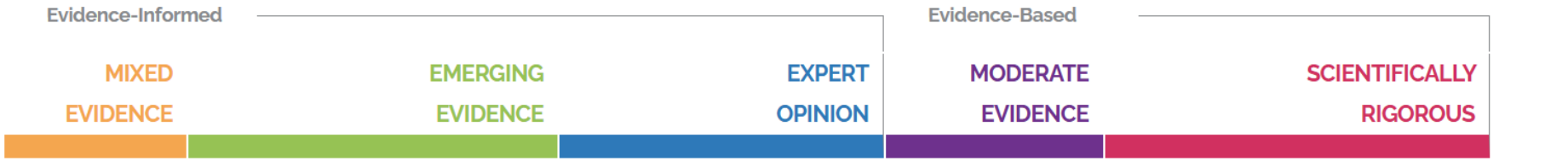
Targeted MCAH Medical Home Work

Evidence-based/Informed Strategies: MCHbest Database

The following strategies have emerged from studies in the scientific literature as being effective in advancing the measure. Use the links below to read more about each strategy or access the MCHbest database to find additional strategies.



- After Hours Primary Care (2023)
- Collaborative Care (2025)
- Dedicated Care Coordinators (2025)
- Home Health Care (2025)
- Medical-Financial Partnerships (2023)
- Policies to Promote Medical Home (2025)
- Provider Alliance and Mid-Level Providers (2022)
- Provider-School Partnerships (2021)
- Shared Care Coordination with Home Visiting (2023)
- Technology and Telehealth (2025)
- Caregiver Engagement and Support (2025)
- Integrated Care (2025)
- Federally Qualified Health Centers (FQHCs) (2023)
- Nurse Practitioner Scope of Practice (2017)
- Patient Navigators (2016)
- Practice Coaches/Facilitators (2019)
- School-Based Health Centers (2023)

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Poll: Do you/have you interacted with school-linked/school-based health centers?

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School-Linked vs. School-Based Health Centers

School-Linked Health Centers:

- School-adjacent, nearby, NOT on campus
- Referrals, partnerships

School-Based Health Centers

- ON CAMPUS care

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School-Based Health Centers

- Youth/parents find SBHCs:
  - Accessible
  - Convenient
  - Family centered
  - Compassionate
  - High quality
  - Trusted
- SBHCs overcome many barriers to care, such as cost, time, transportation, and age-appropriateness
- SBHC access can be additive to a traditional primary care provider for improved quality outcomes

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School-Linked/School-Based Health Centers

- Evidence-informed way to increase medical home (MCH Evidence; County Health Rankings)

Improvements in:

- Access to care
- Utilization of services
- Preventive care rates
- Quality of care
- Student health decisions
- Academic achievement
- Graduation rates
- And so much more!

Reductions in:

- Disparities in health outcomes
- Absenteeism
- Teen pregnancy rates
- Hospital utilization
- Mental illness and substance use
- And so much more!

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Care Coordination through Home Visiting

Home Visiting programs often serve as a bridge between families, healthcare providers, and community services.

- Home visiting services frequently include care coordination, care navigation, or both.
- Activities may include identifying health and social needs, providing referrals, connecting families to services, and supporting follow-through.
- The American Academy of Pediatrics defines care coordination as "deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services."
- Effective care coordination requires communication across health care, education, social services, community-based organizations, and managed care systems.

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Care-Coordination-Evidence-Accelerator.pdf

Why Care Coordination Matters

Benefits

- Improve quality and continuity of care
- Reduce health care costs
- Reduce burden on family/caregivers
- Helps families navigate complex systems of care
- Supports better health outcomes

Common Challenges

- Workforce capacity and training needs
- Family engagement barriers
- Payment/reimbursement for coordination activities
- Information-sharing across systems

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Strategies to Strengthen Care Coordination

Partnerships

- Partnerships between local primary care providers and home visiting services
- Family Outreach and Enrollment/Community Outreach events
- Establish formal care coordination agreements

Information Sharing

- Develop bi-directional communication pathways
- Implement closed-loop referral processes
- Use shared family care plans (where appropriate)

Capacity Building

- Conduct joint trainings across sectors
- Improve family/community engagement practices and outreach
- Partner to address social drivers of health (food access, housing, transportation, etc.)

