Morning Breakout Sessions
A. Breakout Session: Opportunities for Early Childhood in Health Care Reform
Facilitators: Jim Wotring (Gtown) and Neal Horen (Gtown)

*Also see PowerPoint Presentation from this breakout session.

Session Highlights
MUST include in Healthcare Reform discussion:
- Implementation of MH parity will affect CF
- EPSDT billing; underutilization
- Lawsuit against States
- “Imminent risk” criteria
- S-CHIP

James Wotring presentation:
Decades of attempts to achieve HCR
50.7 mill uninsured; 41 mill will be covered
ACA will cover up to 400% FPL
Repeal of ACA would increase fed bud deficit of $230 bill bet 2012 – 21
Take home message:
Participate – know what your state is doing; work with coalitions

ACA is very complex
Provisions
- Temp Hi Risk pools already expanded
- Coverage for young adults has been launched
- Coverage for preventive care
- Grants for Home Visiting programs: 88 mill
- Private Ins. Co. must spend 80% of premiums
- Option for states to enroll beneficiaries with chronic disabilities into health homes
- Young adults previously in foster care will automatically qualify for Medicaid
- Indiv responsibility required to maintain health insurance for themselves
- States rule (47 states have planning grants); voice of young parents needs to be heard
- EPSDT will continue

HEALTH INS EXCH
A govt agency to offer an array of qualified health insurance plan for purchase by
individuals and business. Exch must be in place by 1/1/14

States have wide discretion in setting the standards, requirements, rates

“Benchmark” stds will be established by fed’s (HHS Sec) in Fall 2011
Exch for US citiz and legal immig only and not for those who are incarcerated or
undocumented. There must be a certain level of fluidity, e.g. indiv may move from Exch
to Medicaid to CHIP
Applications must be linguistically competent
Must offer rehabilitative and habilitative services
Ensure parity for MH and AB
Array of services may be from “bare” to Medicaid array “full”
Medicaid & CHIP Expansion to 133% FPL
20% more may need MH/SA services
FMAP incentive: 100% fed first 3 yrs, decreases to 90% 2020
S-CHIP will have a fed increase in match by 23% thru 2019

1915 (i): States can amend their State Medicaid plans: income eligibility to 150% FPL or 300% of max SSI pmt; can target children or young adults w SED, children w specific dev diag, children or adults w 2 or more instit plcmts (this could be a great area in terms of early childhood)

HEALTH HOMES: States can choose to enroll Medicaid beneficiaries with chronic conditions into a HH thru a State Plan Option; behavioral health homes can exist
ACO’s – will be expanded from Medicare to Medicaid; 5,000 (min) covered lives

Children in Foster Care will be covered by Medicaid up to age 26.
Parity: will define the health benefit pkg. CA has parity laws but not enforced.

Florida SOC (Sarasota) – doing mental health consultation thru specialized grants. Expansion of Medicaid will be challenging in Fl. In CA, billing EPSDT for early childhood services is not problematic; “collateral” visits are billed. Part C funding is used to serve indigent, incl. undocumented, families that don’t have health coverage.

Oregon – EPSDT is woven into state plan; screening services are included. Lawsuit is pending.

PA: lawsuit made all children eligible for Medicaid.

MH sevices provided thru FQHC; MA provides MH services thru community health centers. MA is doing Fam partner work; fam partners are included in wraparound.

Health Homes that incorporates MH services. Will they be behavioral health homes. Will they be virtual health homes? Will they look like the specialized health homes that currently exist in tertiary medical centers?

HRSA has invested in this which has a focus on children with special healthcare needs which includes mental health needs. AAP has promoted some models.

Carve-in vs. carve-out’s for MH services for kids. Some lit says carve-in’s are worse for kids. In CA, a report on S-CHIP indicated that if the health plan provided the MHS as compared to the health organization that contracted with a behavioral health org, the former provided x5 more MH services to kids; adol’s generally fared worse in rates of receiving MH services.

Cost data of care may be useful.
Issues for Further Discussion:
Can EC standards of care be promulgated among primary care providers or associations?

Tabletop discussion for this afternoon: EC communities should be sending in comments on the proposal to consolidate SA and MH block grants. There is a very short timeline.

B. Breakout Session: Infusing Family Voice in Early Childhood Systems
Facilitators: Janet Taylor-McDowell (DE) and Frances Duran (Gtown)

1. What specific questions or issues do participants want to discuss during this session?
   - Roll of family partner
   - Training and support
   - Family Engagement

2. What strategies or ideas do participants have to address these questions/issues?
   - **Positive solutions for families**
     - Train the trainer – one family member & one professional – co-facilitator
     - Let community organization choose family member
     - CSEFEL & Vanderbilt - family friendly (free/bi-lingual) curriculum
     - Keep it/make it “Family Driven” – always look in your own backyard.

