

Birth to One

Washington State Children with Medical Complexity Collaborative Innovation and Improvement Network (CMC CoIN)



What is Birth to One?

Birth to One is a collaborative of organizations that provide parent support, primary care medical home and nutrition consultation, and local/state level support for children with special health care needs (CSHCN). This program was carefully designed for families of newborns settling in at home after being discharged from the hospital. We acknowledge navigating multiple resources and services for your child may be a complicated process. We are here to help.

Who qualifies?

Infants 0-4 months with special health care needs.

To Learn More:

- 206-987-2754
- Gabriela.Chavarria@seattlechildrens.org

What we will do for you

Families will receive a written “roadmap” with the current and future services their child is receiving including their contact information and explanations of what each service provides, based on the child’s geographic area. Here is how it works:

- When you enroll, you will be contacted by a Community Resources Care Coordinator who will get to know your child and family
- You will be provided with a personalized “roadmap” based on the services your child is receiving
- We will connect you to other resources based on any needs you identify
- We plan to check in with you periodically to revisit and update your personalized roadmap

What we are asking of you

- Permit us to talk with members of your child’s care team to assure that everyone is communicating effectively and your role as a parent or caregiver is being valued. As we document your child’s roadmap journey, we will review with you what is working and what can be improved.
- Respond to specific questions about your child’s current services as well as any additional resources you identify throughout the process. This is to assure your child’s care team is meeting your needs.
- Participate in a national study by Boston University that will measure gaps and improvements with a goal to help children and families like yours in the future.
- Accept our 25\$ per survey as a thank you for your time and participation.

What is a Medical Home?

The doctors and nurses who get to know your child and family at well child checkups and who help you figure out what to do when your child is sick. They will work with you to plan your child's care, tell you about helpful programs, and help you find the right specialists and equipment for your child. A medical home is not a building or place; it extends beyond the walls of your doctor's office. A medical home builds partnerships with clinical specialists, your family, and community resources.

What is Children with Special Health Care Needs/Public Health Nursing?

All children (0-18yo) who are at risk for or have a health/ developmental condition, and the family needs help with accessing local resources, are eligible for coordination of care, regardless of income. Services are usually provided by your local health department, and may be offered via telephone or through limited home/community visits. Varies by county.

What is Birth to Three?

Sometimes known as B-3, EI, DDA, or ESIT. Some children, due to conditions noticed at birth, special needs, or developmental delays, may risk missing important learning and developmental milestones. Early intervention helps keep these children on a path to making the most of abilities and skills developed during the early years. Families also play a critical role in their child's development. EI services support families to help their child's healthy development and are designed to enable young children to be active, independent and successful members in a variety of settings—home, childcare, preschool, and their communities. An EI agency will usually call you, get to know your child, and then set up an evaluation that determines what therapy services your child qualifies for: speech and language pathology (SLP), occupational therapy (OT), physical therapy (PT) and/or feeding therapy. You may also be assigned to a Family Resources Coordinator (FRC) in this agency that can help you access local resources.

What is Feeding/Nutrition Support?

Sometimes called Nutrition Home. Children with special health care needs (CSHCN) are at increased risk for nutrition-related problems. About 40% of CSHCN have nutrition risk factors that could be helped by referral to a registered dietitian (RD). Preventive nutrition services, as well as intervention for identified problems, can help assure a well-nourished child who is healthy, can participate in education and therapy programs, and is better able to function in all activities of daily life.

What is Parent Support?

Personal support from another parent, who has a child with similarly challenging or fragile needs, can be helpful in coping with challenging experiences. Parent to Parent (P2P) can connect you with another parent of a child with the same or similar diagnosis (volunteer peer mentors).

What are Community Resources?

Agencies that provides wrap around services to CSHCN and their families, helping to meet a certain need whether it be a referral for application assistance, housing support, health education, cultural advocacy, transportation, financial and/or food insecurity or any other basic needs.