



# Health Care Reform and Maternal and Child Health in Region X

## In this issue:

- 1** Introduction
- 3** Medicaid Expansion and Maternal and Child Health
- 7** Oregon State's Reform of Its Medicaid System
- 11** Medical Home Demonstration for Children with Special Health Care Needs in Rural Idaho
- 14** A Public Health and Managed Care Partnership in King County, Washington
- 17** Oregon's School-Based Health Centers
- 19** Healthy Child Care in Washington State
- 22** State Reports
- 27** Resources

**W**hen we first met in January to discuss ideas and articles for the year, we knew a publication on health care reform and maternal and child health would be timely and important. We did not imagine the upheaval between then and now as state governors and legislatures debated if they were in or out of Medicaid expansion; in or out of state-run health insurance marketplaces; in or out of the federally run health insurance marketplace. Following those debates was the 16-day federal government shut-down, and its reopening, and a HealthCare.gov marketplace that has been up, down, and up again. In-out, shut-open, up-down-up. On November 9<sup>th</sup>, HealthCare.gov posted the following update: "While we're still not where we want to be with HealthCare.gov, the site is getting better each week."<sup>1</sup>

"While we're still not where we want to be, we are getting better." That long view and optimism will be familiar to our MCH readership. As articles in this issue illustrate, we are getting better and getting closer to our shared goal of improving the health and well-being of women, children, and families. Heather Vickery and Aaron Katz discuss the important role of Medicaid in improving the health of at-risk pregnant women and children, and the pros and cons of Medicaid expansion for the states. Anna Stiefvater and Beth Gebstadt describe the transformation of Oregon State's Medicaid system into a network of coordinated care organizations. Jacquie Watson describes the development of two patient-centered medical home demonstration sites in rural eastern Idaho. Donna Borgford-Parnell and Crystal Tetrick describe a partnership between a public health agency and a managed care organization in King County, Washington. Carol Opheikens and Dawn Creach describe how school-based health centers are an important part of expanding access to primary care homes in Oregon. Catherine Dewar Paul and Peggy King illustrate the importance of trained child care health consultants and argue that Washington needs to reinstate its Healthy Child Care Washington program. The Region X state reports illustrate the many activities related to health care reform, from new program activities (Alaska) to the re-design of the state-level health care delivery and payment system (Idaho) to a statewide program's reassessment of its role in women's health (Oregon) to the training of in-person assisters (Washington).

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<sup>1</sup>[www.hhs.gov/digitalstrategy/blog/2013/11/healthcare-gov-progress.html](http://www.hhs.gov/digitalstrategy/blog/2013/11/healthcare-gov-progress.html)

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## Updates

We would like to welcome Joan Zerzan, MS, RD, and Cheryl Prince, PhD, MPH, MSN, to the *Northwest Bulletin*. Joan Zerzan is a nutrition consultant for the Healthy Start and Children with Special Health Care Needs programs at the Washington State Department of Healthy Communities. She is also a nutritionist at the High-Risk Infant Follow-Up Clinic, Center on Human Development and Disability, University of Washington. Cheryl Prince is an epidemiologist with the Section of Women's, Children's, and Family Health at the Alaska Department of Health and Social Services, Division of Public Health. She moved to Alaska in May of this year from Atlanta, Georgia, where she was a epidemiology consultant and contractor for the Centers for Disease Control and Prevention.

The *Northwest Bulletin* extends many thanks and best wishes to Yvonne Goldsmith, who will be retiring early 2014. We greatly appreciate her guidance and contributions during her seven years on the editorial board.

## Reader Information

The Northwest Bulletin is published electronically twice a year in the spring and fall. Subscribers receive notice of publication via email that contains a link to the new issue.

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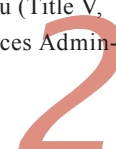
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The Northwest Bulletin is supported by Project #T76 MC 00011 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration.



Editorial . . .

# Medicaid Expansion and Maternal and Child Health

*Heather Vickery  
Aaron Katz*

**H**ealth insurance coverage, including Medicaid, is associated with lower financial stress and improved health for families and children. The Affordable Care Act’s expansion of Medicaid—the largest expansion of the program since 1965—is designed to reduce the number of uninsured Americans. In 2012, the Supreme Court ruled that states can choose whether or not to expand their Medicaid programs. In Region X, Alaska and Idaho have decided not to expand, while Oregon and Washington have decided to expand. Current evidence suggests the states that decide to expand will reap the benefits of improved well-being of families and lower uncompensated costs of care.