   - **Family Groups** – offer in Spanish & English (or whatever languages are appropriate for your community)
     - DE has a family peer meeting with a “kitchen table talk” feel that makes everyone feel involved and that they have a voice
     - Have families drive the topics discussed during these meetings/groups
     - Try to make times & places more family friendly and mobile – easily accessible

   - **Concentrate on creating a relationship**
     - Turnover will reduce success
     - Mental help therapist and family community are key

   - **Family Development, Credentialing Training**
     - Temple has a program called “Family Development Credential”
     - Some states have used/created “Certified Peer Specialist” program
     - Texas has a statewide credentialing program

   - **Training and Support for Families**
     - Parent Leaders Training – Head Start, PTAs
− CA – utilizes “First Five” program – try to build off of what already exists
− Guam – trainings on how to do the everyday/basic things like set goals etc.
  ▪ Picks out ‘strong parents’ (i.e., potential system drivers) to lend to other groups
− The Center for Social & Emotional Foundations of Early Learning (CSEFEL) has “train the trainer” & parent training opportunities and curriculum that are family friendly, bi-lingual and free.

• How to care for children while families are receiving some type of care/assistance
  − Partner with groups (Ex. Boys/Girls Club) to give childcare during
  − “Time Banking” leaning on members in program to help provide natural supports
  − Holding meetings at a “Head Start” or similar site with built-in child care capacity
    ▪ How to deal with ratios and such? Utilize local “Childcare Planning Council”

3. Are there any foreseeable challenges in replicating these strategies in other early childhood system of care communities?

   How to sustain without SAMSHA funding?

4. If so, what ideas do participants have for overcoming these challenges?

   • OK/Other agencies
     Medicaid pays for family role. (Sustained as “Family support partners” thru state in OK).
   • Alameda County, CA – Family Partnership Program
     Family Partners out-stationed at MH Centers/ Medicaid pays
   • Faith based support applied for a grant to aid families
   • Infuse family-driven system-wide
     − Allegheny County, PA – process underway (Year 6)
     − Connect w/Local Area Network (McHenry County)

5. Is there an issue(s) or idea(s) that participants would like to propose for further discussion later today during the “table talk” time?

   How to Infuse “Family Driven” system wide

6. What follow-up technical assistance, training or resources do you need to move forward?
Georgetown’s Toolkit on developing early childhood systems of care, which includes a section on family involvement, will be available online soon.

C. **Breakout Session: Partnering with Child Welfare**
   Facilitators: Richard Cohen (Los Angeles County, CA) and Sandy Keenan (TAP)

   Notes forthcoming.
Afternoon Breakout Sessions

A. Breakout Session Topic: Attending to Promotion, Prevention & Intervention
Facilitators: Gary Ander (Alamance County, NC) and Neal Horen (Gtown)

1. What specific questions or issues do participants want to discuss during this session?
   - What about the need for conveyer belt promotion & prevention – intervention for a community – broad perspective/funding?
   - Prevention model to be used for framework [Institute of Medical (IOM) universal selected indicated prevention vs. tertiary, secondary, primary]
   - Models Needed – put in place to make an impact
   - Look at lessons learned from health care vs. MH reform (look at mechanisms)
   - Funding for various activities, ex. ACA – What about others – EPSDT, exchanges?

*Define promotion, prevention, intervention

2. What strategies or ideas do participants have to address these questions/issues?

*People are on lots of diff. pages

- Models/Frameworks (from various communities)
  - CSEFEL Pyramid (F)
  - Kaufman stuff IH approach (F) – America’s Promise model
  - Shoakloff Framework (F)
  - Parents as Teachers
  - Tools of the Mind (M) – cognitive based classroom curriculum
  - Strengthening Families (M/F)
  - Wraparound (F)
  - America’s Promise Model
  - PBIS/PBS (M)
  - Stride in Cincinnati (M)

- Many communities use so many (some in combination)

- Some choose models based on funding available
  - Look at it dimensionally
  - Look at whole child & then look at child over time
  - Look at the commonalities in the strategies to reduce turf wars, cost vs. no cost, needs to fit the invt of the community

Uber framework vs. breakdown into jurisdiction
3. Are there any foreseeable challenges in replicating these strategies in other early childhood system of care communities?

- Needs to fit the community it’s used in.
- Funding needed to support it.
- Difficult to clearly define prevention
- Need to have a temporal relationship b/w treating one thing & preventing another (look again at drawing funding for one to support the other)
- Making models fit into the framework (ex. Triple P w/levels & related activities)
- Identify values at each level of the framework, but not focus on model as much as long as it is evidence based.

4. If so, what ideas do participants have for overcoming these challenges?

- [Gary] How to develop a system which allows us to do the prevention work (evidence based activities) that will make a difference for families?  
  Ex. Minnesota mapping to define/color code promotion, prevention, intervention
- Need to create a map – where we are in our weaknesses, compass to finding, etc.
- Need to effectively communicate the need & effectiveness for early intervention outside of the early childhood community. To what end? Ex. Reduce crime, poverty, developmental progress or milestones achieved over time
- Look at the problem – bottom up – find problem & find the model that services it.

