



ODJFS/Medicaid

National Academy for State Health Policy:
ABCD Screening Academy Grant -
Stakeholder Advisory Group Meeting

Vern Riffe Government Center
31st Floor; South B & C Conference Rooms
June 19, 2008



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Presentation Agenda

- **Governor Strickland's TurnAround Ohio Vision.**
- **Brief NASHP grant overview.**
- **NASHP Subcommittees report out; Q & A.**
- **Health Disparities & Cultural Competence.**



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TurnAround Ohio: Vision for a Healthy Ohio

“Ohioans are achieving and maintaining optimal health through personal wellness management and a health care delivery system that focuses on the promotion of health and the prevention of disease. At each stage of life, every Ohioan has access to timely, patient-centered, holistic and efficient health care choices. All Ohioans have access to primary and preventive services as well as education and opportunities for healthy lifestyles, and the incidence of preventable diseases are at the lowest levels in the nation across all population groups. Services and care are coordinated through widespread use of health information technology, thereby improving health outcomes and delivering effective, efficient and culturally competent health care.”



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TurnAround Ohio: Children

Goals

- Children are ready to learn when entering school
- Early intervention, prevention & health promotion
- Improve utilization of Ohio's children health & wellness services, programs



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National Academy for State Health Policy Grant

ABCD Screening Academy → Assuring Better
Child Health and Development: Phase II



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Grant Overview

- NASHP Technical assistance grant; funding from The Commonwealth Fund.
- For Medicaid children ages birth through 6, achieve statewide improvement in:
 - Physician use of developmental screening using standard, evidence-based screening tools;
 - Physician treatment, referrals to care for concerns identified;
 - Children's actual use of recommended treatment, referral for care and feedback to physician.



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Grant Goal

- “Measurably improve outcomes for children in Ohio by standardizing the use of structured developmental screening and assessment in practice settings that care for young children and by improved referral for care.”



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How to Achieve

- Rapid cycle improvement method: 6 – 12 months vs. often up to 17 years;
- Physician practice-based pilot testing of “best practice”, standard of care at several sites;
- Measure improvement;
- Identify and overcome policy and delivery system barriers;
- Spread improvement learning state wide through physician champions, work shops, etc.



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Process

- Convene Stakeholder Advisory Group → knowledgeable, influence;
- Establish a Core Leadership Team to manage improvement process;
- Break in to Subcommittees by key issue;
- Identify physician practice pilot sites;
- Develop a communication strategy to implement practice site learning, improvement statewide.



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Practice Sites

- Ohio Pediatrics (Dayton)
- The Rocking Horse Center (Springfield)
- Oxford Pediatrics & Adolescents (Oxford)
- Rainbow Babies & Children's Hospital Pediatric Practice (Cleveland)



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Levels of Child Development Evaluation

- **Surveillance:** “A flexible, longitudinal, continuous, and cumulative process whereby knowledgeable health care professionals identify children who may have developmental problems.” (AAP)
- **Screening:** “The administration of a brief standardized tool aiding the identification of children at risk of a developmental disorder.” (AAP)
- **Assessment:** “A more in depth evaluation, diagnosis of a condition of concern identified by Surveillance or Screening.”

Note: There is some difference of opinion re: the above within the health care field.



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NASHP ABCD III

- NASHP’s planning process to begin soon:
 - Build on national ABCD I & II → Learning re: improving physician and child connection with the developmental health care delivery system;
 - Survey states to identify policies and practices that promote care coordination, linkages;
 - Undertake planning efforts that are intended to lead to a state collaborative focused on care coordination and effective referral of children to intervention services.



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NASHP Subcommittees Report Out



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Provider Communication, Curriculum & Training Subcommittee

Members

- Co-chairs: Melissa Wervey Arnold (OH Chapter AAP); Kate Mahler, (OAFP);
- Core Leadership Staff team: Dr. Carole Lannon (Cin. Children's Hosp./Ctr. For Health Care Quality); Harvey Doremus (ODJFS);
- See Subcommittee members list.



