BUILDING BRIGHT FUTURES

WHEN WE WORK TOGETHER, CHILDREN SHINE

BBF Child Outcomes Accountability Team

High Performing Medical Homes

Thursday, February 25th, 2021

Social Determinants of Health: Health Equity through Social Needs Screening

Shared Vision-Characteristics of Successful Screening (updated)

Providers and practitioners working with children and families increasingly recognize their role in identifying and addressing a family's social and behavioral health needs (food, housing, adult mental health etc.) in addition to efforts for earlier identification of a child's developmental delays and referral for early intervention. Relationships matter. When done well, families have a relationship with the provider and participate in the process followed by professional guidance and referral to connect with the supports they need. Screening is done with respect and with cultural humility.

When screening practices are normalized and universal, less people fall between the cracks, bias is limited and the conversations are destigmatized. Screening is an integrated part of workflow - whether in a medical practice, childcare, school, home or other setting and is routinely administered (3 under 3 for child developmental screening and for social determinants). Providers and practitioners share responsibility and are thoughtfully coordinated, able to share data and use screening and follow up as a tool to support child and family outcomes.

VECAP GOAL 1

1. ALL CHILDREN HAVE A HEALTHY START

Children's healthy development depends on their early experiences, their environment and the health and well-being of their parents and caregivers. We know children are more likely to thrive when they live in safe and stable home environments and when families have equitable access to resources when they need them. To achieve this goal, Vermont will work to ensure all children prenatal through age eight are thriving across 4 primary domains: physical health, social and emotional wellness, developmental and educational results, and adequate basic needs for a child to thrive.

VECAP GOAL 1 - All Children Have A Healthy Start

Child Outcomes Accountability Team

The charge of the Child Outcomes Accountability Team is to improve integration and coordination of early childhood public and private partners committed to the health and well-being of children and their families. The group will inform strategies and monitor progress to ensure that children are healthy, thriving and developmentally on track from the prenatal period to third grade by promoting and monitoring outcomes in the following domains: physical health, development and educational outcomes, mental health outcomes, and basic needs outcomes. Goal 1 also promotes the importance of prevention and early identification across the same domains.

