NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state

TASK FORCE ON ESSENTIALS FOR CHILDHOOD

NORTH CAROLINA INSTITUTE OF MEDICINE
630 DAVIS DRIVE, SUITE 100
MORRISVILLE, NC 27560

AUGUST 29, 2014

10:00 am - 3:00 pm

Goals for the meeting: We will discuss various components of family screening in primary care, including pregnancy medical home, issues around reimbursement, and additional community resources. We will also discuss the draft recommendations around evidence-based programs, social norms, and policies, and begin to finalize our wording and recommendations.

WELCOME & INTRODUCTIONS

Kenneth A. Dodge, PhD
Founding Director
Center for Child and Family Policy
Duke University

Adam Zolotor, MD, DrPH
Vice President
North Carolina Institute of Medicine

Dr. Dodge called the meeting to order and welcomed the Task Force members. Task Force members in attendance on on the conference line introduced themselves, and Dr. Zolotor gave an overview of the meeting agenda.

FAMILY SCREENING FOR BEHAVIORAL HEALTH, INTIMATE PARTNER VIOLENCE, AND ADVERSE CHILDHOOD EXPERIENCES

Melanie Bush, MPAff
Assistant Director, Policy and Regulatory Affairs
Division of Medical Assistance
North Carolina Department of Health and Human Services

Kate Berrien, RN, BSN, MS
Pregnancy Medical Home Program Manager
Community Care of North Carolina

Beth St. Martin, RN
Pediatric Outcomes Manager
Community Care Partners of Greater Mecklenburg

Ms. Berrien gave a presentation about Community Care of North Carolina (CCNC)'s Pregnancy Medical Home (PMH) Program. The goal of the PMH program is to improve birth outcomes, improve quality of maternity care, and reduce costs in the Medicaid population. Some benefits of the PHM program include incentive payments from DMA and a designated pregnancy care manager to work with at-risk Medicaid patients in each PMH practice. The PMH program includes standardized risk screening on all OB patients as well as a standardized depression screening, reproductive life planning and referral for ongoing care in postpartum visit.

CCNC is required to report to DMA on multiple measures. Some of the quality metrics used include timing of entry to prenatal care, the rate of risk screening of pregnant women, and postpartum visit rates. Priority risk factors in screening combine medical, OB, psychosocial, and utilization issues. 50-70% of Medicaid patients have at least one priority risk factor; tobacco use and late entry to prenatal care are the most common. Patients with priority risk factors are connected to pregnancy care managers in local health departments. Finally, Ms. Berrian discussed opportunities to improve identification and management of psychosocial risk for children, including improved linkage between pregnancy and pediatrics using informatics systems and new models of collaboration.

Following Ms. Berrien's presentation, the Task Force discussed elements of the pregnancy medical home that are relevant to the Task Force recommendations on increased screening for psychosocial factors. She reiterated that the PMH program can not provide formal prenatal care to mothers who do not qualify for Medicaid (even if the children do). Ms. Carter asked if there is any continuity of care through private insurers. Dr. Zolotor will continue to discuss this with the steering committee and private insurers like Blue Cross Blue Shield.

Senator Barringer pointed out the importance of focusing on prevention in early childhood and that risk screening may not have much impact. Ms. Hundley Finley commented that the adolescents they interact with at Pregnancy Prevention Campaign see doctors very infrequently in their teen years and so primary care is a key point of both intervention and prevention in terms of conversations about sexual health.

Dr. Dodge mentioned that it is easier to identify women who are at risk when they have had a previous pregnancy and been involved with health care providers, emphasizing this setting as a priority point of intervention. Mr. Cain asked if there are evidence based programs already existing that identify at risk pregnant women. Many states focus interconception care on women that have had a poor birth outcome and prioritize Medicaid coverage for those women. Dr. Dodge emphasized that the focus needs to go beyond Medicaid coverage. He discussed the Durham Connects program which provides

universal home visits for expecting and new families in Durham. Durham Connects is funded by Durham County and The Duke Endowment and connects the family to a nurse who provides relationship and resource connections in the family's home. Dr. Dodge suggested a statewide replication of this program. It is currently being replicated in 4 rural counties where families do not have many formal resources like insurance. Mr.Wilson pointed out the challenge of providing home visits for Medicaid eligible women in less wealthy and/or less population-dense counties.

Next, Ms. Martin discussed implementing the Edinburgh screen in the pediatrictian setting and engaged the task force in a discussion around screening for adverse childhood experiences (ACEs). Dr. Stewart thinks that screening should happen in both the OB office and the pediatric office. Challenges to increased screening include a lack of reimbursement for many screenings and loss of Medicaid eligibility for mothers at 60 days post partum. It was noted that the Pediatric System Checklist is reimbursable by Medicaid. Dr. Stewart mentioned that there is some reimbursement for screening tools from Blue Cross Blue Shield and First Health Carolina. Dr. Dodge suggested a recommendation around providing screening to both Medicaid and non-Medicaid patients, regardless of reimbursement. Ms. Hundley Finley discussed having to use Title 10 funding on patients.

Dr. Stewart mentioned that Health Net is federal funding for people without insurance. People with Health Net can receive care management through CCNC and other health services. Health Net is in 40 counties in NC. Dr. Dodge suggested recommending that Medicaid contract with private investors for funding (i.e. social impact bonds or pay for success). Dr. Dodge, Dr. Zolotor, and Ms. Hundley Finley will have further discussion around social impact bonds and address the idea with the task force at a later time. Finally, Dr. Dodge susggested recommending researching the validity of various screening tools.

Dr. Zolotor wrapped up the discussion and indicated that the discussed recommendations would be brought to the steering committee for further discussion.

DISCUSSION OF POTENTIAL RECOMMENDATIONS

Dr. Zolotor outlined the recommendation discussion and voting process. The task force spent up to 10 minutes collectively discussing each individual recommendation before voting. The Task Force then voted on the draft evidence based program (EBP) recommendations. The recommendations were written on two large posterboards. Task force members were given "dot" stickers to place on the posterboards next to the recommendations they wanted to vote for inclusion in the report. Social norms change, data, awareness/commitment, and policy recommendations will be discussed and voted on in future task force meetings.

OVERVIEW OF NEXT STEPS

Dr. Zolotor thanked the task force for their hard work and noted that those members who were not in attendance would be sent a survey for an opportunity to vote. The next task force meeting will be held on September 25, 2014.