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Provider Communication, Curriculum & Training Subcommittee

Goals

- Improve upon:
 - Communication with providers re: importance of developmental screening;
 - Provider understanding of current Medicaid screening coverage & reimbursement;
 - Provider training, education, curriculum re: well-child care & screening;
 - Involvement of entire physician community (e.g. pediatricians, family physicians, & osteopathic physicians) as well as community providers.



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Provider Communication, Curriculum & Training Subcommittee

Goals

- Improve upon:
 - Provider referral network to ensure children, families receive recommended care;
 - Provider and Medicaid managed care organizations' collaboration;
 - Linkages to child's medical home;
 - Reducing health disparities & improving cultural competence;
 - Develop other improvement opportunities.



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Provider Communication, Curriculum & Training Subcommittee

- Process – Held 3 full Subcommittee meetings, engaged a wide array of clinical experts.
 - Chartered a Developmental Screening Tools & Schedule Work Group, meet 3 times:
 - Led by Melissa Arnold, OH Chapter AAP, Dr. Carole Lannon and Sandy Fuller, Cincinnati Children's Hosp. Medical Ctr., Center for Health Care Quality/CHCQ. They convened an Advisory Group which also met 3 times to draft/revise recommendations for the full Work Group;
 - Pediatricians: Drs. Jim Duffee, Andrew Garner, John Duby (OH Chapter AAP Autism Program Dir.), Mary Applegate (Medicaid Medical Dir.), Jim Bryant (ODH Bureau for Children with Medical Handicaps/BCMh Dir.);
 - Ph.D. Psychologists: Terry Stancin (MetroHealth), Jane Hamel-Lambert (IPAC), David Hammer (OSU Nisonger Ctr. Prog. Dir.); Ph.D., Early Childhood Ed.: Debbie Goldberg (Children's Resource Center).



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Provider Communication, Curriculum & Training Subcommittee

- Process (con't.)
 - Coordinating Physician Curriculum, Training & Education development and roll out with the OH Chapter AAP Autism Program.



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Provider Communication, Curriculum & Training Subcommittee

- Accomplishments
 - Completed a Developmental Screening Tools & Schedule recommendation – approved by the OH Chapter AAP Board of Directors, February, 2008;
 - OH Chapter AAP and OAFP are further communicating importance of developmental screening and care to their members;
 - Physician developmental and autism screening, referral survey nearly ready for implementation.



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Provider Communication, Curriculum & Training Subcommittee

- Work in Process
 - Continue coordinating physician curriculum and training development with Autism Program;
 - Physician & managed care plan screening, referral collaboration;
 - Improve child, family linkage to medical home;
 - Private insurance coverage of developmental screening and care.



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Provider Communication, Curriculum & Training Subcommittee

- Next Steps & Future Work
 - See Work in Process;
 - Reduce health disparities, improve cultural competence.



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Family & Children Communication & Education

Members

- Co-chairs: Alicia Leatherman (ECC); Barbara Weinberg (ODE)
- Core Leadership Staff team: Karen Hughes, Debbie Wright, Debbie Cheatham (all ODH); Donna Bush (ODJFS)
- See Subcommittee members list.



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Family & Children Communication & Education

- **Special thanks to Subcommittee members:**

Gayle Channing Tenenbaum; Carol Keltner; Jenny Golowin; Beth Crawford; Joyce Calland; Sue Meeks; Maureen Meck; Pam Harris; Amy Swanson; Rick Cornett; Barbara Baker; Barbara Duling; Ginger O'Connor; Terre Garner; Luis Guardiola; Jeff Davis; Cathy Kramer; Dr. Stanley Reed; Jon C. Hackathorn, Pat Nobili; Mary Wachtel; Amy Adkins-Dwivedi; Melissa Courts; Karen Boester; Carol Ware; Lauren Phelps; Dr. Carole Lannon; Divvie Powell; Sandy Fuller.