Vermont's Early Childhood Action Plan - Levels of Change

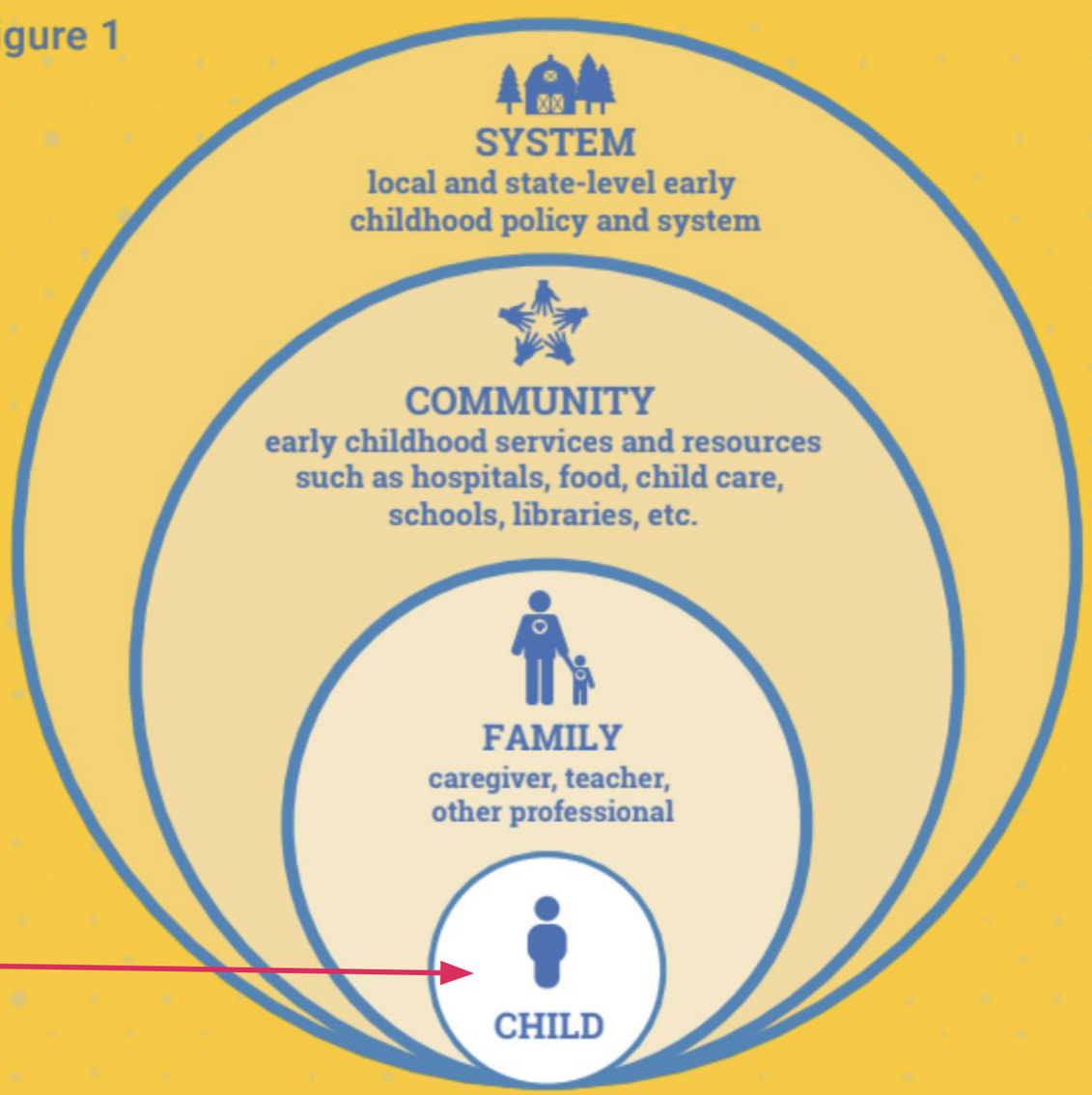
Figure 1

Vermont's local and state-level early childhood policy and systems - Goal 4: The early childhood system will be integrated, well resourced and data-informed.

Community - Goal 3: All Children and Families Have Access to High-Quality Opportunities That Meet Their Needs.

Family - Goal 2: Family and Community Play A Leading Role in Children's Wellbeing.

Child - Goal 1: All Children Have A Healthy Start.



Prenatal ▶ New Borns ▶ Infants ▶ Toddlers ▶ Preschoolers ▶ Kindergardeners ▶ 1st Graders ▶ 2nd Graders ▶ 3rd Graders

Improving child outcomes through promising medical practices

Dr. Breena Holmes

- Child outcomes data walk
- What does the early childhood system need to understand about health systems?
- What are high performing medical homes and different care coordinators models
- Discussion on how can we improve collaboration among pediatric medical homes and community agencies to strengthen families and improve care delivery?

Child Outcomes Accountability Team

Breena Holmes, MD
February 25, 2021

VERMONT
DEPARTMENT OF HEALTH

VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT LARNER COLLEGE OF MEDICINE

Pediatrics and Early Childhood

- Review current outcomes measured in Vermont Early Childhood Action Plan
- Describe the unique position of child health professionals in early childhood system
- Review concept of a High Performing Medical Homes
- Review current Vermont's current care coordination/ integration efforts
- Discussion

Vermont Early Childhood Action Plan - Goal 1 Indicators

Intermediate Indicators

- Percent of mothers with at least one prenatal visit
- Percent of children age 1-4 with a well-child visit
- Percent of children under 18 adequately covered by health insurance
- Percent of children under 9 with a preventive dental visit in the past year
- Number of families receiving home visiting services
- Percent of infants breastfed for at least 6 months

