Notes from Summit

1) Monica Lowell--engaging the community--shared ownership

hospital perspective--vicious circle

what's outside the hospital (or clinic) walls that impacts health outcomes

it's not the clinical care that affects the health, it's these other factors

Latino: 32% are under 18, by 2050 one-third of US kids will be latino

poverty in worc for latinos is 40% vs 20% for overall

Belmont school--CHW working with families re: food/attendance

principal--absenteeism re: asthma esp high (missing 30-35d of school in early grades)

Children's in Boston had had programs since 2006, asked for consultation

used this as pilot at Belmont--trained CHWs (understand community, population, barriers)--going into home can really see the home triggers (mold, rats, dust)

this informed the Prevention-Wellness Trust Fund (PWTF) to expand the lessons to UMass/CHCs

healthy homes office, community legal aid (significant role re: housing--landlord absenteeism, families afraid to rattle the landlord and face eviction); public schools and Head Start program too; pedi ED and pulmonology

standard curriculum (on iPad for home use); CHW came to home with supplies (e.g. vacuum cleaner or mattress covers, medication boxes)

co-chair, regular meetings, interdisciplinary

2.5 yrs--1240 home visits, 85-100 kids getting meds in school, 133 to legal aid; decreased ED visits and admissions, rescue med refills reduced, schoool absenteesim reduced; "highly cost-effective"

tho funding for PWTF has decreased, UMass is continuing the program--making the business case for CHW visits to be reimbursable (e.g. ACO)--e.g. using claims data (health economist from national level giving technical advice)

"anchor mission"--3 pillars to address poverty--workforce development (youth job investment), procurement (invest in local economy), investment

Worcester ASK program--CHWs re: ACEs (trauma in children up to age 10)

2) Fin Mooney--evidence on home visiting

using student nurses

Chen, Alice, Emily Oster and Heidi Williams. 2016. "Why Is Infant Mortality Higher in the United States Than in Europe?." *American Economic Journal: Economic Policy*, 8(2):89-124.

Nurse Family Partnership (NFP) helps mom get education/jobs too

universal program--has advantages for moms/babies even from "socially advantaged" homes (in one study)

which is better, nurses vs CHWs?

"cost effectiveness"--how to assess this? who has researched this?

qualitative data is missing

does expanding a program to population level reduce the quality?

selection bias--those who choose the program may be more likely to do better

IMR hotspots--?minority "stress" from movement into more white/affluent areas? isolation in census tracts, ?access issues (transportation)

3) Sarah Weise--the 4th trimester

"lost to followup"

"optimizing health"--"ongoing process" vs single encounter

language--include midwives, family physicians as prenatal/delivering provider

the postpartum care team--it's a community--define who these are and what are their phone numbers

WHO: dyad visits at 3 days, 1-2wks, 6wks

ACOG: contact within 3 weeks 9everyone)

NICE: screen for resolution of baby blues at 10-12d

audience questions for first section

- home visiting--evidence mostly for first-time mothers (NFP)
- Healthy Families--first time under 21y (funding issue)
- targeting MAT mothers
- to move ahead, ?add to other programs such as Head Start

4) Craig Andrade--State overview

home visiting as the entry point to more comprehensive resources

structural racism--addressing the legacy of our country--the outcomes gap has existed for a long time and overrides other social factors

but training is still important re: how we collect and report data

PRAMS 2012-2015: racism affects stress, emotional/physical disproportionately for black women--for many of them, the first thing they think of each morning is that race is a part of their daily calculation for every interaction

2016 IMR: white 2.8, black 7.8 in MA

Title V block grant--the oldest state-federal partnership

cultural issues--e.g. re: sleeping--if we are giving different messages or seen as being judgmental, then families may not want to allow us into their homes

"marked" and "unmarked"--e.g HBCU--recognizing one's color immediately on waking up--sometimes the only person of color in Starbucks, being asked for ID when white people are not

how to reframe our language about HV if we have to target certain populations due to financial limitations vs universal HV--how to work with strengths and bolster resilience--partner authentically--"there are black mothers who are not having the success that black mothers are having"

5) Claudia Catalano and Katie Stetler--MIECHV--MHVI is the state name
identify and provide EBM HV--improve coordination of services for high need families
statewide system of care--the Welcome Family program

federal structure: it's voluntary and free, and must meet evidence-based criteria
HomeVee--website link
20 models meet the criteria and we have 3 of them
varying length and "dosage"
3 to 5 years ongoing vs one-time HV
weekly visits
29 community programs funded in MA
avoiding term of "at risk"--but what is alternative frame
home visiting is not a panacea--but one component of the system of care

Central MA has many home-based services already--how can we integrate and not duplicate these services

only one nurse-based program that is state-wide (5 locations)
Early Intervention Parenting Partnership Program--embedded in EI
Nurse, chw, social worker or licensed clinician