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Promising Practices for Care Coordination

Emerging evidence suggests successful care coordination efforts often include:

- A designated care coordination lead (e.g., a nurse or other licensed care provider)
- Multidisciplinary care teams that include community-based partners
- Broaden the scope of care providers, especially outside the healthcare setting (e.g., Community Health Workers, Social Workers, School Nurses, etc.)
- Utilize new payment models that reimburse for care coordination services
- Use technology that facilitates meaningful information sharing through healthcare IT systems
- Early identification of children early who could benefit from care coordination
- Individualized, family-informed care planning

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Care Coordination Resources from AAP



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Medical Home Care Coordination Resources

Home Visiting as a Medical Home Strategy



EVIDENCE TOOLS

MCHbest. Medical Home: Overall.

Strategy. Shared Care Coordination with Home Visiting

Approach. Develop early connections to a medical home model through care coordination and collaboration with home visiting



Return to main MCHbest page >>

Overview. Initial research shows promise between a partnership of primary care clinics and home visiting programs in low-income communities to develop a shared protocol for contacting and interacting with families to encourage participation in both well-child visits and the home visiting program. The primary care clinic and home visiting program personnel developed a communication protocol based on identified needs for interacting with families. Neighborhood-based newborn registries, proactive nursing outreach, and collaboration with a home visiting agency aligned multiple clinics in a low-income neighborhood to improve access to health-promoting services within the pediatric medical home.[1]

Evidence. *Emerging Evidence.* Strategies based on emerging evidence show promise but have not undergone extensive testing. While these approaches demonstrate potential, their effectiveness remains unconfirmed. Prioritize rigorous monitoring to ensure they achieve desired outcomes for all MCH populations.

Access the peer-reviewed evidence through the MCH Digital Library or related evidence source.

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MCHbest. Medical Home: Overall. | MCH Evidence

Home Visiting as a Medical Home Strategy

Home visiting and primary care partnerships can strengthen connections to a medical home

- Key components include:
  - Coordinated outreach to families
  - Shared communication protocols
  - Referrals between primary care and home visiting programs
  - Collaboration with community partners
- Emerging evidence suggests these partnerships can:
  - Improve access to preventive and treatment services
  - Strengthen family engagement
  - Address social drivers of health
  - Support long-term connections to a Medical Home
- Evidence status: Emerging evidence with strong potential to improve Medical Home outcomes.

MCHbest. Medical Home: Overall. | MCH Evidence

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Medical Home "Package"