Vermont Early Childhood Action Plan - Goal 1 Indicators

5-Year Indicators

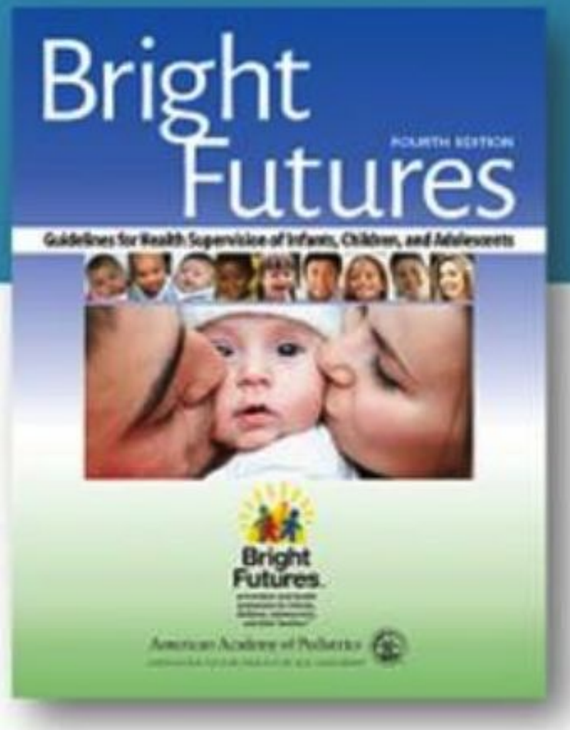
- Percent of low birth-weight babies
- Percent of children who are fully vaccinated by age 2
- Percent of children age 2-5 who are overweight
- Percent of live births to women who used substances during pregnancy

Vermont Early Childhood Action Plan - Goal 1 Indicators

Intermediate Indicators

- Percent of children with a developmental screening by age 3
- Percent increase in use of Vermont's Developmental Screening Registry (VDH)

Pediatric Medical Home and Bright Futures 4th Edition



Focus on Social Determinants of Health

- Greater focus on lifelong physical/ mental health
- Strength based approaches

The healthcare setting offers three key advantages in providing parenting support

1. Reach virtually all families in early years (> 95% of Vermont infants receive routine health care with a child health provider in the first month of life)
2. Lack of social stigma attached to using medical care
3. High level of trust that families extend to their child's healthcare provider, whose active endorsement encourages engagement in other services

Bright Futures Road Show-2017

8 regional dinners, **264** human service community providers, **48** health care providers

- **Objective:** Discuss collaboration among pediatric medical homes, community agencies and organizations in each region to strengthen families and improve care delivery (with special focus on addressing social determinants and ACES prevention)
- **Global Theme emerged:** Importance of increasing capacity in pediatric medical homes to conduct screening, provide parent/family support and facilitate connections (through Children's Integrated Services) to community resources. DULCE is on solution to accomplish these objectives and there are other care coordination models as well