Welcome Family: universal nurse home visiting, as an entry point
90min nurse visit, and a follow up call
all the nurses are lactation counselors
universality=eligibility for all newborns, offer to all, reaches all regardless of SDH characteristics
grant-funded limitation re: expanding the model
how is language/culture addressed?
communication with infant provider (mothers know this better than their OB?)
sept 2013 start of this program--mixed methods evaluation
how well implemented, short term outcomes
outcomes--serving a younger/less educated/more publicly insured/more immigrant/WIC than eligible population; nurses identified unmet needs not already w/ services, 30% of referrals successful at f/u phone call (enrolled or waitlisted) although this has improved to 75% in the last year; nearly 3/4 of breastfeeding moms said WF helped this
performance measures monthly; learning collaborative quarterly to target
no long term data yet e.g. pp visit attendance, PPD identification, breastfeeding duration, WCV attendance, vaccine rates, reducing acute care costs

article in MCH journal--will send out to attendees

Worcester did not apply during the WF procurement? note: did we even know about this

6) Anna Fox Doherty--SomerBaby program
naming shared values--prioritizing equity--access and quality
collaborative perspective; multigenerational
environmental--housing perspective
"gateway city"--is there a definition for this?

originally described 11 cities across the state that are struggling regional economic centers. In 2009, the Legislature officially defined Gateway Cities in state law as any city with a population greater than 35,000 but less than 250,000, a median household income and a per capita income below the statewide average, and a rate of educational attainment of a bachelor's degree or higher that is below the state average.
Under the state's definition, 24 cities are entitled to call themselves Gateway Cities and qualify for certain state grants, tax credits, and investments in economic and community development. The list of 24 includes Springfield, Worcester, New Bedford, Holyoke, Lawrence, Quincy, Lowell, and Fall River.

By All Means education sector and health sector--bridging these (Harvard School of Education)
universal kindergarten readiness

SomerPromise-HHS (mayor's office)--close gaps/duplication of services in supporting families--cradle-to-career community change collaborative

SomerBaby--learning collaborative--outreach of public schools--colocated
identify families as early as possible, more of single-visit model
pipeline--connect to public schools and resources
high mobility rate--lack of basic info about community resources
changing the thinking that pre-K is only in family realm--how can the community support families
creating habit-forming in those critical first few months of identifying oneself as a parent, setting priorities
single point of entry connection for the city--how can SomerBaby do this? website for "somervillehelp.org"

doulas as a resource--how many does Somerville have?

their community health report has a whole section on prenatal/infant care

stores/laundry information

funded thru general fund for city--mayoral and superintendent priority--they come together monthly and SomerBaby is a big topic every year, metrics to line up with budget cycle
Kiwanis club and church/temple support some of the bag materials
<$100K including visiting --saw about 130 families
single visit as soon as possible, followup call, sometimes 2nd visit
communication--referrals but not ongoing concerns

7) Sheilah Dooley--Pernet -- 60 years in Worcester

MDPH programs--High Risk Infant, Family Home Visiting (home advocates), then PPSP (CHW and RN model), Healthy Families MA, 3rd party and medicaid reimbursed nursing visits

HF MA--14 critical elements, partners with MSPCC, funding got cut for Pernet

no medical director, but each client's medical orders--reimbursed up to a point, 1-3 visits covered (not quite enough re: relationship building)

HomVEE--the evidence of effectiveness

MIHOPE--evaluation of the four main HV models

Pernet--trying to assess parent job/education needs--assessing the family system not just the nursing assessment

what is their evaluation--they don't have funds for extensive evaluation

1 yr's data:96 mothers in a year, 18 preterm, avg 3 risks, only about 1/3 go to PPV at 6wks, almost all referred to EI, one DCF removal, no hospital readmissions, nearly 1/3 addressed education/job training

$200 per nursing visit, paid for by health insurance, EI assessment is free

at 2500 births/yr, cost is $500K

fathers' program

being a HV is an art, don't want to barge in

how do we address that the professionals are white and the clients aren't?

Seattle--central intake, everyone who was pregnant got enrolled

Funding SubGroup notes

Sara Shields
Tinamarie Fiorini from Springfield--integrated BH in FP/pedi/OB practices
Anna Doherty, Somerville HHS--Essentials for Childhood project from DPH--municipal checklist/inspiration list--forming a children's cabinet with dedicated local public dollars
Pam Dolan-Smith--SVH nurse manager--oversee MBU
Ha Toohey--FHCW advocate
Luz Muller--FHCW advocate/case manager perinatal to age 2
Ed Doherty--MOD
Katie Stetler
Mary Ann--DCF

