WASHINGTON CHAPTER
AMERICAN ACADEMY OF PEDIATRICS
Incorporated in Washington

Strong Families, Early Supports

Summary Report

September 2023

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Background

The Washington State Early Childhood Comprehensive Systems (ECCS) Initiative is a five-year funding opportunity to promote the creation of integrated maternal and early childhood systems of care. ECCS strives to use a prevention approach to promote early developmental health and family well-being during the prenatal and early childhood period, and specifically looks to include the health care system in these efforts. The goal is to advance the provision of equitable, integrated, sustainable, comprehensive, culturally appropriate, evidence-based, and family-centered access to care for young children and families, prenatal to 3, in Washington State.

On September 12, 2023, about forty thought leaders, including individuals from the Department of Health, the Department of Children, Youth, and Families, the Health Care Authority, community organizations, a Managed Care Organization, Early Relational Health programs, a state legislator, physicians, and parents gathered to advance the ECCS goals. The WCAAP Summit, entitled Strong Families, Early Supports, had several objectives:

- Build strong and committed partnerships.
- Coalesce around a shared vision for health integration, namely "Strengthening the foundations of lifelong health through equitable, integrated, family-centered systems of care for young children and families (prenatal to three) in Washington State."
- Develop a shared understanding of the current state and opportunities for change.
- Develop agreements and initial action plans for advancing the vision.

Washington Families are strong

Health care providers reflect on the strengths of their patients

"Families are resilient."

"Engaged fathers."

"Family and Community Supports."

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Provider Landscape Scan

WCAAP surveyed pediatricians, family physicians, prenatal providers including obstetrician/gynecologists and midwives, community health workers and advanced practitioners from around Washington to assess the current state of opportunities and obstacles in providing care to the prenatal to 3 population. The scan reflected the well documented burnout of Providers. Physicians find themselves stretched thin, unable to provide the supports, resources, and education their patients need. Providers also reflected on a fragmented, siloed healthcare system with inadequate, infrequent, and uncoordinated interactions with the broader early childhood system.

Top 4 challenges Healthcare Providers reported children and families facing

1. **Parenting Education** - challenging behaviors, sleep, discipline
2. **Parental Support** - parenting groups, fathers' groups, breastfeeding support, postpartum mood disorders, mental health
3. **Basic Needs** - food, housing, transportation
4. **Vaccine Hesitancy/ Misinformation**

Top 4 barriers preventing Healthcare Providers from addressing these issues

1. **Lack of Time**
2. **Resource Limits** - I know where to send families and would do it, if there were enough resources to serve them
3. **Lack of Staff Support**
4. **Lack of Knowledge** - where to connect families

"We have a severe shortage of support staff, staff burnout is high, and not enough time."

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Landscape Scan

Healthcare Provider Interactions with the broader early childhood systems

"Difficult knowing who to contact and how."

"These programs are overwhelmed and difficult to communicate with in a smooth manner."

"We interact with them peripherally only. Time is the main challenge."

"No time to interact with these systems."

"I feel our system could be more integrated. Our contact with outside systems is limited. It is helpful when it happens, but it is not consistent. Our collaborative care managers can be a bridge for us sometimes."

"Not enough support staff to keep up on available programs or to help families connect or stay connected with programs."

Washington State Department of HEALTH

Washington State Department of Health leadership shared about current programs and initiatives focused on young children and families.

Perinatal Health

- Perinatal Health Systems Development – Title V
- MCHBG
- WA State Perinatal Collaborative & Quality Improvement
- Centers of Excellence for Perinatal Substance Use
- Pregnant, Parenting, Children, Families and Substance Use Workgroup
- Maternal Mental Health Access (MaMHA)
- Maternal Mortality Review Panel (MMRP)
- Birth Equity Project
- WIC Nutrition
- Lactation Promotion

