Notes

Children and Youth Behavioral Health Work Group – Prenatal through Five Relational Health (P5RH) Subgroup

August 7, 2024

Glossary of Terms

CHW: Community Health Worker
DCYF: Department of Children Youth and Families
ESIT: Early Support for Infants and Toddlers program
H2H: Hospital-to-Home
HCA: Health Care Authority
IFSP: Individualized Family Service Plan
NICU: Neonative Intensive Care Unit
PMAD: Perinatal Mood and Anxiety Disorder
PMH: Perinatal Mental Health

Meeting Topics

Announcing the new P5RH co-lead
Presentation: Hospital-to-Home Systems Change, Tiffany Elliott (Northwest Center)
Collaborative Discussion of P5RHS workforce priorities

Discussion Summary

Announcements

1. The group has a new co-lead: Sandra Diaz, Washington State Association of Head Start & ECEAP!

Hospital-to-Home Care Model & Systems Change

Tiffany Elliott (Northwest Center)

1. Washington State Landscape:
    a. There are significant ethnic disparities in preterm births and outcomes.
    b. There is a higher level of Neonative Intensive Care Unit (NICU) care concentrated in urban areas.
    c. There are maternity care deserts affecting certain regions of the state.
2. The preterm brith rate across different ethnicities and geographical areas is about 10%.
    a. 1.3% of all live births in Washington from 2020-2022 were among the American Indian/Alaska Native population; however, this population has the highest preterm birth rate at around 13%.
    b. The Greater Columbia area has the highest preterm birth rate, at 17.6%.
3. NICU distribution:
    a. There are 27 NICUs across the state, with 585+ beds.

   b. The highest level of care is Level IV, and there are 5 hospitals across the state that provide that level of care.
4. Maternal Health Deserts in Washington state:
   a. People need to travel long distances to care.
   b. The care needs are high, and among certain ethnicities and people in maternity health deserts, there are higher levels of preterm births, in addition to having to travel further.
   c. Additionally, the number of birthing hospitals is decreasing.
5. WA DOH neonatal levels of care among birthing hospitals in WA (2022) map.
   a. In addition to disparities in access to care, there is not a good transition from higher level NICUs to lower level NICUs, so families are spending weeks to years traveling and staying at hospitals far from home.
6. Psychosocial Challenges for NICU Parents:
   a. Families experience social and emotional well being challenges when their baby needs high level medical care.
      i. NICU parents are at higher risk of developing Perinatal Mood and Anxiety Disorders (PMADs), which creates obstacles to sucessful bonding and attachment; this in turn increases the likelihood of PMAD, which has negative implications for babies and parents.
      ii. This cycle continues, unless it can be broken by embedding perinatal mental health concepts within that setting.
   b. The cycle of creating bonding and attachment around feeding is also disrupted.
      i. Infants go home still learning how to feed, and often require special feeding considerations.
      ii. Parents equate success to their ability to feed their baby.
      iii. Getting access to timely care and resources after discharge is very regionally and hospital dependent.
7. Why does this matter?
   a. By the time a family arrives back home, it is 90% likely that one or both parents are suffering from PTSD or postpartum depression or anxiety.
   b. Data shows that only about 1 in 5 babies with the preterm diagnosis actually gets into services and has an Individualized Family Service Plan (IFSP) within six months of their birth.
8. What can we do?
   a. It is important to address the service cliff between NICU discharge and home, as it challenges parental emotioinal well-being.
   b. It is critical to make timely referrals and provision community therapy services for infant development, as this has been shown to reduce parental stress, improve parent-child attachment, supports better infant health outcomes, and may reduce overall medical expenditures.
9. Northwest (NW) Center created the Hospital-to-Home (H2H) care model in 2015.
   a. The foundation of the H2H model is that support for emotional wellbeing can be embedded into supports for feeding and development as part of home visiting to provide holistic care.

