LAUNCH Young Child Wellness Council (YCWC)

June 11, 2014

MEETING NOTES

YCWC Attendees: Nancy Anderson, Meg McElroy, Molly Day, Diane Tutch, Jamie Colvard, Leslie Brown, Erin Fairchild, Jeanne Lemieux, Debby Kernan, Bruce Spilde, Elizabeth Carroll, Sherri Alderman, Maxine Fookson, Barbara Ferre, Helen Bellanca, Jean Rystrom,

Working Group (staff & contractors): Working Group: Ashley Lawrence (211info Family), Callie Lambarth, Natasha Smith, Beth Green, Melissa Maebari (PSU), Peg King (OR Pediatric Society)

Visitor: Jamie Colvard works for Zero to Three. She provides resource assistance to four LAUNCH grantees: Multnomah, El Paso, Colorado, and DC. She is also doing some infant-toddler work with State of Oregon, through a grant.

Children's Relief Nursery (CRN)

Please reference the PowerPoint handout (sent out with minutes).

Leslie Brown is the Program Director and Diane Tutch is the Grant Coordinator for CRN SAMHSA grant. The CRN is part of Lifeworks Northwest. They provide respite care, home visiting, parenting classes and also clinicians who provide parent child psychotherapy. Last year they served 227 children at this site. They've been here since 2000.

CRN has been becoming more aware of physical health concerns. Now, with the integrated care grant from SAMHSA (October 2012), they can develop system to track children with health issues.

They have added a screening for health and wellness at intake. A partnership with the OHSU nurse intern program and the Health Department allows them to have a Community Health Nurse come to both CRN sites. The nurse looks at screening and intake.

SAMHSA grant has four main components

- Direct Services: Based on Child-Parent Psychotherapy (CPP); parent/infant groups, parenting education and CPP.
- Training: CPP Learning Collaborative for clinicians in Oregon. Part-day trainings to non-clinicians.
- Military collaboration: Assure that services are offered to military families and that they are appropriate.
- Integrated Care: integrating health information into our trauma-focused services and establishing relationships with primary care providers.

They have a new cohort of clinicians who are learning CPP. They also provide trainings for non-clinicians on young children and trauma.

The Breakthrough Series Collaborative is a research partnership led by Johns Hopkins. CRN is a partner. Diane, Leslie, Dr. Sherri Alderman, and graduated parent are the Portland team in the Breakthrough Collaborative.

Plan Do Study Act. (see model in PowerPoint). ***"Small test of change"***. In the "plan" part, spend the least amount of time deciding what to do and what you'll learn. CRN decided to give ASQ score sheet to a physician with a letter saying they would follow up. "Do" – they did it with one child and one physician (Sherri Alderman). Then they "Studied" what happened.

Sherri – was surprised and didn't know she'd get the letter. It was a family she'd had concerns about but lost contact with. Got letter that they were at CRN. "It was great communication to get that information". She was able to give feedback to CRN on how to improve the letter to make it more useful to physician.

They adjusted to make it a fax cover sheet with 4 bullets to share with physician. Includes name of case manager at CRN.

"Act". They will do the ASQ and fax at intake and every 6 months.

Now they do it on all intakes, but haven't fully integrated the follow-up call. A consent form covers sharing info back and forth with doctors. Information on every child goes into an Excel spreadsheet with health issues, primary care provider, etc.

Maxine and Jean asked if there was any thought about bringing Community Health Workers into the model for a cultural overlay? Leslie expressed interest in doing that. Molly said that ELM got a State innovation grant and will house community health worker in Cesar Chavez cluster. Molly and Leslie will connect about the possibility of including Community Health Workers in this CRN work. *(Note: This is LAUNCH system building happening at the YCWC!)*

The CRN model isn't to ask primary care providers (PCPs) to do ASQs. They do it and send them. Some know how to read it and some don't . Their note shows what they're concerned about. There is a critical mass of children who don't have coordinated care on medical issues.

Maxine – what part of ASQ is sent? It's the back scoresheet. What do providers want? Sherri says majority just want the score page, not whole questionnaire. Barb said that a lot of PCPs are doing ASQ anyway, so easy to access questions.