Early Childhood Health

- Child Health Systems Development – Title V
- MCHBG
- Child Well-Visit Promotion
- Pediatric Community Health Worker Training (early relational health)
- Early Childhood Comprehensive Systems: Health System Integration Initiative
- Early Childhood Developmental Health Systems Initiative
- Essentials for Childhood
- Watch Me Grow WA (Child health mailers)
- Childhood Immunization
- Childhood Lead Program

Children with Special Health Care Needs

- CYSHCN Health Systems Development – Title V (MCHBG)
- Medical Home Partnerships
- CYSHCN Nutrition Network
- CYSHCN Communication Network
- Maxillofacial Review Boards
- Neurodevelopmental Centers of Excellence

Screening & Genetics

- Newborn Screening
- (Public Health Lab)
- Early Hearing Detection, Diagnosis, & Intervention
- Strong Start Universal Developmental Screening Data System

Surveillance & Data

- Maternal and Child Health Needs Assessment
- Pregnancy Risk Assessment and Monitoring System (PRAMS)
- Child Wellness Survey (0-5 years—in development)
- Birth Defects Surveillance
- Vital Records (Birth Data)

Washington State Health Care Authority leadership shared about current initiatives focused on pregnancy, infancy, and early childhood.

IECMH

- Evidence Based Practices Institute
- Mental Health Referral Service (MHRS)
- Wraparound with Intensive Services (WISe) for Birth – 5
- Mental Health Assessment for Young Children (MHAYC)
- IECMH Toolkit
- IECMH Statewide Tour

Parent Supports

- Family planning/Sexual and Reproductive Health
- Parent Child Assistance Program (PCAP)

Maternal Health & Development

- 12 months comprehensive postpartum coverage
- Midwifery Led Care/midwifery models
- Medicaid Finance for Doulas
- First Steps Maternity Support Services (MSS), ICM and Child Birth Education

Perinatal Mental Health

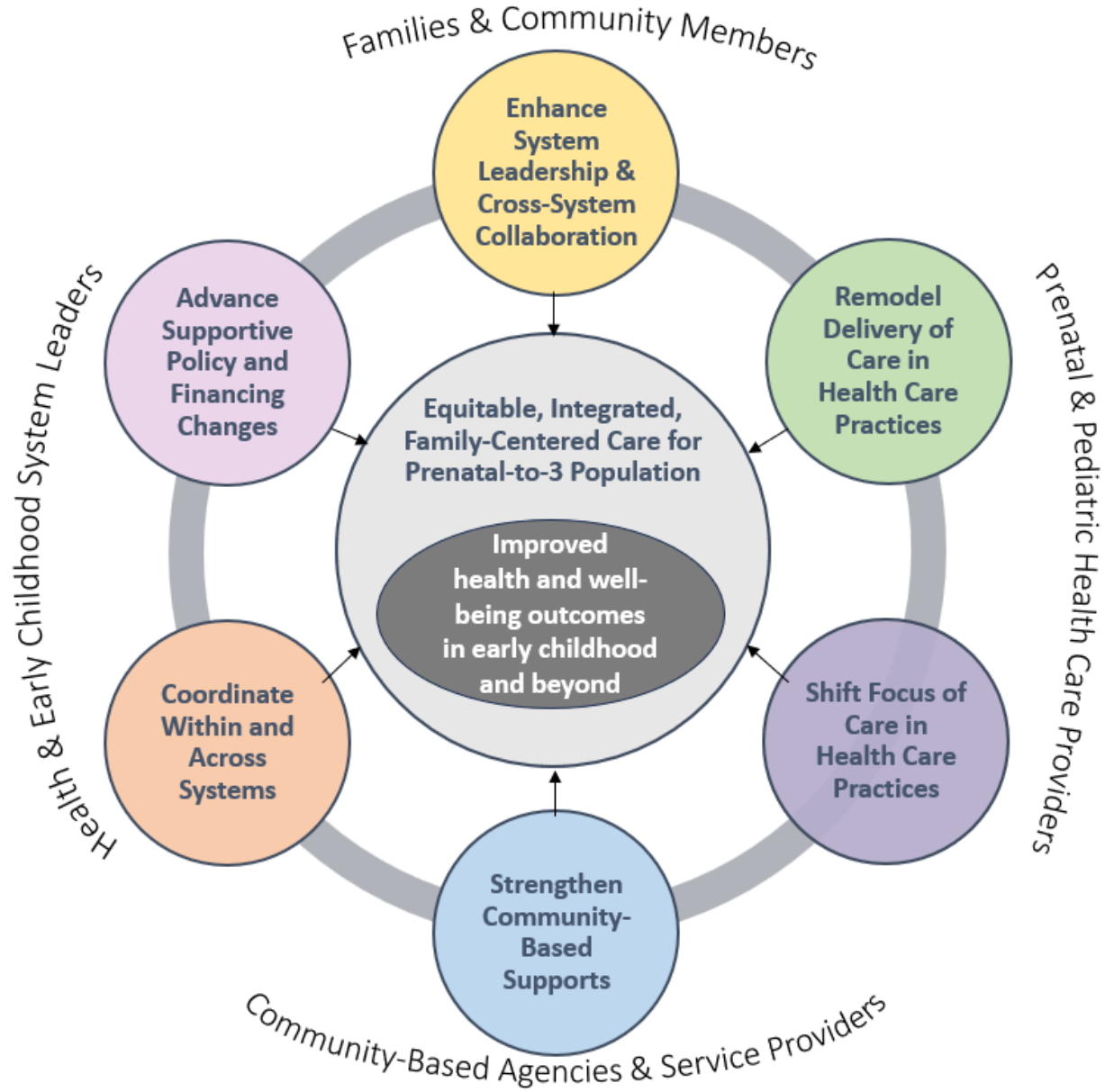
- Perinatal Psychiatric Consultation Line (PPCL)
- Perinatal Support Washington (PS WA) Warmline
- Perinatal caregiver depression screening (peds practice)
- Substance-Using Pregnant People (SUPP) Program
- Pregnant & Parenting Women (PPW) Residential Treatment & Housing Supports