   b. The systems change work is to address the barriers, gaps in care, and inequities that exist for infants and caregivers transitioning from the hosptial into Early Support for Infants and Toddlers (ESIT) and community therapy services throughout Washington state.
10. There are three pillars of the H2H systems change: Hospital, Home, and Advocacy.
    a. Hospital involves connecting with referral sources to educate hospitals about ESIT services, and support communication and information sharing.
    b. The home pillar revolves around building workforce capacity in Perinatal Mental Health (PMH), feeding, growth and development, and developing a community of practice and replication sites.
    c. The Advocacy side involves convening a PMH Task Force, presenting and attending conferences, and supporting state-wide policy and system change.
11. Evolution of hospital-to-home systems change:
    a. Most of this work has been unfunded or underfunded via subsidized piecemeal grants across different systems.
    b. The biggest source of funding came last summer from a sole source contract with the Department of Children Youth and Families (DCYF) and the Strengthening Families Washington PMH grant.
12. Building Statewide Provider Capacity:
    a. NW Center has been building statewide provider capicity through a three-day training involving PMH; supporting infant feeding, growth, and development; and special topics such as communication with medical providers.
        i. There have been four cohorts of providers attending this training, with close to 300 individuals trained.
    b. NW Center is also using the ECHO model to perform peer learning.
        i. Three different ECHO series have been offered, with 17 sessions across 25 learning hours, and 155 unique participants.
    c. Providers who have participated in these trainings span various disciplines and 80% of the counties in Washington state.
13. The H2H Task Force is funded by the PMH Community Capacity Building grant.
    a. The purpose of the task force is to engage diverse stakeholders statewide to identify strengths and needs, reduce barriers to care, increase access to support services, expand stakeholder engagement, and enhance community capacity to address perinatal mental health by educating those who interact with families in various contexts.
14. Policy and Funding Considerations:
    a. NW Center would like the P5 subgroup to consider how resources can be pooled, and how to create a sustainable provider capacity training in different ways, including a recurring ECHO series.
    b. Additionally, it is important to consider how to address service delivery across different hospital settings, and focus on the transition from the hospital into home and into the variety of services.
    c. Another consideration is the aggregation of data across systems and the creation of a statewide program to support transition, enrollment and support.
    d. Family support needs are in the hands of the hospitals and determinations around funding for staff that can provide phone calls and support to the families after discharge.
15. Contact the H2H Systems Change Team:

a. Email:
    i. traininghospitaltohome@nwcenter.org
    ii. hospitaltohomesystemschange@gmail.com
b. Website: http://www.hospitaltohomesystemschange.org/
c. Phone: 206-437-9057

Collaborative Discussion of P5RHS workforce priorities

1. P5RHS Recommendation Criteria:
    a. Community-Informed. *Prioritizes approaches and ideas that strengthen child and family well-being, as shared by members of impacted communities and those that serve them,*
    b. Centers and advances equity. *Holds the promise to measurably close the gaps in health access and outcomes utilizing anti-racist and anti0oppressive practices.*
    c. Realistic and achievable. *Size and scope are appropriate for Washington's budget context policy landscape.*
    d. Capacity. *Implementation could be described and executed well and quickly.*
    e. Strengthens/Transforms. *Helps to build, sustain, or transform foundational systems.*
    f. Fit – *Fits within the P5RH Subgroup & CYBHWG scope and avoids duplicating the work of other groups.*
2. There are three topic groups for consideration:
    a. Continuing priorities.
        i. Expanding Early ECEAP slots.
        ii. Increasing investment in IECMH-C
        iii. Complex Needs Funds.
            - DCYF is still discusing decision packages and there will be an update in about a month when they are due.
            - The complex needs ask and need is still massive and beyond the available funds up to this point.
        iv. Maternal mortality review recommendations.
            - The P5RH subgroup will be hearing about this topic at the 8/21 meeting.
        v. Community health workers (CHWs) in early childhood.
            - The BHI subgroup is looking at CHW reimbursement rate enhancement.
        vi. Maternal support services
    b. P-5 supports for kids & families.
        i. Hopsital-to-Home systems change
        ii. Fatherhood supports
        iii. WA Plan of Safe Care
        iv. Maternal supports
    c. Workforce supports.
        i. Alternative-payment model for IECMH
            - Inclusive of quality assurance
        ii. Family therapy rates
        iii. Caregiver MH screening rates
        iv. Early childhood provider care coordination/referral network
        v. Early relational health training for providers

vi. Burnout & attrition (recruitment & retention)
    - Hoping to address this through the HCA IECMH Statewide Tour Report and UW Barnard Center's People Powered Workforce initiative.