CDPH/MCAH Drafted Deliverables **IN PROCESS**

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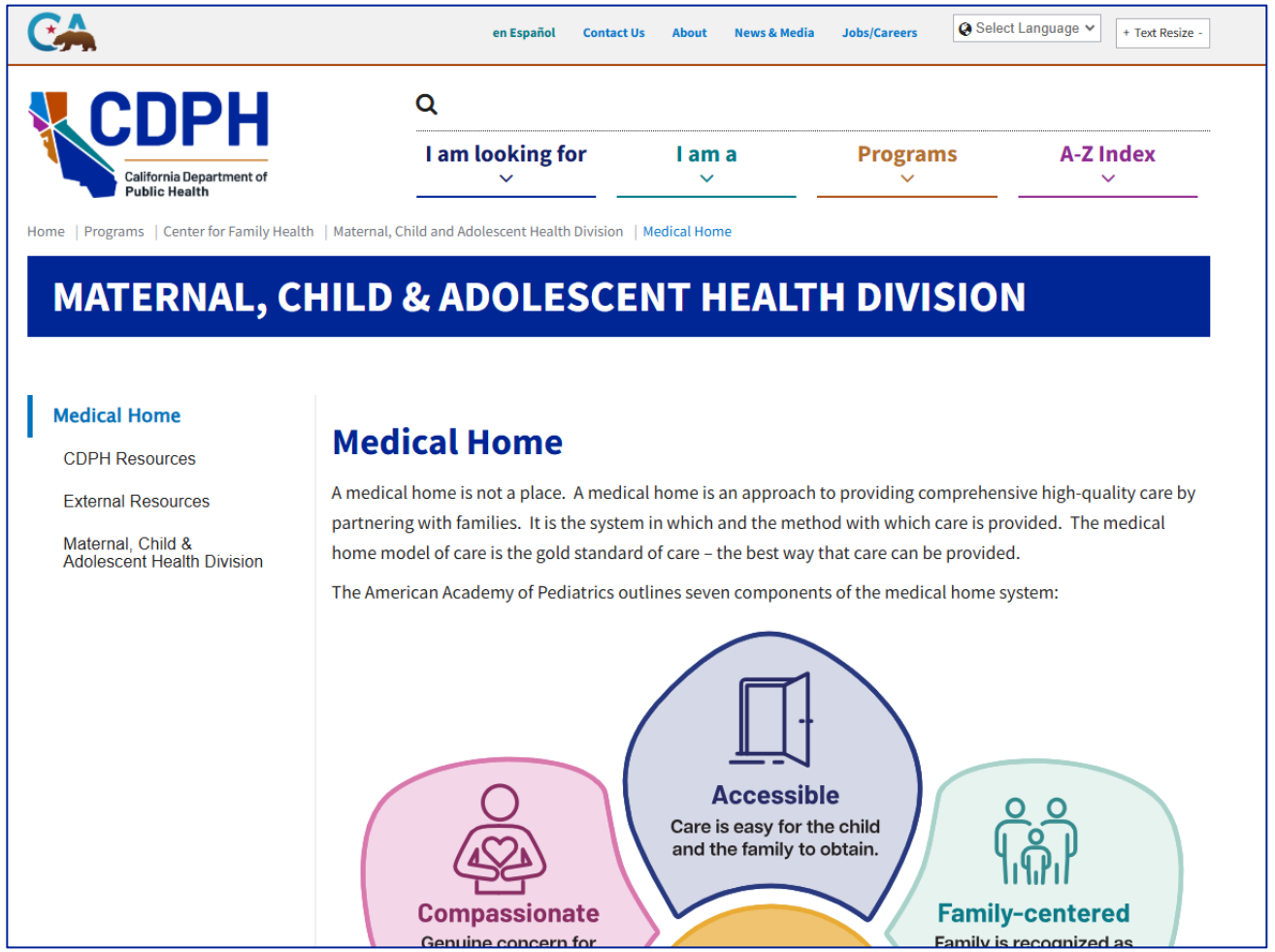
Medical Home Webpage

Medical Home



Medical Home Hub & Materials



One-Pager:

English (PDF)

Spanish (PDF)

Chinese (PDF)

Vietnamese (PDF)

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Medical Home Components Table

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CDPH/MCAH Medical Home Components

Component	Definition	Examples *(How can the definition be applied/implemented)*	Family/Patient Experience Examples *(What it feels like as a child/youth/family)*	Implementation Resources
Accessible	Care is easy for the child and family to obtain, including geograph access a insurance accommo ation	**Physical Accessibility**: -Transportation assistance to clinic is available if needed. -Telehea ap intm ts are offe d an vail le if des ed/a propri - P vent e and ur nt pointm ts are available in a timely manner. - Clinic-based care coordinators provide appointment reminders, support with accessibility needs, and help with referrals. -Clinics accommodate physical, developmental	I am able to enroll/renew my child/youth's health insurance and access health care at locations and times that are conv ent for me I c fin provide who are in-n work f my/m I receive sup rt m a care coordinator within my health plan. My health plan's care coordinator works with me to ensure that I have all necessary information about locations, appointments, services, and	**Language Access**: Language Access | Family Voices - Family Voices Sp n Language Health Re urces | MCH Library **Ac ss to specialists**: AA Find a Pediatrician Tool Project ECHO: a telementoring model that can help build capacity among PCPs to delivery specialty focused care to medically underserved areas. Best Practices Guides from HRSA for providers **Coverage Access:**