Child Health & Development

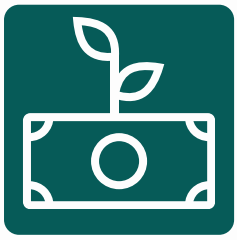
- Early Periodic Screening Diagnosis & Treatment
- Developmental & Social-Emotional Screening
- Child & Youth Psychiatric Consultation Line (PAL)
- Continuous Eligibility Birth - 5
- Well Child Checkup Program
- Community Health Worker (CHW) Grant
- Early Supports for Infants & Toddlers (ESIT)
- Eat, Sleep, Console (non-pharmacologic treatment)

Framework

In order to organize the thinking during the summit, WCAAP and DOH leaders considered various frameworks. We ultimately created our own organizational structure of six areas of focus. They are illustrated in the diagram below. Within each of the six areas, participants at the summit focused their group discussion on identifying existing programs that could be sustained and scaled to maximize impact. They also identified an innovative idea which merited further exploration.



Themes



Community Health Workers

- Funding and scaling the workforce

Shared Vision and Framework

- Aligning and coordinating priorities (e.g. Early Learning Coordination Plan)

Coordinated Access to Care

- Strengthening resource and referral linkage systems (e.g. Help Me Grow WA) and home-visiting/family support programs (e.g. Family Connects)
- Developing Interoperable Technology Platforms

Innovation

- Developing a framework of Early Childhood Impact Analysis for all Legislative Priorities.
  - Modeled after the Environmental Impact Statement or the constitution of Iceland which states that children by law be guaranteed the protection and care that is necessary for their well-being.
- Developing a “Family Passport” that travels with patient from prenatal to postnatal.
  - Strengths based document
- Developing a partnership between Dolly Parton’s Imagination Library and Reach Out and Read.
- “All In” funding strategies that include private, commercial, state, and hospital system funding.
- Single point of entry for all public benefits with a connection to electronic health record.

Recommendations for next steps

Convening

Reconvene partners and draw from strategies identified to create an action plan.

Alignment

Review existing state level plans and groups to determine opportunities for advancing shared priorities.