vii. Sustainable funding for P5 initiatives – consumer tax

3. Prompts for discussion:
    a. Does this [topic] meet the P5RH subgroup criteria for a recommendation?
    b. If not, what could be added/changed to make it a viable recommendation?

Look Ahead: 24/25 Schedule

Next meeting: 8/21/2024 12-1:30PM

P5RHS PRINCIPLES

Est. 2019

1

Hear the voices of families and proactively embed family voice in recommendations where possible.

2

Close health disparities, fueled by system oppression and institutional racism, for families of color.

3

Provide immediate relief for behavioral health needs for families, especially those who are most vulnerable.

4

Focus on the needs of children and their families particular to the prenatal through age five phase of life, during this time of great potential and vulnerability.

P5RHS RECOMMENDATION CRITERIA

COMMUNITY-INFORMED
Prioritizes approaches and ideas that strengthen child and family well-being, as shared by members of impacted communities and those that serve them.

CENTERS & ADVANCES EQUITY
Holds the promise to measurably close the gaps in health access and outcomes utilizing anti-racist and anti-oppressive practices.

REALISTIC & ACHIEVABLE
Size and scope are appropriate for Washington's budget context policy landscape.

CAPACITY
Implementation could be described and executed well and quickly.

STRENGTHENS/TRANSFORMS
Helps to build, sustain, or transform foundational systems.

FIT
Fits within the P5RHS and CYBHWG scope and avoids duplicating the work of other groups.

P5RH 24-25 TOPICS TO DATE

Continuing Priorities

- Early ECEAP (0-3 Early Childhood Education & Assistance Program)
- (IECMH-C) Infant & Early Childhood Mental Health Consultation
- Complex Needs Funds
- Maternal mortality
- Community Health Works in early childhood

P-5 Supports for Kids & Families

- Maternal supports
- WA Plan of Safe Care
- Fatherhood supports
- Hospital-to-Home Systems Change

Workforce Supports

- Alternative-payment model for IECMH
- Family therapy rates
- Maximum timeline for licensing
- Burnout & attrition (recruitment & retention)
  - Reflective supervision
  - Administrative burden
- Early childhood & IECMH provider training
- Caregiver MH screening rates
- Provider care coordination
  - Integrated ERH

https://docs.google.com/document/d/1cqZd3xaOdBSSccKSOeZSSSnumG4f8bb7AQDLUE71VmA/edit?usp=sharing

Hospital-to-Home Care Model & Systems Change

Tiffany Elliott, MS, CCC-SLP, CNT, IBCLC
Sara Circelli, MA, IMH-E, PMH-C

P5RH subgroup meeting: August 7, 2024

1

Overview

- Hospital-to-Home Care Model
- Hospital-to-Home Systems Change
- Funding, advocacy, and next steps

2

Terms Used During this Presentation

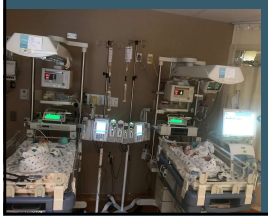
- NICU – Neonatal Intensive Care Unit (infants need this ICU level of care for variety of reasons - prematurity, low birth weight, birth trauma, or genetic anomalies)
- ESIT – Early Support for Infants and Toddlers (Name for Part C of IDEA services in Washington State)
- Perinatal – Refers to the time from conception to a year postpartum
- PMADs – Perinatal Mood and Anxiety Disorders
- PFD – Pediatric Feeding Disorder
- Hospital-to-Home (H2H) Care Model – interdisciplinary approach to ESIT services for infants discharging from the NICU integrates support for the perinatal mental health of parents within therapeutic support for the infant's feeding, growth, and development

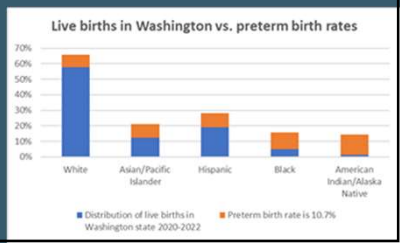
We will use the terms caregiver and parent interchangeably, recognizing that not all individuals who fulfill parenting roles are biologically related. We acknowledge that all birthing people do not identify as women and mother.

