

**Commonwealth Council on Childhood Success
Health and Well Being Workgroup
February 12, 2015 Meeting Notes**

Attendees:

Catherine Hancock, DBHDS Early Intervention Coordinator (Co-Chair)
Lisa Specter-Dunaway, Home Visiting Consortium (Co-Chair)
Ashley Harrell, Maternal and Child Health, DMAS
Ipek Taffe, The Planning Council (Norfolk)
Dr. David Buchsbaum, Anthem
Becky Boswell, Autism Society Central VA
Johanna Schuchert, Prevent Child Abuse Virginia
Margaret Schultze, Commissioner, Dept of Social Services
Heidi Lawyer, Virginia Board for People with Disabilities
Michele Chesser, Joint Commission on Health Care
Marty Kilgore, VA Foundation for Healthy Youth
Heidi Hertz, VA Foundation for Healthy Youth
Rebecca Bates, ODU Doctoral Student, working with Becky Bowers-Lanier
Laurel Aparicio, Home Visiting Consortium
Dr. Lauri Kalanges, Virginia Department of Health
Danny Saggese, VFHY
Tonya Vidal Kinlow, Children's National Health System

Workgroup Updates

This is the last meeting with presentations; the group will focus on recommendations from here on out in preparation for May meeting.

Presentation on Home Visiting (HV) by Laurel Aparicio

Laurel has recently started as the Director of the Home Visiting Consortium, and presented an overview of what home visiting is, how the consortium works, and data outcomes. [Her entire power point presentation is online here.](#)

- Data drives innovation and improvement in service delivery, more true today than ever
- HV consortium provides professional development courses, and is working on a common certificate program for professionals
- Highlights from Outcome Data:
 - 75% more likely to give birth to healthy weight babies
 - CHIP babies spend 50% fewer days in the NICU
 - Better use of medical homes and preventive care
 - Participants are 50% less likely to abuse or neglect children (nationally); original purpose of many HV programs
 - Participants are 50% less likely to be retained in 1st grade
 - 40% increase rate of employment after 1 year in a HV program
 - \$5.70 return on investment for every dollar invested in HV
- HV programs are currently serving only 12% of the need in VA. Really just a resource issue. Closed in Halifax and Farmville, those programs were dependent on state funding and when that disappeared the sites closed.

- William and Mary study on Hampton from a few years ago indicates that 50% of eligible babies born each year need to receive services before the community outcomes begin to change.

Discussion and Questions:

Is it hard to find families to participate in these programs? No, many have wait lists.

Is there research out there on the value of providing services beyond child's entrance to Kindergarten? Some with transitions through the kindergarten year; beyond that no known research

Is there an increased number of localities without services? Yes, 6 Healthy Family sites closed in recent years

How do the payment models and insurance reimbursements work? It depends on the model and program. Some get Medicaid reimbursement through nursing services; other programs housed in CSB's who are reimbursed through targeted case management.

CHIP - because of nurse model, they have contracts with 2 MCO's to serve high risk babies and toddlers. The reimbursement pays for about 1/3 of the cost of the home visit.

On the mental health side- Healthy Families have MOA's with local CSB's. Their model is designed to be proactive and built on existing systems in the community. When the CSB is the fiscal sponsor of the program CSB bills Medicaid for targeted case management, put up the match until reimbursement comes in, after which it goes to Healthy Families. Some Healthy Family sites are not fiscally sponsored by CSB's but have similar MOA set up.

Presentation on Long Acting Reversible Contraceptives (LARC's) by Dr. Lauri Kalanges (VDH)

Dr. Kalanges is the Deputy Director, for the Office of Family Health Services at the Virginia Department of Health. She was asked to provide the group with more detailed information on LARC's given the conversation during Commissioner Levine's presentation at the last workgroup meeting on Thriving Infants and the role LARC's have.

Dr. Kalanges gave the group an overview of the types of LARC's that are FDA approved, and a bit about the history of their evolution. She then discussed the health benefits associated with appropriately spaced births and shared some of the outcome data from studies on LARC's in St Louis and Colorado. [Her full presentation is online here.](#)

Benefits of LARC's

- Reduce unintended pregnancy
- Increase inter-birth interval
- Improved birth outcomes
- Increased thriving infants

Missed/ current opportunity to promote immediate post partum long acting reversible contraception (IPP LARC), which are safe, reversible and highly effective. But challenges to policy implementation include:

- Bundling of prenatal, delivery, and postpartum services based on diagnosis related group guidelines.
 - Under the current reimbursement guidelines, if a practitioner were to provide a LARC method following placental removal, the hospital would not be reimbursed for the device and the practitioner may not be paid for the insertion fee.
- Public Awareness of LARC benefits
- Provider awareness
- Hospital systems change

Dr. Buschbaum explained that Anthem will be rolling out a program this spring to cover LARCs and decouple the funding so that practitioners and hospitals are reimbursed.

There are also challenges around publically funded reimbursements, including:

- Publically funded reimbursement
 - South Carolina
 - J-codes and family planning modifier
 - Colorado, Iowa, New Mexico, Georgia, Alabama, New York and Washington D.C.
- MCOs
 - Medicaid budget authority needed
 - MCO contract and capitation rates would need modified
- As Medicaid goes, so go other reimbursement plans?

There was also extensive discussion about the fact that any provider that touches the family needs to be trained and informed on the issue, from pediatricians to internists.

Presentation on Preventing Youth Tobacco Use, Danny Saggese, VFHY

As part of the desire to continue the conversation from Dr. Levine's presentation on thriving infants, Danny was invited to share a bit about the segmented marketing campaigns that VFHY does. The goal being to help us think about how to connect these smoking cessation efforts with the profound impact tobacco use has on thriving infants.

Danny explained a bit about how segmentation is used to better reach specific audiences because it is incredibly hard to change behavior (changing preferences is easy - coke to pepsi).

Data indicates that 15% of high school youth still smoke in the state; and teens are driven by their social identity, which varies dramatically from teen to teen.

Smoking teens didn't trust the VFHY's last campaign, as it wasn't speaking to the population it needed to.

Danny explained that demographics matter little in these campaigns, but rather group culture and identity cut across demographics. And VFHY found different prevalence rates of smoking for each of these different cultures.

This led to segmentation marketing based on the values of each different culture/ "peer crowds." They identify 5 major peer crowds, knowing that some teens identify with multiples. They tested each message with the respective peer crowd, before blasting to whole group.

One of his recommendations for the group to consider is to include the I-Base survey info in the VA youth survey instead of spending \$200,000 and taking 18 months to do it separately.

His [full presentation is online here.](#)

Sample videos are online here:

Alternative- <https://www.youtube.com/user/SYKEVA>

Country/ Rural - <https://www.youtube.com/user/DownandDirtyVA>

Hip Hop - <https://www.youtube.com/user/FreshSocietyVA>