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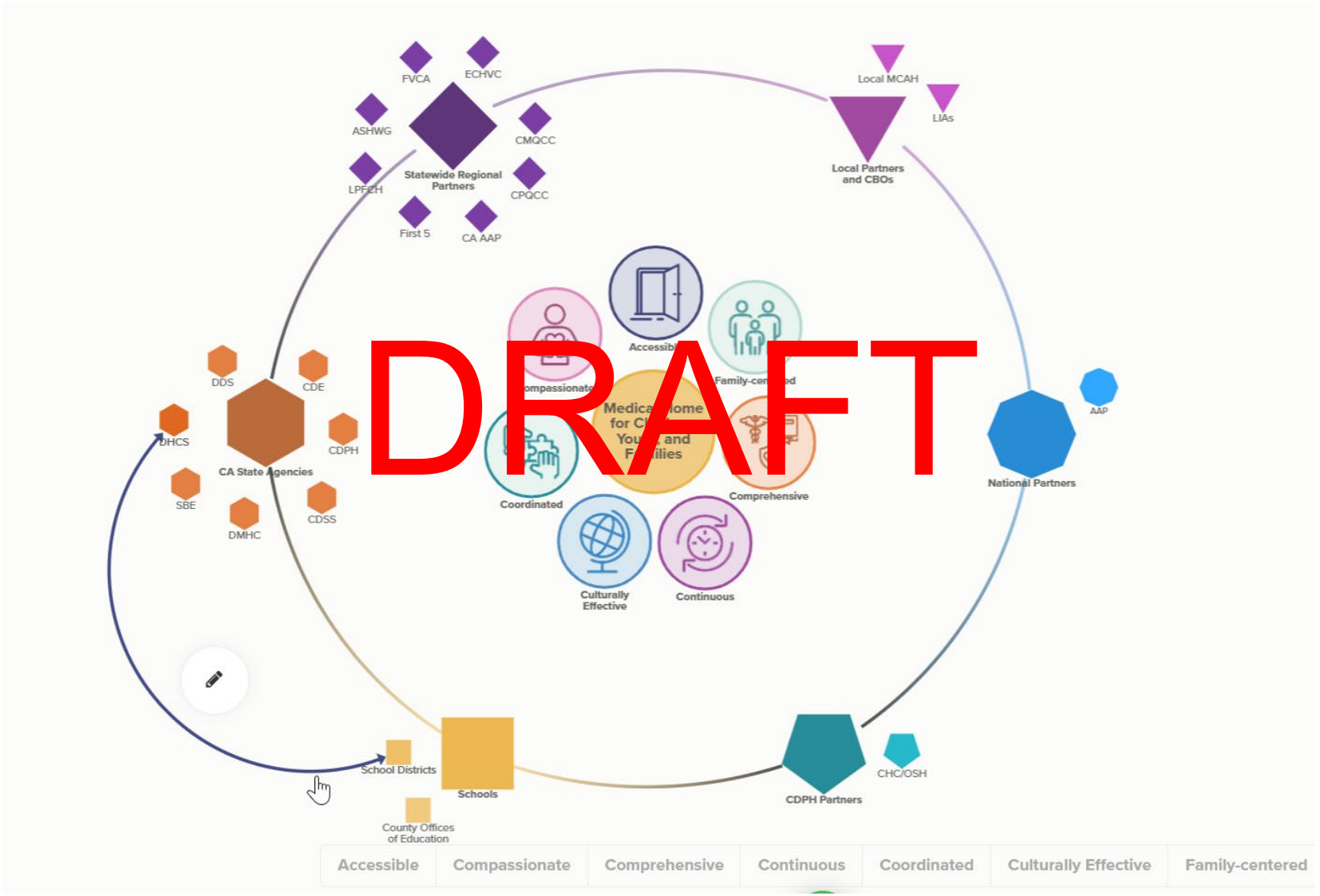
Medical Home System Map



Medical Home Projects/Collaborations

Current Medical Home Projects

- Technical Assistance:
  - National AAP (CYSHCN)
  - HRSA Workforce Development Center
  - ASTHO LEAH-P (School Based Health Centers)
- Collaborative Projects:
  - CPQCC/HRIF/First 5 Medical Home Pilot
  - Promoting School-Based/School-Linked Health Centers with OSH
  - Youth Friendly Care Guidelines with OSH
    - Collaboration with Northern CA and Southern CA Societies of Adolescent Health and Medicine

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How Can ICC Support, Promote and Advance Medical Home?

Alignment with ICC Mission

Interagency Coordinating Council On Early Intervention (ICC)

ICC Mission Statement

To promote and strengthen a coordinated system of services and supports for infants and toddlers, birth to three years old, who have or are at risk for a disability and their families. We are committed to a relationship-based, family-centered approach that fosters meaningful partnerships between families and professionals and encourages effective interagency collaboration.

As an advisory body to the California Department of Developmental Services (DDS), the Interagency Coordinating Council (ICC) seeks input and guidance from a diverse group of stakeholders. By incorporating a wide range of lived experiences and perspectives, we aim to ensure that our recommendations are inclusive, culturally responsive, accessible, and reflective of the needs of all communities we serve.

CDPH Title V Priority Need Statement for CYSHCN:

Improve access to supports and services for children and youth with special health care needs.