3

Washington State Landscape: Realities & Challenges

- Ethnic disparities in preterm births and outcomes (also see WTN)
- Higher level NICU care is concentrated in urban areas
- Maternity care deserts affecting certain regions of the state





4

Preterm Birth Rates in Washington State

Health Disparities relate to Ethnicity and Geographic location

Distribution of live births in Washington 2020-2022

57.6% White, 12.4% Asian/Pacific Islander, 19.0% Hispanic, 5.0% Black, 1.3% American Indian/Alaska Native

Preterm birth rate is 10.7%

American Indian/Alaska Native (13.0%) HIGHEST
Blacks (10.7%)
Hispanics (9.2%)
Asian/Pacific Islanders (8.9%)
Whites (8.2%)

The Greater Columbia area has the highest rate at 17.6%

American Indian/Alaska Native infants 2X more likely than White infants to be born preterm

5

Washington State NICU Data

27 NICUs, with 585+ beds
Level IV (highest level of care) – 5
- Multicare Tacoma General Hospital – 70 Beds
- Providence Sacred Heart (Spokane) – 61 Beds
- Seattle Children's – 32 Beds
- Swedish First Hill (Seattle) – 75 Beds
- UW Montlake (Seattle) – 42 Beds

Level III – 12
Level II – 10

6

Maternal Health Deserts in Washington state

Areas without access to birthing facilities or maternity care providers

Number of birthing hospitals decreased by 30% from 2019 to 2020

1,002 babies were born in maternity care deserts, accounting for 1.2% of all births

While 2.9% of babies were born to women in rural counties, only 0.7% of maternity care providers practice in rural counties.

Women with one or more chronic health conditions have a 58% higher chance of having a preterm birth compared to those without any chronic health conditions.

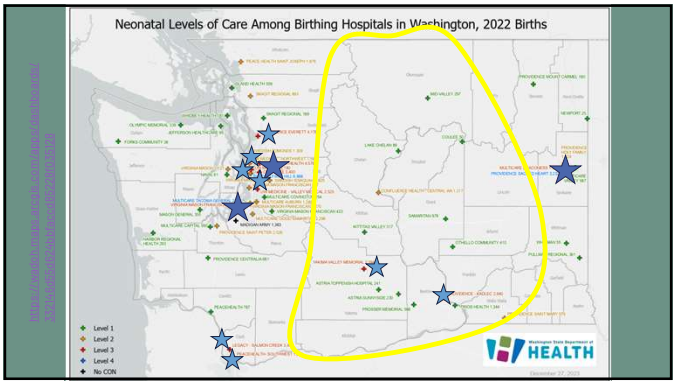
34.9% of women have one or more chronic health conditions

7.7% of counties face a high burden of chronic health conditions and a high rate of preterm birth

Among BIPOC birthing individuals, those in areas with high socioeconomic vulnerability have a 19% greater likelihood of inadequate prenatal care compared to those in areas with low socioeconomic vulnerability.