5. Is there an issue(s) or idea(s) that participants would like to propose for further discussion later today during the “table talk” time?

- How to move early childhood education away from just mental health and into the category of public health?
- Focus on hard science related to the issues to show evidence (EBP’s) to inform legislators & drive/direct funding.
- Show Why does “Early childhood matters?” – get away from soft science  
  Ex. Neurons to Neighborhoods”
6. What follow-up technical assistance, training or resources do you need to move forward?

We need:
- More ways to combine the message of promotion & prevention with intervention (CMH is not just TX!)
- Relate evidence/research to social marketing & advocacy – get heart to connect to the $ - tie it to cost effectiveness
- [Note of caution:] Be careful not to over-simplify MH needs b/c it is sellable to legislators or makes it easier to find results – ex. Schizophrenia

**Summarizing Questions for Reporting Out During the Debriefing**

1. What were the “aha’s” that came out of this session? For example, was there one particular issue that rose to the surface? Was an innovative strategy or approach discussed?

   - Ex. *Results Based Accountability Sarasota County – Framework that starts w/results & works on how to fit array of groups, families, services into the process
     - Look at population
     - Measurable indicators
     - Who can play a role?
     - Look at data
     - Revise model
     - Make a plan “What are we going to do?”

   - Importance of using common language

   - The model is not the key – define the problem, create the framework & then fill it in w/the models (they all have commonalities)/sometimes need to pick ones that best lead to funding

   - Show that it is evidence based

   - Has outcome that can be show to larger community as effective
2. Is there an issue(s) or idea(s) that breakout participants would like to propose for further discussion later today during the “table talk” time? (See #5 above)

Wrap Up Idea

– (Neal) Figure out what’s happening, determine gaps, develop strategic plan, make it fit for your community. (Map is similar, roads have diff names)

3. What follow-up technical assistance, training or resources do you need to move forward?

Who buys the gas to make it go?

↓

Funding Drives Services

↓

Take what science shows to sell to legislators to create sustainability/show how we make a difference

– Should be health related
  - Define it
  - Need to institutionalize it
  - Increase political leverage to make early childhood education everyone’s problem

4. Anything else that should be shared with the full group on this topic?

Ex *Strategies:

* OR (CSEFEL model) – Wraparound, PBIS, Parents as Teachers, Incredible Years Framework
* Picked some models in a framework
* Social marketing
* Curriculum (for bullying)
* (Wraparound) Pick an approach to roll out services
* Write letters to governor to roll out wrap statewide
* Roll w/changes in govt structure & access to funding
* Make it simple & understandable to make it understandable among multiple systems (MH, Child Welfare, Schools)
* Involve families in planning, social marketing, roll out, evaluation, education (a goal to…)


B. Breakout Session Topic: Effective Messaging on Key Early Childhood Topics
Facilitators: Ginny Stack (RI), Liz Doyle (McHenry County, IL) and Frances Duran (Gtown)

Topics Discussed:
- Addressing stigma through social marketing
- Communicating effectively that early childhood mental health is about promotion and prevention, as well as intervention
- Culturally and linguistically competent approaches to social marketing around early childhood mental health

Strategies for Addressing Stigma and CLC
- Capture Child/Family Stories “in their own voice”
  - Digital Stories (Multnomah County, OR; Los Angeles County, CA)
  - Thru art (Sarasota, FL)
- Frame the issue:
  - Connect social/emotional health to being successful in school
  - Be wary of ‘mental health’ terminology
  - Data is key in getting message across effectively
  - Engage influential ‘messengers’ - note the variance in who may be considered influential/respected within different community groups
- Do a Genogram for your community – good way to get cultural information to inform various aspects of systems development, including social marketing
- Develop a common language/way of talking about early childhood mental health
  - Embed in all levels
  - Need to speak in native/1st language
- Increase understanding that young children do have MH issues
- Partner w/ local establishments not typically associated with ‘mental health’:
  - Children’s Museum
  - Rita’s Italian Ice (DE) – “get the scoop on children’s mental health”
  - Partnerships w/faith-based communities, YMCA
- Community Engagement
  - ‘Girls Night Out’
  - Cultural ‘mini-grants’ to community groups to help in crafting social marketing materials geared toward specific populations (RI)
- Engage families
  - Build trust w/families by letting them ID information needs and meet them
  - Outreach materials designed by parents
  - Focus Groups can help identify messaging and outreach strategy needs for specific cultural groups
Talking about Promotion/Prevention/Intervention

- Frame: ECMH is everyone’s responsibility

- Need to help adult-serving systems “get” ECMH
  - Cross-system education is needed

- Frame: A “well child” model – mental health is one component and/or mental health is just a component of health

- Frame: Stress – we all deal w/it

- Pre-Service Education – important to help future clinicians and others working with children and families to understand the importance of attending to promotion, prevention and intervention; good strategy to focus some effort on higher education/training programs

C. Breakout Session: Life After the Grant
Facilitator: Sandy Keenan (TAP)

Notes forthcoming.