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Immediate Focuses for ICC & Medical Home

- Endorse a common California definition and talking points for pediatric Medical Home to reduce confusion across systems.
- Promote care coordination competencies and reasonable caseload guidance across agencies and vendors.
- Champion school-linked/school-based health partnerships as on-ramps to Medical Home, especially for adolescents.
- Support closed-loop referral protocols between primary care, home visiting, managed care plans, and Family Resource Centers.
- Elevate family-centered measurement (e.g., NSCH components) and encourage local reporting on referrals and coordination.

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Local MCAH Referrals/Early Intervention

- Partnering with Local CCS program staff (nurse, coordinator) to improve connections and referrals between CCS and Local MCAH/Home Visiting
- Recruitment and cross-training of public health nurses to serve both CCS and MCAH programs
- Collaborating with County CCS program to support CYSHCN families as they transition from Classic to ECM and Whole Child Model care
- Local MCAH staff work with families to identify and address needs, ensuring connection to health insurance, well visits, age-appropriate preventive care and developmental screenings. This often includes referrals to MediCal, WIC, CalFresh, and other support services.

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CDPH/CHVP Referrals to Early Intervention Services

- CDPH/CHVP LHJs convene or participate in Community Advisory Boards (CAB)
  - CABs assist LHJs in participant recruitment
  - Establish linkages with community services
  - Integrate CHVP program into local early childhood system of care
- The CAB includes members from agencies that represent a variety of community resources that could benefit home visiting participants and families.

500-10 Early Childhood Systems Integration Policy and Procedure

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CDPH/CHVP Referrals to Early Intervention Services

- CDPH/CHVP LHJs develop collaborative relationships with other agencies that serve families from pregnancy through kindergarten entry and coordinate services families need to thrive. Examples of other early childhood services agencies include but are not limited to:
  - Local medical providers, hospitals, medical clinics, and Managed Care Plans
  - CalWORKs and other Home Visiting Programs
  - Women, Infants and Children (WIC)
  - Early/Head Start Programs
  - Mental health/behavioral health providers and resources

Home Visiting Best Practices - September 2026.pdf

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Referrals within Black Infant Health

- BIH programs are operated by county departments or community-based organizations (CBOs).
- The BIH team includes **three Family Health Advocates (FHAs)/Group Facilitators**, a Public Health Nurse who provides home visiting, a Mental Health Provider, a Coordinator, a Community Outreach Liaison, a Data Entry Lead, and Child Watch Staff.
- **FHAs** are primarily responsible for identifying referral needs and connecting participants with additional supports and services. They co-facilitate group sessions with **Group Facilitators**.
- Throughout the program, **FHAs (or other roles)** identify participants who may benefit from additional services or who raise concerns requiring follow-up.
- From 07/01/2025 through 06/30/2026, the BIH Program made 15,191 referrals for 2,640 unique participants.[1]
  - Among the total referrals made, a total of 2,790 (18%) were for early services including parenting education (1,461), child injury prevention (482), home visiting services (206), childcare referral services (158), services for CYSHCN (130), primary care or immunizations (130), childcare subsidies (107), nutrition education (88), developmental concerns (15), and family violence services (13).[2]

1. Source: Preliminary data extracted from Black Infant Health Program's Efforts to Outcomes (ETO) data system on October 13, 2026. ETO Report "Referrals During a Specified Time Period".
2. Approximately 10% of referrals (n=1,547) were classified as "Other", which may obscure the true number of referrals made for early childhood intervention services.