VERMONT DEPARTMENT OF HEALTH

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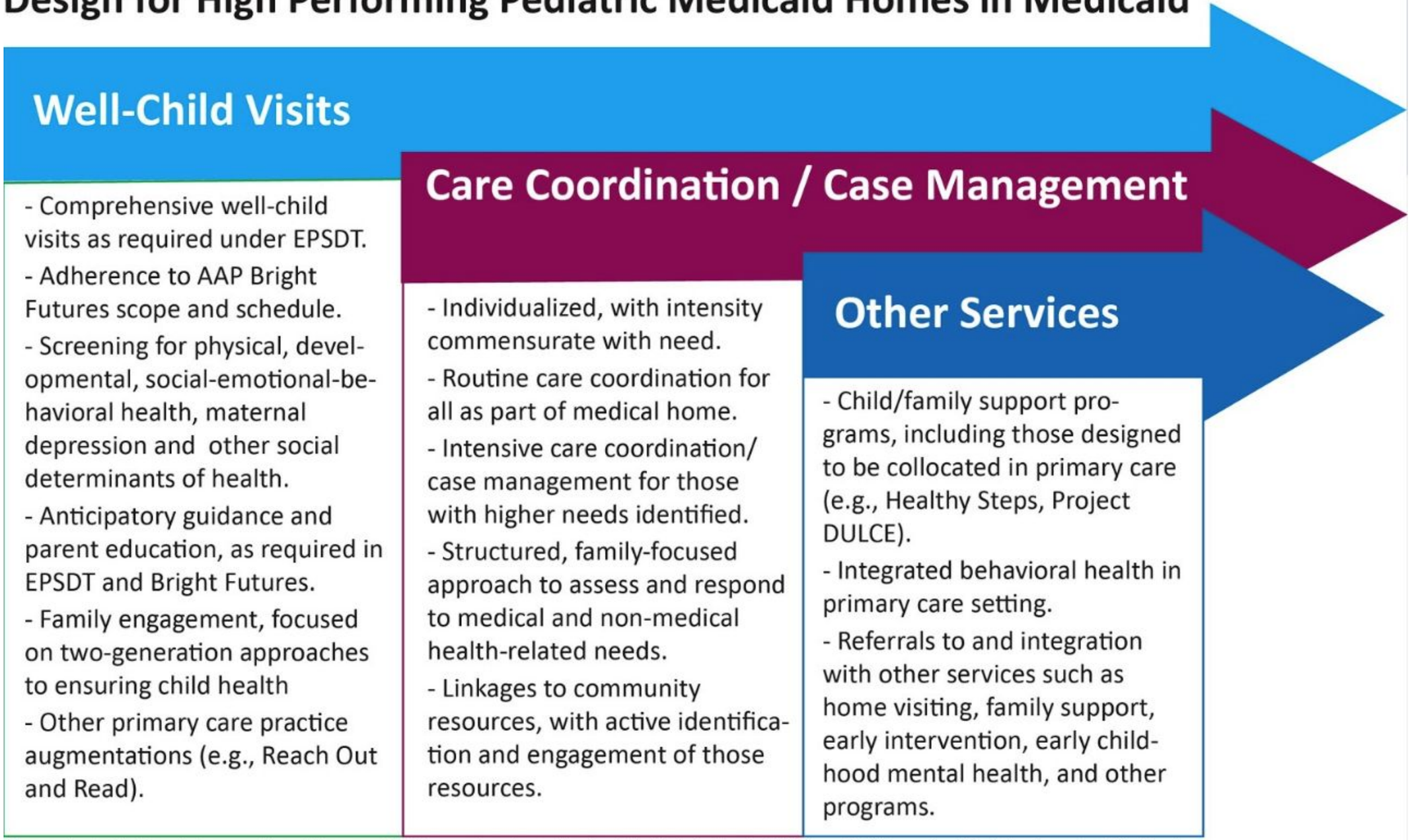
Opportunities for Medicaid to Transform Pediatric Care for Young Children to Promote Health, Development, and Health Equity

- Ascend at the Aspen Institute
- BrunerChildEquity, LLC
- Center for Health Care Strategies
- Center for the Study of Social Policy (CSSP)
- Georgetown University Center for Children and Families
- Johnson Group Consulting, Inc.
- National Institute for Children's Health Quality (NICHQ)
- ZERO TO THREE

Design for High Performing Pediatric Medicaid Homes in Medicaid



Suggested citation: Johnson K and Bruner C. *A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health*. Child and Family Policy Center. October, 2018.

Care Coordination-Seeking Clarity

- Developing, validating and sharing tools
- Data collection
- Matching professionals and types of care coordination
  - universal support for all families
  - children, youth and families navigating developmental services and mental health systems
  - children, youth and families navigating systems for children with complex medical condition

Where are the Opportunities for Coordination?

- Vermont's efforts
  - Integration of mental health/behavioral health-medical homes
    - Designated Agencies
  - Health reform efforts -Blueprint, OneCare,
  - Children with Special Health Care Needs medical social workers
  - Parent Child Centers
    - DULCE
- Early childhood systems
  - Early Care and Learning
  - Help Me Grow
  - CIS including Home Visiting
  - WIC

COVID and Pediatrics

- Ongoing efforts to maintain a high-functioning Medical Home for patients and families: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, culturally effective
- Assure completion of 4 goals of well-child visit: health promotion, disease prevention, disease detection, anticipatory guidance
- Partnering with medical homes is particularly valuable as we respond to the triple crises related to COVID-19, economic downturn, and social justice that affect families and communities.
  - People are out of work, grappling with access to adequate food, housing, and other necessities.
  - The pandemic has amplified the need to address social determinants of health.

Discussion

Child Outcomes Accountability Team

As we prepare for COVID recovery, how can we improve collaboration among pediatric medical homes and community agencies to strengthen families and improve care delivery?