## Background

A main goal of the Affordable Care Act (ACA), signed into law by President Obama on March 23, 2010, is to decrease the number of uninsured Americans. The law takes a four-pronged approach to achieve this goal:

- ◆ require nearly all Americans to have health insurance
- ◆ expand Medicaid eligibility to all Americans living at or below 133% of the federal poverty level (FPL) (current FPL is \$19,530 for a family of three)
- ◆ create new health insurance “marketplaces” through which individuals and small businesses can obtain coverage
- ◆ provide subsidies for families with incomes between 100% and 400% of the FPL

Opponents of the ACA challenged the law’s constitutionality. In 2012, the Supreme Court upheld most of the law but ruled that the federal government could not force states to expand Medicaid, effectively making Medicaid expansion optional for states. Because lawmakers had thought that all states would expand Medicaid, they only provided premium subsidies for those whose incomes fell between 100% and 400% of the FPL.

As many of the states that have chosen not to expand Medicaid have eligibility levels below 100% of the FPL, residents with the lowest incomes will neither qualify for Medicaid nor subsidies. These residents are more likely to



belong to minority populations. The percent of whites who are uninsured is 13%, compared to 32% of Hispanics, 27% of American Indians, 21% of blacks, and 18% of Asians. The percent of whites making less than 133% of the FPL is 44%, compared to 63% of American Indians, 62% of blacks, 57% of Hispanics, and 46% of Asians. (1) Women are also more likely to be living in poverty: 20% of females and 18% of males earn less than 100% of the FPL.

At this writing, 26 states have decided to expand their Medicaid programs and 25 have chosen not to. Region X is evenly split between Washington and Oregon (yes) and Alaska and Idaho (no). (2)

### Medicaid Matters for At-Risk Pregnant Women and Children

Medicaid currently pays for approximately 40% of all births in the United States. It covers the costs of prenatal care throughout pregnancy, the costs of delivery, and the costs of 60 days of postpartum care. Women at high risk for less-than-optimal birth outcomes benefit especially from prenatal care. For example, Scholl et al. found that very young mothers who followed care guidelines increased their likelihood for normal weight gain during pregnancy by a factor of two, decreased their odds of preterm birth, and increased their child’s birth weight by an average 157 grams. (3)

Prenatal care also reduces low birth weight by increasing the likelihood that a woman will stop smoking while pregnant. (4) In fact, Weller et al. found that obtaining prenatal care in the first trimester increased the probability that a woman would stop smoking by 33%. (5) Research also suggests that quality prenatal

care increases the probability a woman will maintain a healthy weight after birth. (6)

Medicaid coverage is also important for the health of children living in low-income families. Medicaid-eligible children are entitled to receive Early Periodic Screening Diagnosis and Treatment benefits, a set of comprehensive and preventive health services considered by the American Academy of Pediatrics to be the “gold standard” for children. (7) Access to pediatric screening and immunizations are important for childhood health. Children who have regular pediatric care are much less likely to use the emergency department, and children with insurance are more likely to have regular pediatric care. (8) Also, evidence suggests that children whose mothers have regular medical and dental care are more likely to use medical and dental services. This is especially true for black and Hispanic children. (9)

### Current Medicaid Eligibility

Currently, Medicaid provides coverage to some low-income people, including families with dependent children, pregnant women, the elderly, and some people with disabilities. Eligibility requirements are at the discretion of the states, but the federal government sets minimum standards, which states can then exceed.

Under current law, a state’s Medicaid program must cover children under the age of six years and pregnant women with family incomes up to 133% of the FPL and must cover other children and teens up to 100% of the FPL. Most states have already expanded beyond this and cover all children and teens up to 133% of the FPL, or beyond, in either their Medicaid program or Children’s Health Insurance Program (CHIP) (this program provides

health insurance for children in families with income levels too high for Medicaid but who still cannot afford insurance). (7)

Table 1 shows the 2013 Medicaid eligibility levels set by the states in Region X. It is important to note that Medicaid expansion will make the eligibility floor for everyone at 133% of the poverty line.