Engagement of Health Care System + Providers

Nearly all children ages 0-3 see a consistent primary care provider, creating an ideal setting to reliably reach families.

Appendix

WCAAP Summit Attendance List

Name	Organization
Ali Goodyear	WCAAP
Amber Ulvenes	WCAAP
Angie Funaiole	Department of Health
Anisa Smith	Family Connects
Astrid Newell	Department of Health
Beth Tinker	Health Care Authority
Chalon Ervin	Parent Advocate
Charissa Fotinos	Health Care Authority
Christina Pease	Pediatrician
Colleen McCarty	WCAAP
Danny Low	Family Medicine
Douglas Russell	Psychiatrist
Elexis Jackson	WCAAP
Francie Chalmers	Pediatrician

Appendix

WCAAP Summit Attendance List

Name	Organization
Jackie Litzau	HelpMeGrow
Jason McGill	Health Care Authority
Jennifer Sass-Walton	Skagit Public Health
Jessica Mortensen	Reach Out and Read
Kailani Amine	WCAAP
Katie Eilers	Department of Health
Lacy Fahrenbach	Department of Health
Lisa Callan	Legislator
Maria Gutierrez	Family Navigator
Mary Ann Woodruff	Pediatrician
Michele Roberts	Department of Health
Monica Burke	Department of Health
Rachel Hall	WCFC
Sarah Rafton	WCAAP

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WCAAP Summit Attendance List

Name	Organization
Sarah Holdener	DCYF
Shayla Collins	WCAAP
Tamiko Nietering	Parent Advocate
Taylor Caragan	WCFC
Taylor Kaminski	Parent Advocate
Tumaini Coker	Pediatrician
Tory Gildred	Molina

Appendix

Health System Opportunities for Change

Shift Focus of Care in Health Care Practices

- Use a multi-generational approach - screen adults in pediatric setting as the caregivers' well being is central to child health
- Support a full range of screening, assessment, and support beginning prenatally (e.g., social determinants of health, mental health, trauma/resilience, development)
- Expand early relational health interventions (e.g., Reach Out and Read, Promoting First Relationships)
- Expand mental health promotion, parenting support, ACES prevention/intervention

Remodel Delivery of Care in Health Care Practices

- Expand use of multi-disciplinary and team-based care (e.g., family and developmental health specialists, behavioral health)
- Expand access to culturally and linguistically appropriate care through non-physician providers (e.g., doulas, midwives, Community Health Workers)
- Implement family advisory roles and family-led approaches to care

Coordinate Within and Across Systems

- Strengthen coordination across health specialties (e.g., between maternal and pediatric care)
- Develop resource referral platform and two-way referral processes between health systems and early childhood systems
- Enhance capacity and health provider connection to state and local Coordinated Intake and Referral Systems (e.g., Help Me Grow WA)
- Streamline and align eligibility and enrollment forms and processes for public assistance programs
- Promote data sharing and data integration across systems

Strengthen Community-Based Supports

- Expand availability and access to community-based caregiver supports (e.g., peer to peer supports, father supports, parenting programs, home visiting)
- Expand a system of universal resource referral for families in the newborn period (e.g., Family Connects)
- Strengthen connections between P-3 healthcare providers and community services (e.g., home visiting, WIC, legal aid)
- Expand Basic Needs Supports (this is huge, don't get lost)

Enhance System Leadership & Cross-Sector Collaboration

- Prioritize early support for children and families in health system policy decisions (e.g., Early Childhood Impact Statement similar to Environmental Impact Statement)
- Shift mindsets to focus on Equitable, Proactive (vs Reactive), Long term (vs Short term), Multi-disciplinary (vs Siloed) care
- Strengthen family and community engagement and leadership within clinical and broader health systems
- Advance shared vision, goals, and strategies (e.g., Early Learning Coordination Plan)
- Establish shared accountability structure and metrics across systems (e.g., K-Readiness in Oregon