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Family & Children Communication & Education

Goals

- Improve upon:
 - Families' awareness of the importance of health and developmental screenings and well-child care;
 - On-going connections between families and resources, including Medicaid, that support or provide well-child care, health and developmental screenings, and follow-up care;
 - Meaningful interactions and communication between families and providers of supports and services.
 - Reducing health disparities & improving cultural competence.



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Family & Children Communication & Education

- Committee Conversations
 - Identified where families go for information about their children;
 - Examined ways in which families and practitioners communicate, including barriers;
 - Decoded Medicaid acronyms, terminology, Managed Care operations and the Healthchek (EPSDT) program;
 - Considered “critical messages” to families across systems;
 - Considered the value of branding.



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Family & Children Communication & Education

- More Conversations
 - Identified best practices for communication between families and providers, and the need to empower families with knowledge about the meaning and value of health and developmental screenings, including social-emotional;
 - Worked with others on a Consumer Focus Group study;
 - Evaluated the web as a way to disseminate info
Considered other media for message delivery (e.g. TV, radio, newspaper, brochures, etc.).



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Family & Children Communication & Education

- Voices for Children Focus Group Study Demographics:
 - Families with children under age 19;
 - Families eligible for Medicaid;
 - Families with and without health insurance;
 - Families representing a variety of ethnic groups;
 - Families represented by men.



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Family & Children Communication & Education

- Voices for Children Focus Group Study Highlights:
 - Parents believe developmental screening is related to the physical milestones of a childhood.
 - Parents are not responsive to the context of “social-emotional” as it relates to developmental screening.
 - Parents believe that a developmental screening should not be mandated. Fear of labeling a child for life.
 - Developmental screenings should be done by a doctor.
 - Most parents are very comfortable with their own doctors.



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Family & Children Communication & Education

- **Voices for Children Focus Group Study Highlights:**
 - Loved the developmental wheel produced by the ODH HMG.
 - Suggested sending information home with child from day care/school (but not at the beginning of a school year), placing information in physicians office, emergency rooms, Babies R Us, Wal-Mart, PSA's, maternity wards and churches as ways to communicate with families.
 - Thought a Web site that included easy to use, well-organized organized information without a lot of reading, that was interactive, had music and lots of resources would be valuable.



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Family & Children Communication & Education

- **Web Site Evaluations:**
 - Do not overwhelm parents with too much information;
 - Provide lists of and/or links to resources ;
 - Avoid dead ends;
 - Use color and lots of pictures (real life photos);
 - Provide side bar tools that are efficient and useful;
 - Don't be too wordy;
 - Alphabetize the search service;
 - Make it simple and easy;
 - Maintain focus;
 - Highlight parent resource section;
 - Overall favorite: www.rif.org (Reading is Fundamental).



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Family & Children Communication & Education

Recommendation #1:

- Create an inter-agency communication plan that includes input from parents/consumers to develop consistent, easy to understand messages and materials that help educate Ohio's families about ways to increase the well-being of their young children.



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Family & Children Communication & Education

Strategies:

1. Disseminate culturally sensitive materials to families and providers regarding the value and importance of: regular, on-going, well-child care (medical home) and health and developmental screenings, (including social/emotional).
2. Use various media (e.g. billboards, PSA's, brochures, posters, videos, state-wide and local websites) to reach families with information about child development and other topics of interest.
3. Develop and update lists of stakeholders/organizations to assist with dissemination of materials (i.e. OB-GYNs, Ohio AAP members, Clinics, Early Care and Education programs, etc.).



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Family & Children Communication & Education

Recommendation #2:

- Develop a consistent “brand,” logo, visual approach to help families easily locate needed resources in a timely manner.

Strategies:

1. Seek consumers/stakeholders input to prior to releasing media and messages.
2. Focus on attracting diverse family groups, including: first-time parents, young families & grandparents.