### Expansion of Medicaid

If all states were to expand Medicaid, more than 21 million additional people could obtain

State	Non-Working Parents	Working Parents	Pregnant Women	Medicaid/Children’s Health Insurance Program
Alaska	74%	78%	175%	175%
Idaho	20%	37%	133%	185%
Oregon	30%	39%	185%	300%
Washington	35%	71%	185%	300%



health care coverage through Medicaid. The decision about whether to expand has raised many issues, the biggest one being cost. Today, the “federal match rate” (the percentage of Medicaid costs covered by the federal government) varies according to the strength of a state’s economy.

In Region X, the percent of Medicaid costs currently paid for by the federal government range from 50% in Alaska and Washington to 62% in Oregon and 71% in Idaho. Under the ACA, the federal government will pay 100% of the costs of expansion through 2016 and no less than 90% after that.

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If all states were to expand Medicaid, more than 21 million additional people could obtain health care coverage through Medicaid.

Even though states would incur some costs, expansion seems to be a good deal for them. Off-setting increased costs are anticipated savings, such as reduced uncompensated care, decreased use of emergency rooms, and some improved health outcomes.



In 2008, Oregon decided to expand Medicaid partially using a lottery. Compared to those who didn’t win the lottery, those who won the lottery (enrolled in Medicaid) were more likely to use preventive services, receive a diagnosis of diabetes, and use their medications, while they were less likely to have positive screenings for depression and catastrophic out-of-pocket medical expenses. (10) It is also possible that providers, especially rural hospitals and clinics, could see improved revenues

serving communities with higher rates of uninsurance.

In Region X, Washington and Oregon have decided to expand Medicaid, and Alaska and Idaho have declined. With expansion, Washington is expected to cover 227,000 more people, reducing the number of uninsured by 26%; and Oregon could insure as many as 471,000 people, reducing its uninsured population by 51%. If Alaska and Idaho chose to expand, they would likely reduce their uninsured population by 52% and 50%, respectively. (11)

State expenditures would increase modestly with Medicaid expansions in Region X. However, when the fact that states would spend less money on uncompensated care is taken into account, the projected cost of expansion is reduced further. Current projections show that Alaska’s expenditures would increase 1.5%, Idaho’s 3.7%, Oregon’s 2.3%, and Washington’s 0.2%. (11)

## Conclusion

Historically, Medicaid has been a successful strategy for providing health insurance coverage, and some research suggests that health insurance can improve the health of women and children (especially those at high risk). Given the differing state decisions, Region X presents us with a “natural experiment” to see if the “new” Medicaid will follow the same path by increasing health insurance rates and improving health. ☺

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## On-Line Training Opportunity. . .

### Life of a Benchmark (and Benchmarks for Real Life)



The University of Washington Maternal and Child Public Health Leadership Training Program invites you to join us December 12<sup>th</sup> for a webinar “Life of a Benchmark (and Benchmarks for Real Life).”

**Add to your calendar: December 12<sup>th</sup> at noon (Pacific Time)**

**Watch for our email** We will send you an email through the *Northwest Bulletin* listserv in early December with information on how to register and dial-in instructions.

**Description** State and tribal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs are required to measure program processes and participant outcomes for 35 constructs categorized into six benchmark topic areas. Programs must show improvement in at least 50% of the construct measures within at least

four of the benchmark areas.

This webinar will examine lessons learned from Oregon’s MIECHV experience and principles that can be used for selection and use of performance measures. By stepping through the entire process from measure selection and definition, through data collection and analysis, and interpretation and use of measures in continuous quality improvement (CQI), the webinar will illustrate the interconnection of the steps in the process, intended and unintended consequences of each step, and the balance between data goals and program goals.

**Presenter** Kathleen Anger, PhD, is a policy analyst for the Oregon Health Authority, Public Health Division, Maternal and Child Health Section. She is the evaluation and CQI lead for Oregon’s federally-funded Maternal, Infant, and Early Childhood Home Visiting Program.



# Oregon State's Reform of Its Medicaid System:

## Local and State Public Health Agencies Play a Crucial Role

*Anna Stiefvater  
Beth Gebstadt*

The skyrocketing costs of health care and decades of experience in health care reform provided Oregon with the impetus to transform its Medicaid system into coordinated care organizations (CCOs). These CCOs are local and regional networks of primary care and specialty care providers, behavioral health specialists, and dental health care providers. They serve people who receive health care coverage under the Oregon Health Plan (Oregon Medicaid). (See page 8 for a listing of key features of CCOs.) The goal of CCOs is to provide better health care, reduce costs, and improve the overall health of clients (the “triple aim”). (See page 8 for more information about the “triple aim.”) Both the local and state public health agencies play a crucial role in the transformation of Oregon’s health care system.