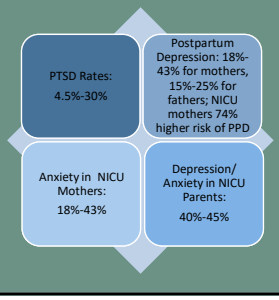
1.6% of BIPOC individuals did not receive prenatal care

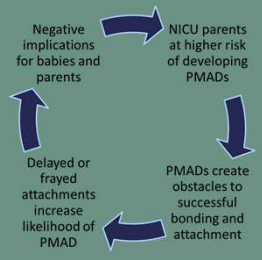
7



8

Psychosocial Challenges for NICU Parents





9

Psychosocial Feeding Considerations for post-NICU discharge

- Parents equate success to ability to feed their baby
- Infant stable to go home but still learning feeding skills
- Need to "de-NICU-tize"
- Learning to follow infant cues rather than medical cues
- Skilled service providers can remind parents to focus on "inchstones", rather than milestones
- Going from 24 hour care to managing it all on their own

www.feedingmatters.org/pfd-alliance/advocacy/

More info: www.feedingmatters.org/what-is-pfd/

10

Addressing the Service Cliff: Why does this matter?

By the time a family arrives on your (community) doorstep, it is 90% likely that one or both parents suffer from PTSD or postpartum depression or anxiety.

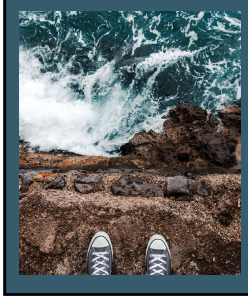
One or both parents may be actively grieving the loss of a "normal birth" and "normal baby."

Respectful acknowledgement and proper labeling of the difficulties helps build attachment and supports development/feeding outcomes

Others may not have mentioned PMADs

11

Addressing the Service Cliff: What can we do?



The service cliff during NICU discharge challenges parental emotional well-being, making timely referral and provision of community therapy services for infant development is critical.

- Reduces parental stress
- Improves parent-child attachment
- Supports better infant health outcomes
- May reduce overall medical expenditures

12

Service Delivery Opportunities & Care Model

Community-based infant feeding and developmental therapy can support caregivers' emotional well-being by:

- Providing therapy in the natural environment (e.g., home)
- Offering family-centered care
- Connecting families to community resources

Hospital-to-Home Care Model (Early Support/Part C Services)

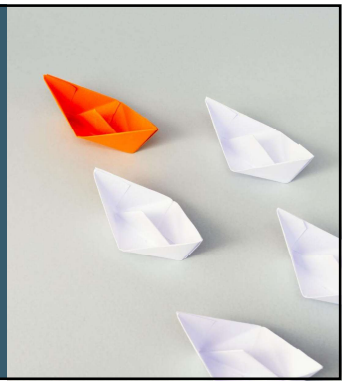
- Specially trained team
- Rapid follow-up post discharge
- Interdisciplinary team
- Understanding and supporting of Perinatal Mental Health
- Clear communication with families and medical providers

Care Model Continuum Handout for Providers

13

Mission of Hospital-to-Home (H2H) Systems Change Work

Address the barriers, gaps in care, and inequities that exist for infants and caregivers transitioning from the hospital into Early Supports (ESIT) and community therapy services **throughout Washington state.**



14

Hospital-to-Home Systems Change

improving systems for families & programs

Hospital	Home	Advocacy
▪Connecting with referral sources to: • Educate hospitals about ESIT services • Support communication and sharing of information • Understand the landscape throughout the state	▪Building workforce capacity in PMH, feeding, growth & development ▪Developing a community of practice ▪Supporting development of replication sites	▪Convening PMHI Task Force ▪Presenting at conferences ▪Supporting state-wide policy and system change

Perinatal Mental Health

15

Evolution of Hospital-to-Home Systems Change

- **2015** – Hospital and community providers collaboration started to address service cliff between NICU and home.
- **2016** – Department of Health Nutrition Contract convened stakeholder meetings.
- **2018** – Northwest Center ESIT program, began trialing processes that evolved into the Hospital-to-Home care model.
- **2020** – ESIT adopted a qualifying diagnoses list that included prematurity, low birth weight etc.
- **2021** – Initial 3-day Hospital-to-Home training launched for Washington state feeding teams
- **2022** – Training was offered to second cohort of feeding teams.
- **2023** – 2 more trainings and launching of ECHO series
- **2024** – Hospital-to-Home Perinatal Mental Health ECHO series and Convening of Hospital-to-Home Perinatal Mental Health Task Force

16

Building Statewide Provider Capacity Improving Care for Families *Creating Systemic Change*

Hospital-to-Home 3-Day Training

- **Day 3** – Special Topics – such as communicating with medical providers, tube feeding, joining with families, and screening for PMADs
- **Day 2** – Supporting infant feeding, growth, and development
- **Day 1** – Perinatal mental health

ECHO Series

The ECHO model is based on the principle that adults learn best from peer-to-peer learning opportunities and through discussions of real-life scenarios.