SomerBaby--bringing city and schools together
insurance/ACO--it doesn't reduce immediate cost but rather the longer term population cost
IEPs cost a lot of money--how is this an IEP prevention program--could we figure out the math
Somerville--more and less explicitly--this is high school graduation; schools are better funded than social services/Early Childhood so how could they own some of this early needs--it shouldn't be new what the 5 year olds are needing--it's not about academics at birth but that health is so foundational

billable service--for early discharge at least, it's paid for--but now there aren't enough nurses to do this, only high risk are referred (Pam)--but the agencies feel it's too costly to do these, not paid enough in reimbursement

multidisciplinary--could there be a team that could decide who is the best person to go into the home
but insurers won't pay for CHWs at this point
per Katie--MH says theory is great, but they're not going to pay for additional services unless show hard health outcomes in our own programs/our own specific services

the ACOs have their own DSRIP funding and have some money for pilot programs
partner with colleges--research arm for this

could the home visit be the PPV--but who would employ the nurse for this (but does it have to be a nurse, focus on different tiers and could CHWs do more?)

SomerBaby--it is blended, it has to be a mix of services and funding sources

Salem, MA--mental health into public schools and Oakland/Alameda also--children's cabinet
taxing such as for community preservation funds

funding--what is the return on investment? NFP data
is there a state or city that has best practices?
Healthy Families--Children's Trust and Tufts evaluation team
Durham Connects (Family Connects)--RCTs showed cost-savings in reducing ER visits (1-3visits up to 12wks postpartum)

nursing schools? RN to BSN or masters' program to be able to be billable/licensed
could a nursing student do a phone call (study cited by Fin)

preK--supporting early needs saves $7 for every $1 spent (special ed, police issues, earning potential)

EI was initially $18mill investment, now about $29mill--saves the state $18 per $1 invested

SBHC program

what data do insurers gather re: the early discharge visits?

Mass Budget Center--?pull up by health indicator or age group--could we ask them to look at this issue

if a woman stays another night, what does that cost the insurer vs the hospital or is it all part of a DRG or lump sum?

eligibility for an early discharge visit in insurance companies
billing for outpt LC visit w/o doctor's order

MH --> ACO, so what would it take to get them to cover this?

state regulation for HV-->take out the 48 and 96hr rules, get the reimbursement to be reasonable

legislative solution--> health mandate--could we advocate for this--write a policy to get MOD to advocate for this

"strong moms, healthy babies" is MOD "tagline"

legislative women's caucus
PPD issues

say that at the very least, substance using moms get these visits (EI is automatically seeing these families)
"plans of safe care"

anxiety issues in preK-->maternal mental health, parental stressors

foundation grants--partnership with Head Start programs (family advocate model, blending wraparound and education programs)

early Head Start--federal income-eligibility programs are out of sync with cost of living in Boston area so needy families are not getting the services

what about resources from organizations like Zero to Three? or NICHQ?
connecting with tech-savvy people
Katie Stetler knows some of these resources

Center for Developing Child--brain science in young children research--pair this with home visiting education to teach parents to become their own experts

ACOG's 4th trimester

Community/Consumer subgroup notes

framework for communication with Hispanic community

what should/could be included

objectives: healthy mother/baby and resilience

audience: the 2500 Worcester residents (6000 births in both hospitals)

messages: screen, get more services to those who need it
1-3 day phone call to every family--including interpreters
scripted interaction: the MDs, social media, TV presentation to tell families to expect this phone call--a trained paraprofessional who could cover specific areas, as first contact--refer to EI for next contact
preparation/skill set for these scripts
what are the agencies that are already involved?
Pernet, EI could do some of this? could do within 10 days
any of these families referred to these agencies get an intake visit, and then decide re: eligibility--transitions for any family who leaves the agency no matter the length of the involvement, can refer to other agencies
EI has to see every family that is referred
Tina G--look at the census tract map and start with those
portal contact--to recognize the number so they'll answer the phone

EI staff--PT/OT/speech/nurses/social workers/developmental specialists--they can bill insurance if one of these disciplines is involved
VNA nurse who used to do home visits--only difference is no stethoscope
they are centered around baby, so would need some training around mom's PPD
needs to do this screening but already shifting somewhat to family/parent services

outreach strategy: small gift for mom as incentive to talk on phone, accept home visit

what about outlying areas like Southbridge? how to access lists for services in their home area for further evaluation

can EI absorb additional visits? their services are lower cost re: not nursing-level but if going to call it nurse visit then will need better reimbursement--could nurses do this as practicum

Data Subgroup notes

finding a more precise explanation for why IM is in these pockets

we've looked at census tract level, but it might be more at street/neighborhood level
would need to map on address level

collecting qualitative data--an area that's missing in HV literature?
can be harder to get
families may feel this is more intrusive
how to do this through HV nurses

small numbers make it harder to do analysis
use preterm birth as a marker instead

how to measure/act on structural racism/minority stress--the CHIP

are there environmental factors? what else could be going on? e.g. lead, asbestos, old industrial buildings
Dr Alker--the mapping for vulnerable areas did include those near toxic sites or highways, but that is not where the IM mapped to
?revitalization projects and groundwater contamination
has the city evaluated this?