

**San Andreas Regional Center**  
**Prevention Plan**

**January 2010**

**I. Prevention Program Contact:**

The primary contacts for this program at San Andreas Regional Center (SARC) are the Directors of Consumer Services and the Early Start Program Managers.

**II. Purpose:**

The purpose of the Prevention Program is to provide intake, assessment, and case management services as well as referral to generic agencies for infants and toddlers who are:

- 1) at **high risk** for a developmental delay or disability as defined in Section III below, but do not yet manifest a delay; or
- 2) who are at least 24 months but not more than 34 months of age and have a developmental delay in one functional domain, as defined below.

**III. Criteria for Eligibility:**

An infant or toddler is eligible for the Prevention Program when:

- 1) The regional center determines that the infant or toddler is at high risk for a developmental delay due to a combination of two or more of the following factors:
  - a) Prematurity of less than 32 weeks gestation or low birth weight of less than 1500 grams.
  - b) Assisted ventilation of 48 hours or longer during the first 28 days of life.
  - c) Below the third percentile of gestational age on the National Center for Health Statistics growth charts.
  - d) Asphyxia neonatorum associated with a five minute Apgar score of 0 to 5.
  - e) Severe and persistent metabolic abnormality, including but not limited to hypoglycemia, acidemia, and hyperbilirubinemia in excess of the usual exchange transfusion level.
  - f) Neonatal seizures or non-febrile seizures during the first three years of life.
  - g) Central nervous system lesion or abnormality.
  - h) Central nervous system infection.
  - i) Biomedical insult including, but not limited to injury, accident or illness which may seriously or permanently affect developmental outcome.
  - j) Multiple congenital anomalies or genetic disorders which may affect developmental outcome.
  - k) Prenatal exposure to known teratogens.

- l) Prenatal substance exposure, positive infant neonatal toxicology screen or symptomatic neonatal toxicity or withdrawal.
  - m) Clinically significant failure to thrive, including, but not limited to weight persistently below the third percentile for age on standard growth charts or less than 85 percent of the ideal weight for age or acute weight loss or failure to gain weight with loss of two or more major percentiles on the growth curve.
  - n) Persistent hypotonia beyond that otherwise associated with a known diagnostic condition.
- 2) The infant or toddler is determined by the regional center to be at high risk for a developmental disability because his or her parent is a person with a developmental disability.
  - 3) The regional center determines that a toddler between the ages of 24-35 months at the time of referral has a developmental delay in one domain of at least 33 percent but no more than 49 percent. The developmental domains that a regional center must consider are:  
communication; cognitive; social/emotional; self help/adaptive; and physical.

**IV. Intake, Assessment, and Eligibility Determination:**

Infants and toddlers from birth to 34 months are assessed simultaneously for eligibility for the Early Start and Prevention Programs. For purposes of assessing the child's development to determine eligibility for the Prevention Program, the regional center uses chronological age, starting at 24 months, and for children under 24 months with two high risk criteria, SARC will use the adjusted age.

- 1) Review of medical records to confirm greater than or equal to *at risk* diagnoses
- 2) Initial developmental assessments at intake to rule out significant delays

**V. Monitoring the Child's Development:**

Once a child is found eligible for the Prevention Program Plan, the Service Coordinator (SC) is responsible for ongoing monitoring of the child's development through periodic contact with the child and family, and completion of the following:

- 1) Ages and Stages Questionnaire- this will be completed at every periodic review
- 2) The frequency of assessment and frequency of monitoring will be determined at the time of eligibility determination. The service coordinator will develop the prevention plan within 60days of the child being found eligible for the prevention program. The service coordinator will then have a follow up meeting with 90 days of the development of the prevention program plan. From that point, the service coordinator and family will agree to the frequency of contact and monitoring, not to exceed six months between monitoring visits.

## **VI. Service Coordinator Training/Responsibilities:**

- 1) Service coordinators have been trained to administer the Ages and Stages questionnaires.
- 2) Trained to coordinate/collaborate with community resources providing services.
- 3) Trained in key areas of parent education and anticipatory guidance.
- 4) Trained to provide referrals to community support services/additional assessments.  
\*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.
- 5) Service Coordinator will identify and build on the family strengths. They will use 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

San Andreas Regional Center uses a "mixed caseload" model for serving young children. Service coordinators will be responsible for meeting the needs of all of the children on their caseloads. These SCs provide ongoing monitoring for the infants and toddlers receiving prevention services as well as family support and referral to generic agencies. Specific case management responsibilities include:

- 1) **Prevention Program Plan Development:** Upon determination of a child's eligibility for the Prevention Program, the SC works collaboratively with the family in the development of a written Prevention Program Plan (PPP). This plan (see attachment 1) includes the following information:
  - a) Factors supporting the child's eligibility for the program
  - b) Date of plan development and the date that it was provided or sent to the parent
  - c) The service coordinator's name
  - d) Frequency of contact with the family/child
  - e) Type and frequency of monitoring
  - f) Type and frequency of assessment
  - g) Identification of community and other generic resources and referrals, as appropriate
  - h) Additional services, if any, that the child will receive

A copy of the written PPP is provided to the family within 15 days, but in no case later than 30 days, of the initial referral to the Prevention Program.