Advance Supportive Health Policy and Financing Changes

- Develop innovative payment models and incentives that assure a continuum of screening, assessment and treatment services for the P-3 population (including dyadic service models)
- Ensure reimbursement for skills development to implement universal screening and referral
- Fund reimbursement for services provided by non-physician providers
- Deliver and finance prevention and health promotion strategies in community settings in coordination with healthcare systems (e.g., home visiting)

Appendix

Summary of the six breakout groups

Systems Leadership and Cross-System Collaboration

- United Framework and Vision - Like in Early Learning Coordination Plan - ENACT framework to do a crosswalk of goals/strategies to identify points of leverage/alignment
- Elevate Family Voice and Leadership
- Funding Strategies - "All in" - Private (VCs), Commercial, State, Hospital Systems
- Legislative Priorities - Early Childhood Impact Analysis like Icelandic model

Coordinate Within/Across Systems

- Standardize as many forms and processes across systems and practices as possible
- Forms linked to medical EHR - WIC, Head Start, etc
- Interoperability - Access by ALL - like the VA?
- Streamline processes for families, providers, organizations
- Utilize CHWs/navigators as connectors/coordinators
- "Family Passport" that travels with family - strengths based - what is going well, what does family think it needs, what does provider think it needs, what referrals have been made to follow up upon.
- Recognize duplication, competing systems
- Help Me Grow or other centralized, coordinated referral system with closed loop referrals
- State coordination. oversight, and accountability across state agencies for delivery of services, licensure, funding, etc

Remodel Delivery of Care

- Expand care team - CHWs, Doulas, Behavioral Health Integration (peer specialists, BH support, mental health counselors), Family Navigators, etc
- All of the above supported by workforce development - racial, linguistic diversity
- Family centered/family voice
- Early Relational Health - Reach Out and Read, Promoting First Relationships, etc

Appendix

Summary of the six breakout groups

Focus of Care

- Screening - Using patient centered language and process - safe private
- Response to Screening Results - need infrastructure, capacity, funding - HMG or similar coordinated referral source with closed loop referrals can help
- Early Relational Health - Reach Out and Read, Promoting First Relationships, etc
- Expand the focus to the whole family instead of just the child
- Reflective Practice Supports for Primary Care Providers
- Connect to Programs outside of the Healthcare setting - VROOM, ESIT, Bright by Text, SPARKS, RUBI training, Economic Supports, Cooking classes, gym memberships
- Expand the care team (CHWs, Navigators) - link to resources outside the clinic. expand the capacity of the physician, antidote to physician burnout, teach physician, clarity of roles

Policy and Financing

- Create road map to flip from Fee for Service to Value Based Payment - one tool should be incentivizing reducing gaps in outcomes (equity)
- Increase Primary Care Funding
- FQHC Funding Model - pays for cost of care
- Equity - families receive same level of care regardless of payor
- BIPOC leadership
- Family Partnerships
- Prioritize Family Financial Well-Being - basic income, housing. etc
- Things to Fund - Home Visiting, Birthworkers, Lactation support, Autism. Developmental screening, CHWs and paraprofessionals more broadly (advocate by sharing what families want, telling stories, sharing data)

Appendix

Summary of the six breakout groups

Community Based Supports

- Caregiver supports in communities
- Workforce Supports - training and resource sharing
- Funding - continuous and stable
- Special Populations - fathers, special healthcare needs, age-based
- Peer Support - new parent meet up groups/PEPS/Baby Lounges
- Make the above UNIVERSAL
- Communication and Outreach - programs reach out to families rather than the inverse - target ages. zip codes, etc

- Coordinated/Improved Access to Services
- Family Resource Centers
- Family Resource Navigators
- “Coordinate the Coordinators”
- ACHs Accountable Communities of Health
- MCOs Managed Care Organizations
- Family Connects
- One place - centralized resource navigation

- Connections Between Healthcare and Community Services
- Singe Point of Entry for all public health benefits with connection to EHR
- Services consult with one another
- Warm hand-off, closed loop referrals

- Basic Needs
- Co-locate in healthcare clinic
- Sustainable funding model