Each session includes a panel of Subject Matter Experts, a didactic presentation followed by discussion of a de-identified case study.

Topics have included:

- Grief
- Supporting Oxytocin
- Non-birthing caregiver/fathers
- Experiences that increase risk

17

Between 2021 – 2024:

Hospital-to-Home Training:

- 4 cohorts of providers attended the 3-day training.
- Close to 300 individuals were trained.
- Ongoing requests for additional trainings for new providers.

ECHO Series:

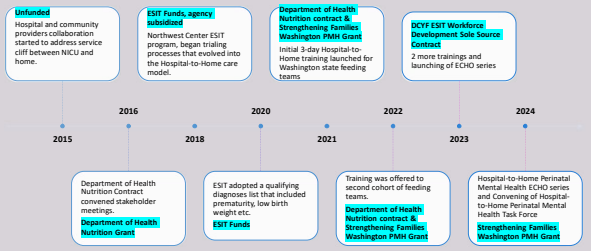
- 3 different series were offered.
- 17 sessions conducted.
- Total of 25 learning hours.
- 155 unique participants.

Representation:

- Various disciplines.
- 80% of counties in Washington state.
- Attendees from outside of Washington, including:
  - U.S. states: Alaska, Colorado, Nevada, New Mexico, Ohio, Texas.
  - Countries: India, Kenya, and South Africa.

18

Evolution of Hospital-to-Home Systems Change



19

Hospital-to-Home Perinatal Mental Health Task Force

Funded: By the Perinatal Mental Health Community Capacity Building grant

Purpose: Engage diverse stakeholders statewide to identify strengths and needs, reduce barriers to care, increase access to support services, expand stakeholder engagement, and enhance community capacity to address perinatal mental health by educating those who interact with families in various contexts.

Focus: Community Asset Mapping, Needs Assessment, & Data aggregating

20

What did we hear from the Task Force?

Community Provider Capacity	• Need to support confidence and competence of providers. • Cost of sending staff to trainings, reduces service provision time. • High turnover rate among staff.
Service Disparities	• Differences in how services are provided throughout the state.
Billing Issues	• Confusion working with Medicaid. • Challenges billing for caregiver mental health services when the infant is the patient.
Data Management	• Difficulty in aggregating data due to different systems.
Family Support Needs	• Assistance in navigating complex systems. • Support for non-birthing caregiver

21

Policy & Funding Considerations

Community Provider Capacity	• Sustainable funding to train providers for live and asynchronous learning • Community of practice (recurring ECHO series)
Service Disparities	• Primer for hospitals and community providers on best practice for these dyads related to PMH and potential feeding/development • Deploy mentors across programs / counties to reduce burden
Billing Issues	• Reduce barriers in ESIT to bill Medicaid • Clarifications on billing mental health services when the infant is the patient.
Data Management	• Aggregate data across systems (same time frame and data parameters) • Consider state-wide program to support transition/enrollment/support, refer to EHDDI program as an example
Family Support Needs	• Follow-up phone call / support (right now dependent on each hospital or program and very inconsistent, low priority) • PMAD screening of birthing and non-birthing caregivers

22

What is next?

- 3-DAY TRAINING
- ECHO SERIES
- TASK FORCE MEETINGS
- ONGOING CONSULTATION
- ADVOCACY

23

Contact Us: Hospital-to-Home Systems Change Team

Email: traininghospitaltohome@nwcenter.org and hospitaltohomesystemschange@gmail.com

Website: http://www.hospitaltohomesystemschange.org/

Phone: 206-437-9057

24