1a) The Prevention Program Plan Review (see attachment 2) will be completed at every monitoring review. It will be placed under the master PPP copy.

1b) The service coordinator will complete the baby cder (ESR) for every prevention child. The following information from the ESR will be entered:

- \*2. Initial referral source
- \*3. Report reason
- \*4. Report date

\*19. Consumer 0-35months of age, a high risk factor with no other qualifying factors, or

\*20. Consumers 24-35 months of age at the time of intake, a developmental delay of 33-49% in one domain only.

- 2) **Family Support and Education:** The SC provides ongoing support and education to the family while recognizing and building on the family's strengths, natural supports, and available community resources and remaining sensitive to the family's cultural preferences.

The SC provides the family with information about the child's developmental level and activities that enhance child development. The SC also provides or refers the families to sources of information about child development.

- 3) **Assistance in Identification and Accessing of Services:** The SC assists families in identifying generic services and supports, provides referrals to those resources and helps parents connect and obtain services. The SC also advocates for families as necessary and assists families in developing advocacy skills that will enable them to more effectively represent their child.

Relevant generic services in the SARC service area with which SARC intends to collaborate for the Prevention Program include the following:

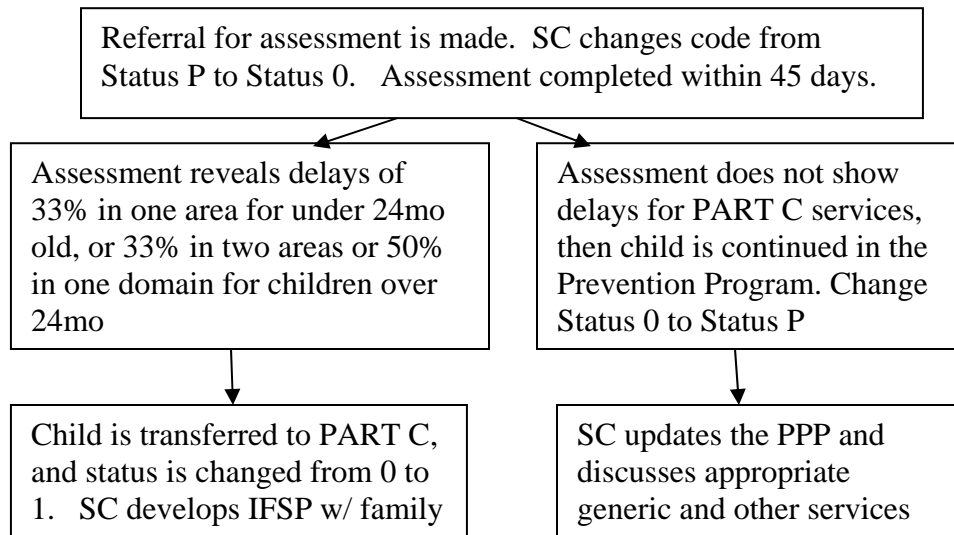
- a) Early Head Start Programs
- b) Parks and Recreation Programs
- c) Local Learning Activities/Training Classes
- d) First 5 Commission
- e) NICU Follow-Up Clinics
- f) California Children's Services
- g) Mommy and me programs
- h) local library programs

- 4) **Assistance in Transitions to Other Programs:** The SC facilitates a family-friendly referral and transition to other ongoing services or programs, as appropriate. These may include:
- a) the regional center's Early Start Program
  - b) services provided through the Local Education Agency (LEA), as appropriate
  - c) other programs serving preschool age children, such as Head Start and First 5 funded local programs, or neighborhood preschools.

## **VII. Transition from Prevention to Early Start:**

A child receiving Prevention services may be referred for assessment of eligibility for Early Start based on evidence obtained from periodic screening (ASQ results raises concerns) or a concern identified by the family, SC or other professional. If such a referral is deemed appropriate, the SC, as necessary may consult with their manager and,

if needed, a regional center clinician to determine the type of assessment that should be completed. An SC may request a full intake assessment, or use a targeted assessment for a given developmental concern.



### **VIII. Family Resource Center**

San Andreas Regional Center will allocate 2% of the Prevention Program monies to the Family Resource Centers, which will provide trainings, support, and referrals for community agencies for the children in the prevention program.

### **XI. Transfer Between Regional Centers:**

When a Prevention consumer moves with his or her family to another regional center area, the client becomes the immediate case management responsibility of that regional center. The procedure followed to complete the transfer is described in the inter-regional center memorandum of understanding, *Regional Center Transfer Procedures*, dated 7/19/09. There is no transfer of regional center funds for these consumers.

The SC will enter a transfer *Interdisciplinary Note* (ID note) in the consumer record. This note describes the consumer's current living situation and other significant information such as ongoing medical concerns or special care needs.

### **IX. Data Requirements:**

The regional center maintains data on Prevention consumers using the Early Start Report. The service coordinators will complete the early start reports for all prevention children. The minimum data tracked includes:

- 1) basic demographics;
- 2) date of report;
- 3) high risk factors; and
- 4) type of developmental delay.