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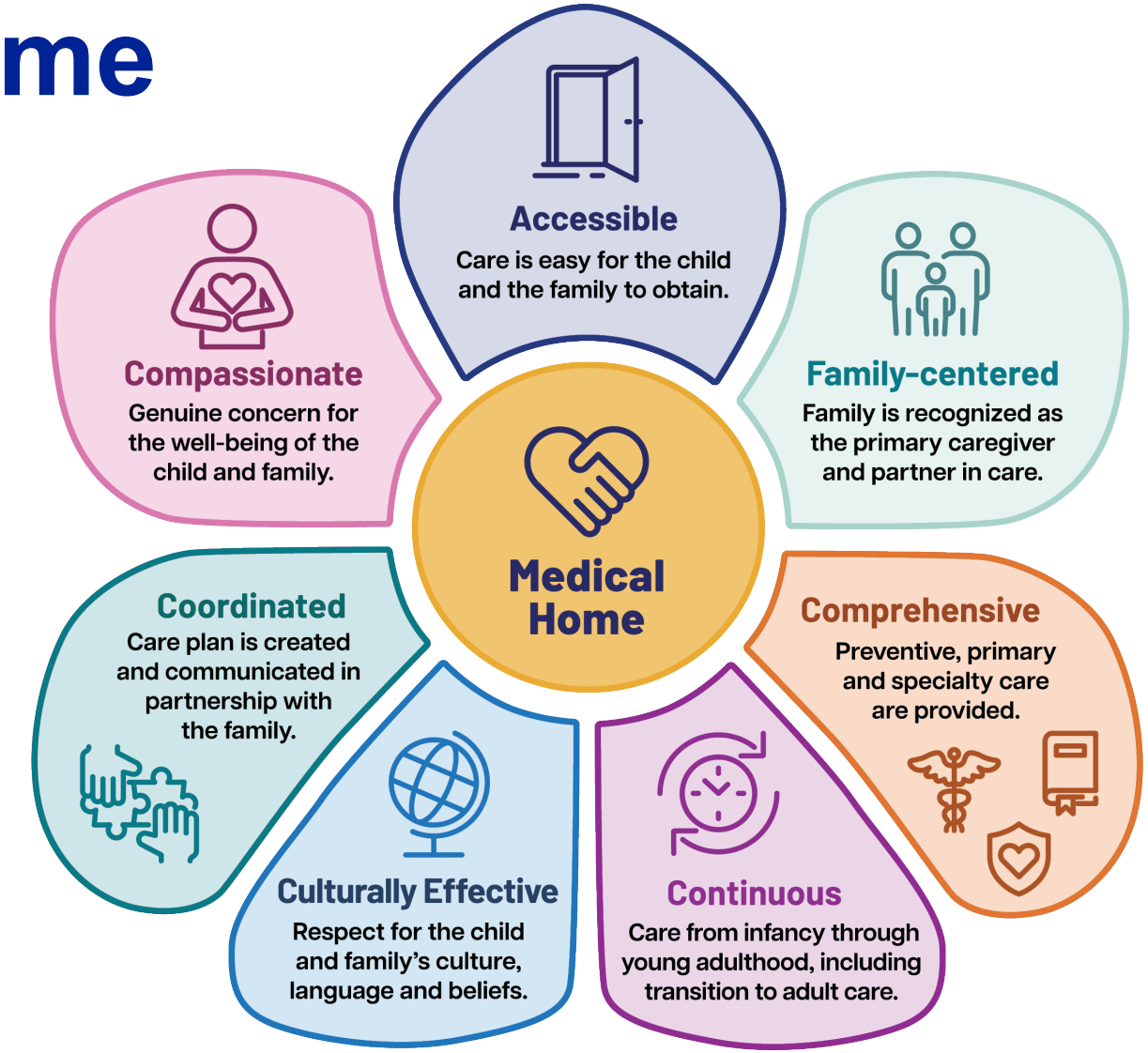
ICC and Medical Home

- What role could the ICC have in:
  - Medical home socialization/understanding?
    - Providers
    - Patients/families
  - Medical home promotion?
  - Advancing medical home?
  - Contributing as a care provider to quality improvements in moving towards a medical home model?



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Q&A

Discussion





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EARLY CHILDHOOD HOME VISITING COLLABORATIVE (ECHVC)

Lupe Morimune and Terri Soto



CDPH
California Department of Public Health

Early Childhood Home Visiting Collaborative Overview

California Home Visiting Program

CDPH California Home Visiting Program

What is the California Home Visiting Program (CHVP)?

CHVP pairs expectant and newly-parenting families with trained professionals for in-home visits, offering guidance, coaching, and access to vital services.

These visits aim to foster positive parenting and child development, strengthening family and community bonds.

Delivered directly in the family's home, personalized sessions provide support and resources, enhancing family well-being.