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Delivery System Resources for Assessment & Referral

Members

- Co-chairs: Ben Kearney (BCHFS); Angela Sausser-Short (FCFC)
- Core Leadership Staff team: Kay Rietz (ODMH); Dr. James Bryant (ODH)
- See Subcommittee members list



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Delivery System Resources for Assessment & Referral

Goals

- Improve upon:
 - Communication with providers and families about available, local developmental assessment, and referral providers and services;
 - Care coordination to assist families in actually accessing recommended services;
 - Delivery system capacity to provide needed care, services;
 - Reducing health disparities & improving cultural competence.



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Delivery System Resources for Assessment & Referral

- Process - Held 11 monthly meetings of Stakeholders, heard from a variety of experts:
 - ODJFS/Medicaid Healthchek (EPSDT) program – Karen Boester;
 - ODJFS/Medicaid managed care – Kara Miller;
 - ODH Help Me Grow/HMG (IDEA Part C birth to 3) – Debbie Wright, Debbie Cheatham;
 - ODE Special Education (IDEA Part B 3 – 6) – Barbara Weinberg;
 - Cincinnati Children's Hosp. Medical Ctr., Center for Health Care Quality/CHCQ (NC developmental screening experience) – Sandy Fuller;



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Delivery System Resources for Assessment & Referral

- Process (con't.)
 - Nationwide Children's Hospital (national AAP Medical Home Project) – Dr. Kelly Kelleher;
 - ODH Early Childhood Comprehensive System (ECCS) – Melissa Courts;
 - ODJFS/Child & Family Services Step Up to Quality (infant & toddler guidelines) – Jamie Gottesman;
 - Screening and referral pathways - Dr. Marian Earls, North Carolina; Dr. Mary Applegate, Medicaid Medical Director; Dr. James Duffee & Dr. James Bryant, community pediatricians;



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Delivery System Resources for Assessment & Referral

- Process (con't.)
 - Interprofessional Partners for Appalachian Children/IPAC (managing/co-locating care) – Jane Hamel-Lambert;
 - ODJFS/Medicaid HIPAA requirements (tool kit documents) – Rob Bergin;
 - ODMH Network of Care (web-based county behavioral/MH providers listing) – Liz Henrich (OACBHA);
 - ODH School Nurse Program – Dorothy Bystrom & Dr. James Bryant;
 - North Carolina Special Educ. & Public Health Nurse program – Sandy Fuller.



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Delivery System Resources for Assessment & Referral

- Process (con't.)
 - Work group of physicians & ODJFS, ODH, ODMH staff met 6 times to work on a Physician Referral "Tool Kit":
 - Reviewed existing tool kit documents from NASHP, national AAP, other states, Cin. Children's Hosp. Medical Ctr./CHCQ.
- Accomplishments
 - Drafted a Physician Referral Tool Kit, OH Chapter AAP physicians are reviewing, providing feedback;
 - Created an improved understanding of the Help Me Grow, Special Ed. and provider referral systems.



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Delivery System Resources for Assessment & Referral

Work in Process

- Finalize Tool Kit;
- Further discuss, understand HMG children transition to Special Ed.;
- School nurse developmental screening, referral for care, communication with child's primary care physician.



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Delivery System Resources for Assessment & Referral

- Next Steps & Future Work
 - Research, make recommendations re:
 - HMG, Special Ed. and referral provider improved feedback to primary care physician;
 - HMG to Special Ed. transition;
 - Delivery system provider gaps;
 - Improving care management for children referred by physician practices;
 - Reduce health disparities, improve cultural competence.



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Health Disparities & Cultural Competence

Overview



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Health Disparities

- With the launch of Healthy People 2010 in January 2000, the Department of Health and Human Services committed the nation to an overarching goal to eliminate health disparities that occur by race and ethnicity, gender, education, income, geographic location, disability status, or sexual orientation (Carter-Porkras and Baquet, Healthy People 2010).
- The National Institutes of Health defines health disparities as “differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States” including disparities related to socioeconomic status.