Helen – process you're describing makes sense, but know that developmental screening is a primary issue in the CCO framework, and PCPs are getting different messages. They hear from CCOs that we want you to do screening, and there is an incentive. And if they get message from CRN that they've done the ASQ and referral, the PCP will wonder what to do? Should they enter and code and get credit? Another piece is that there is new wave of referral, because PCPs are doing ASQs now, and so there is a concern about overwhelming Early Intervention (EI). And, there are new conversations among developmental pediatricians about *their* role. They do EI, but also developmental pediatrics. How do we manage this as a community? We are sending different messages. The PCP is responsible (incentive measure) for interpreting the ASQ, communicating with parent, and documenting it.

Nancy – the highest rate of families closing (got referral and they said not interested, lost contact) were from primary care. You can do an ASQ, but without a very warm referral, the connection to

service is not happening. She would like to bring that report to this group, unpack it, and consider a pilot.

Beth Green – it would be interesting to talk with parents to see how the PCP messaged the referral.

Leslie – they have also had conversations about ASQ-SE (social-emotional). Often talk with MECP and nurses about that score. MECP helps them with the regular ASQ scores. Having a case manager coordinate care makes difference.

Barb – in process of developing medical home they are closing the loop. They used to send patients off with a referral, and it wasn't for something urgent, they didn't follow up as much. For developmental referrals, she checks to see what happens. CCOs will ask PCPs if they closed the loop.

Helen – one of the pieces the State is working on is some way that we could all know about screens. Like the immunization system – if a kid comes to her, she could query a database to see if an ASQ was done and what referrals have been made. Need to know who else is doing ASQs.

Leslie – can PCPs count the ASQs CRN has done as theirs? Answer: In order to bill Medicaid, they have to interpret it, communicate with parents, and coordinate a referral.

Jeanne – common thread is communication with parents, and to make sure the communication gets action. Everyone doing ASQs (PCPs, child care providers, home visitors) need training on what it means and how to communicate with parents so there is action. Also, it's supposed to be tool to give to parents to understand development and what they do to make that happen. The whole stream around parents is getting lost in this conversation.

Erin – pediatric focused Community Health Workers for the families referred by primary care could bridge that gap.

Meg – do you give parents copy of fax communication to doctor? Leslie - Parents aware but staff needs to show what doing and why.

Bruce – stigma for some families to think child has emotional and/or developmental issue. It can take up to 6 months of ongoing conversation and, unfortunately, watching child fail. It's not going to always be a one time screening that leads to action.

Peg – one of the START models is on autism spectrum disorder. Includes parent saying what it was like to hear the news from physician. Leslie said that they might include their parent graduate in the training. The parents told her that it took a long time for the news to settle in.

Nancy – they might be referred and then when they realize they're being referred to Special Education, that flips it. Include public and private. Some might not want to go to public entity and have kid in "special ed", vs. use private insurance and get speech therapy. They track every family that declines service and often that's why – it follows their kid through K-12 as "Special Ed." Jean added that people don't want medical labels for same reasons.

Jean – how much is it under State's or CCO's control of what counts – could it be making referrals OR coordinating with child care provider?

Helen – for us the metric is the HEDIS metric negotiated with CMS. It's federal dollars for performance under metrics. It's negotiable, but must be approved. Maybe state can negotiate with CMS (federal).

Further discussion about if an organization does an ASQ and makes referral, and then PCP codes it, should Medicaid pay for that, or is it fraud? It's different if the PCP talks with the family about child care provider and says go to appointment etc. But now clinicians don't have time in their schedules to do that. Maybe if review screen, make a plan. Don't need to solve right now, see what happens. Most likely, that child will be screened multiple times.

Next steps for Young Child Wellness Council

Elana said that we have discussed ASQ a lot at the YCWC, and asked the group to help think of what we should do now.

- Meg – we've gathered so much information. We should write a report to share with the state. Jeanne added that Multnomah county has ¼ to 1/3 of the state's child care population. We need to communicate what we're doing.
- Beth Green – agrees with Meg that we've had a lot of discussion. This YCWC is an incredible brain trust we should use to inform our work, but what can LAUNCH do? What can this council do? Let's discuss that at the next meeting. Have State level and practice level people join us here. Let's plan what to do in the last year of LAUNCH. Callie added that it could be good to compile what is being done already.