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CDPH/CHVP Goals

- To promote maternal health and well-being
- Improve child health and development
- Build family resilience
- Cultivate strong communities

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CHVP Supported Home Visiting Models

CHVP supports the following 5 evidenced-based home visiting models

- Healthy Families America (HFA)
- Nurse Family Partnership (NFP)
- Parents as Teachers (PAT)
- Family Connects (FCI)
- Home Instruction for Parents of Preschool Youngsters (HIPPY)

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California Home Visiting Landscape

- Home Visiting programs are funded through various funding sources:
  - **CDPH California Home Visiting Program (CHVP):**
    - **Maternal, Infant, and Early Childhood Home Visiting (MIECHV)**
    - **State General Funds**
  - CalWORKs Home Visiting Program
  - First 5 County Commission Funding
  - Other local funding

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ECHVC Purpose

Early Childhood Home Visting Collaborative

The Early Childhood Home Visiting Collaborative (ECHVC) is a statewide partnership between home visiting and early childhood system partners to better serve California families.

An early childhood system brings together health, early care and education, child welfare, and other family support program partners, community leaders, families, and other partners to reach agreed-upon goals for thriving children and families*.

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*Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program – Base and Matching Grant Awards (p.67)

ECHVC Timeline

2012

CDPH received MIECHV funding establishing the California Home Visiting Program:

- The *SIT Home Visiting Workgroup was established to fulfill CDPH/CHVP's HRSA requirement for collaboration with key state-level partners.

2016-2019

SIT for Children, Youth, and Families ceased meetings.

- The SIT Home Visiting Workgroup continued to meet.

2019

CDSS CalWORKs HVP

- CDSS received State General Funds establishing CalWORKs HVP
- CDSS CalWORKs HVP joined as co-leaders of the SIT Home Visiting Workgroup meetings.

2020

COVID-19:

- SIT Home Visiting Workgroup meetings paused due to the COVID-19 pandemic.

2021

ECHVC

- Received confirmation that the SIT disbanded. The SIT Home Visiting Workgroup transitioned to an independent collaborative with the approval of members. This workgroup became the **ECHVC**.

2025

Redefined the ECHVC

- Vision, Mission, and Core Objectives

*SIT = State Interagency Team for Children, Youth and Families

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Vision

A California where home visiting services are well-integrated into early childhood systems of care and families have equitable access to culturally responsive home visiting services.



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Mission

Strengthen collaboration between home visiting and early childhood system partners and foster a forum for learning and growth to support California's diverse home visiting landscape.



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ECHVC Core Objectives

Center Families and Healthy Communities

- Leverage shared knowledge of barriers to improve equitable access to home visiting services.
- Discuss solutions to address gaps and connect families with needed support.
- Promote early childhood preventive care measures such as developmental screening and access to early intervention.

Foster a Quality Home Visiting Workforce

- Identify ongoing training needs and facilitate cross-training opportunities.
- Foster a community of learning to uplift workforce successes and challenges.

Strengthening Collaboration

- Strengthen referral networks and linkages across home visiting and community resources.
- Promote collaboration between home visiting experts and early childhood system partners.
- Identify emerging practices to support high-quality home visiting services.

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ECHVC Member Contributions

Participate

- Attend quarterly meetings.
- Participate in ad-hoc meetings and workgroups.
- Share home vising information and material within their organization
- Provide updates on home visiting activities and goals.

Provide Input

- Provide input on training, technical assistance, and materials.
- Discuss strategies to address barriers and strengthen service linkages.
- Provide feedback on planning, implementation, and evaluation of home visiting programs.

Reflect and Assess

- Reflect on available data for continuous quality improvement.
- Assess information from meetings and provide feedback on statewide practices and policies.

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ECHVC in Action

Promoting Early Childhood Preventive Care with a focus on Medical Home and Developing Screening	• Learned about the Medical Home approach and shared information with networks and partners • Currently identifying a deliverable to promote early childhood preventive care (e.g., statement of support)
Joint Agency Home Visiting Best Practice Letter	• ECHVC members provided input on the recently released Joint Agency Home Visiting Best Practice Letter
MCAH Strategy in Action: Advancing Black Birth Equity Together in California	• ECHVC members helped spread the word by sharing the action plan across their networks and partners

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Thank you!

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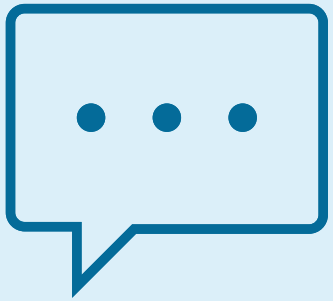

CLOSING COMMENTS

For more information, please contact the BABYLINE: 1-800-515-BABY (2229) or earlystart@dds.ca.gov

For Children and Youth, please contact childrenandyouthtransitions@dds.ca.gov