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Health Disparities

- There is some disagreement about definitions and measures of health disparities (Carter-Porkras and Baquet).
 - Some definitions include or imply an ethical judgment about the avoidability, unjustness or unfairness of health differences.
 - Some definitions include many components such as: engagement in health behaviors (voluntary and involuntary), environment, access to, utilization of, and quality of health care, health status, or a particular health outcome.



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Child Health Disparities

- Disparities in children's health are not nearly as well documented as disparities among adults.
- One consistent measure is infant mortality:
 - In 2006, non-Hispanic blacks (13.6 per 1,000 live births) had twice the rate of infant mortality than the national average (6.78), and almost three times the rate for whites (5.66) (CDC).
 - American Indians, Alaskan Natives, and Puerto Ricans also had rates higher than the national average.



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Child Health Disparities

- Obesity: The epidemic of childhood obesity is well documented in the U.S., and the burden falls more heavily on minority children (Ogden et. al.)
 - In 2004, 20.0% of black children and 19.2% of Mexican-American children ages 2-19 were overweight, while only 16.3% of white children were overweight.
 - Black children are about 1.6 times more likely to be overweight than white children.



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Cultural Competence

- “Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.”

(HHS Office of Minority Health)



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Cultural Competence

- Cultural competence is a developmental process that evolves over an extended period of time. Both individuals and organizations are at varying points on the cultural competence continuum with different levels of awareness, knowledge, and skills.

(National Center for Cultural Competence Health)

- The complexity of achieving cultural competence does not allow for a quick, step-by-step approach. It is often helpful for systems and organizations to conduct self-assessments and use the results to set meaningful goals for growth.



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Cultural Competence

- Institutions and organizations with high levels of cultural competence have these characteristics:
 - A mission statement with accompanying policies and procedures that integrate cultural and linguistic competence into each core function of the organization.
 - Ensure consumer and community participation in the planning, delivery, and evaluation of the organization's core function, and engage the community in the reciprocal transfer of knowledge and skills.
 - Identify and use evidence-based practices that are culturally competent.
 - Policies to recruit, hire, and maintain a diverse workforce, including individuals with expertise in cultural and linguistic competence.
 - Actively pursue resource development and provide fiscal support for improving and enhancing cultural and linguistic competence.



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Disparities and Cultural Competence In Ohio

- The Ohio Chapter, American Academy of Pediatrics current approaches:
 - Continuing Medical Education;
 - National AAP resources.
- The Ohio Academy of Family Physicians current approaches:
 - Continuing Medical Education;
 - Research, white papers;
 - Limited English Proficiency Resources.



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Health Disparities & Cultural Competence

- How should Ohio define disparities in developmental screening, care and approach the goal to eliminate them?
- How should Ohio define and improve upon provider cultural competence?



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Online Resources

- National Partnership to End Health Disparities; HHS:
<http://www.omhrc.gov/npa/templates/browse.aspx?lvl=1&lvlid=13>
- National Center for Cultural Competence at Georgetown:
<http://www11.georgetown.edu/research/gucchd/nccc/>
- Culturally Competent Medical Care Online Resource Center (Harvard Medical School)
<http://medweb.med.harvard.edu/cccec/index.htm>
- Multiethnic Advocates for Cultural Competence:
<http://www.maccinc.net/>
- Ohio Commission on Minority Health
<http://mih.ohio.gov/>



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Online Resources, cont.

- American Academy of Pediatrics
 - http://www.aap.org/commpeds/resources/cult_effectiveness.html
- American Academy of Family Physicians
 - Cultural Proficiency Resources:
<http://www.aafp.org/online/en/home/clinical/publichealth/culturalprof.html>
 - Health Disparities:
<http://www.aafp.org/online/en/home/clinical/publichealth/ptpops.html>



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QUESTIONS?



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