Maternal and Child Health (ACEs)

Meeting Summary, January 31, 2018

Support and Backbone Staff: Jennifer Brackeen - *CHOICE*, Laura Spoor - *CHOICE*, Megan Moore - *CHOICE*, Michael O'Neill - *CHOICE*
In Attendance: Katie Strozyk – *Lewis County PHD*, Gretchen Thaller – *Thurston County PHD*, Christina Garcia - *Molina*, Garry Burris – *Child Care Action Council*, Liz Davis – *Thurston Thrives*, Apple Martine – *Thurston County PHD*, Afsaneh Rahimian - *Seamar*, Greg Endler – *Behavioral Health Resources*, Jennifer Houk – *Providence*, Lynn Nelson – *ESD 113*, Melissa Taylor – *Lower Columbia CAP*, Mike McIntosh – *Grays Harbor Co. Social Services*, Jennifer Helseth – *Department of Early Learning*, Kristina Patnode – *ESD 113*

I. Welcome and Introductions

Jennifer welcomed the group, facilitated introductions, and reviewed the objectives for the meeting:

- Review Project Application and next steps
- Identify assessment needs
- Finalize target population
- Committee updates
- Review R-MCH activities and develop our vision
- Next steps and closing

II. Project Application Submittal

After the Project Plan submission and first write back, we did not receive a second write back. From this, we are expecting a high score, and we should know the score by end of next week. Our score will determine how much funding we can disperse, and CPAA hopes to receive funding by mid-May.

III. Assessment Completion DY2, Q2

After receiving an update from HCA, CHOICE has learned that there is no strict format for the assessment and that it can be used to inform and guide planning and implementation of the different project areas. CHOICE wants to use the assessment piece to do community health needs inventory and identify work already being done in the community around ACEs. The survey will be released in March. The semi-annual report based on that assessment will be due to HCA by July 31st.

Jennifer had the group review the draft assessment questions, found here.

Group feedback:

- Are the chlamydia screenings all covered under insurance or only if you're in a high risk group?
    - Medicaid is covered, should also be covered under private insurance plan
- Do not see questions around staffing/resources
    - Do they need CHW, CNAs, Nurses, etc.?
    - Need to add questions around capacity
    - Do they have protocols in place around counseling, follow up after a positive screening?

- What are the incentives for providers to complete the assessment?
- Best method to receive/discuss survey responses?
    - Focus groups
    - Online surveys
- Are there data sources we could use to get an approximation of general information on a state wide/national level as a starting point?
- Suggestion to focus on not just chlamydia screenings but gonorrhea and other diseases too
    - Focus on the goals of each project and not just the specific metrics
- Outreach and community engagement as successful strategy in increasing immunization rates
    - Auto reminder calls, distributing cards, etc.
    - Smaller clinics vs. bigger clinics
- Staff Capacity and training questions

IV. Finalize Target Populations

Jennifer informed the group that a target population must be finalized by July 31, and the group supported moving forward with identified target population, found here.

Jennifer then asked the group if they needed to target sub-regions?

- One suggestion to only use geography as just one category with data, not always most impactful way to look at the data
- Trying to keep health equity lens, wrap around certain communities that may need more resources
- Need to make sure that a diverse group is involved in the conversations

V. Committee Updates

Jennifer shared updates from the Clinical Advisory Committee (CAC). The members represent primary care, behavioral health, pediatrics, oral health, public health, MCOs, and BHOs. Each county in the region (except Wahkiakum) is represented and meetings are held once every other month. The previous meeting focused on technology/systems improvements, value based payments, and securing formal commitments from providers. Some key points from the meeting were the CAC decided to create a group focused only on data/technology because it is too big of a topic, needing clarity on the format of commitment letters due by July 31st, developing a regional strategy for value-based payment, and incentives to support transformation goals.

Jennifer also shared updates from the Consumer Advisory Committee. They brought up the idea of having well child visits and immunizations worked into home visiting to expand the scope of services. They also discussed incorporating Telehealth into home visits, having an on-sight nurse to help bring a human touch to Telehealth.

Group feedback:

- Immunizations are extremely hard to transport, temperature sensitive
- One suggestion to change a home visit to a guided visit to doctor's office instead.
    - They could help facilitate the appointment for their patients

- NFP has done family planning delivery during home visiting
- Telehealth is not the best fit, better for specialty care
- Is there an opportunity for school based immunizations in our region?

VI. CPAA ACEs Mitigation Visions Statement

Jennifer reviewed the Vision Statement to make sure the group still felt it was accurate in reflecting their goals. The group reviewed the statement below and is still in full support of it:
"Childhood abuse, neglect, and family dysfunction in our communities is reduced; children are raised in a healthy, safe environment. Our communities' resilience to social trauma is strengthened. There are early intervention and prevention services which provide our communities with strong social-emotional, behavioral, and physical health care, allowing children and adults to better manage adverse childhood experiences."

VII. R-MCH Draft Logic Model 2018 - 2021

Jennifer reviewed the draft logic model, found in the presentation- slide 10, and asked for their feedback.

The group suggested that parents, consumers, non-profits, and MCOs be added to the WHO column. They also suggested that decreasing absenteeism, decreasing homelessness, reducing child deaths, and increasing birth weights be added to the METRICS column. Jennifer is also going to break the GOALS column into two different categories: short term and long term.

Group feedback:

- Could use WA kid's data for information but no personal student identifier to link the two
- Large percentage of children in well child visits will end up in clinical office; could try and improve data collection there
- Maybe create a resiliency column
- Create a plan around MCOs visiting schools and educating about vaccinations, annual mobile clinic

VIII. Oral Health Recommendations

For Maternal and Child Health, Jennifer suggested integrating oral health education into home visiting. The group was in support of this idea, but they want to make this contractual. Also, HCA is interested in working with Head Start around preventative care for kids ages 3-5, which could also impact dental care.

IX. Overlap of Project Areas

Jennifer had the group individually look to see where R-MCH can work in other buckets. She then had the group report out their findings:

Bi-directional

- Initial screenings for depression and anxiety for home visiting
- Telehealth for behavioral health

- Better connections for clinical and behavioral health
- TCPI data and well child visits, possible integration, full loop referral system (blood pressure checks, etc. can be done)
    - Navos in Seattle as an example
- Developmental screenings for well child visits
- Family planning screenings for people with SUD diagnosis, additional training for staff
- Maternal mental health screenings at the pediatric visit

Care Transitions

- Children with special health care needs (could be under chronic disease as well)
- Transition coach
- Referrals for the family
- NFP RNs see postpartum moms for 6 weeks after they are released from the hospital

Care Coordination

- 20 pathways for maternal child health
- Whole family care approach
    - Make sure existing resources and pathways hub have strong partnership to create referrals process and not duplicate efforts, cross training
- Child special health care needs families flagged
    - Children with Special Health Care Needs RN can do referrals
- Nurse Family Partnership makes referrals for pregnant and/or parenting moms

Chronic Disease

- Ongoing case management in behavior health
- Integrate routine follow up and visits in home visiting
- Telehealth
- Make connection for mothers after birth on their personal care

Opioid Response

- Distributing naloxone during child home visiting
- Safe use and disposal of substances
- Prevalence and availability for pregnancy
- PCAP
- Peace Health St John is doing work around opioid and birth outcomes

X. Next Steps & Closing

- Next meeting is Wednesday February 28th from 3:15pm – 5:15 pm
- https://global.gotomeeting.com/join/978213053
  United States: +1 (786) 535-3211
  Access Code: 978-213-053