### Background

The first CCO was approved in July 2012. Currently there are [16 CCOs](#) organized with consideration to geography, natural partnerships, and local population needs, serving 90% of Oregon’s Medicaid clients. The CCOs are in different stages of transformation as they were approved at different times.

The Oregon Health Authority, the agency responsible for this health care transformation, also directs the following divisions: Public Health, Addictions and Mental Health, Medical Assistance Programs, and Health Policy. There is also a newly formed [transformation center](#) within Oregon Health Authority. This center supports the CCOs in achieving the triple aim and expanding the

adoption of the coordinated model of care. It also provides technical assistance and coordinates learning collaboratives. Each CCO also has an assigned “innovator agent” whose role is to champion innovative ideas.

### Oregon Public Health Division and Coordinated Care Organizations

One of the priorities of the Oregon Public Health Division’s [strategic plan](#) is to support CCOs in achieving their community health goals. The division has created an internal health system transformation staff position and a health system transformation work



group to help implement evidence-based health initiatives, meet incentive measures, and improve population health. This work group coordinates the development of resources and technical assistance for CCOs and local public health authorities. The team includes members representing many of the programs within the Public Health Division, including Maternal and Child Health (MCH) and Women, Infants and Children (WIC). Activities of this team include:

- ◆ Mobilization of partnerships through the development of a community prevention grants initiative for local public health agencies and CCO consortia to work on health issues utilizing an evidence-based approach
- ◆ Support for the Coalition of Local Health Officials Health System Transformation Committee in developing programs and policies that support individual and community health efforts
- ◆ Creation of a repository of evidence-based practices that may be considered for inclusion in the community health improvement plan
- ◆ Development of an incentive measure toolkit, which contains information on evidence-based interventions that innovator agents can use when advising CCOs on how best to achieve incentive measures

Not only has the Public Health Division allocated staff to support the efforts of the CCOs, but the core functions of public health—assessment, partnership, program and policy development, and assurance—inherently support the success of CCOs and are essential to the successful transformation of Oregon’s health care system.

### Medicaid Waiver with the Centers for Medicare and Medicaid Services

To enable such significant system reform, Oregon applied for and was awarded a health systems transformation waiver and innovation grant by the Centers for Medicare and Medicaid Services. This additional funding is being used to support infrastructure development. In return, this [agreement](#) requires Oregon to reduce health care costs below the projected trend by two percentage points over the next five years while simultaneously improving quality and access.

In order to assure improved quality and access, in addition to cost-savings, the Oregon Health Authority is

## Key features of Oregon’s Coordinated Care Organizations (CCOs)

- Shared financial risks and savings** managed through one global budget
- Accountability for the health outcomes** of the population they serve
- A local governing body** made up of health care providers, community members, and stakeholders in the health systems
- Flexible Medicaid dollars** that can be used for public health services and social determinants of health (e.g., housing, food, and transportation)

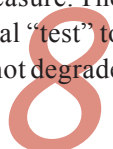
## The IHI Triple Aim

Developed by the Institute for Healthcare Improvement, the IHI Triple Aim is an approach to improving the United States health care system by simultaneously addressing the following three areas:

- ◆ Improving the patient experience of care (including quality and satisfaction)
- ◆ Improving the health of populations
- ◆ Reducing the per capita cost of health care

For more information, go to [www.ihl.org/offers/Initiatives/TripleAIM/Pages/default.aspx](http://www.ihl.org/offers/Initiatives/TripleAIM/Pages/default.aspx)

using quality improvement [metrics](#) to measure progress. Oregon is tracking 17 incentive measures for CCOs and 16 additional statewide performance measures. CCOs will be awarded additional “incentive” funding if they improve their performance on an incentive measure. The statewide performance measures are an annual “test” to ensure that quality of and access to care does not degrade





during health system transformation. Examples of measures that are both incentive and statewide performance measures include adoption of electronic health records and enrollment in patient-centered primary care homes. Other measures that are specific to women and children include developmental screening in the first 36 months of life, alcohol and drug screening and referral, follow-up care for children prescribed ADHD medications, timely prenatal care, and adolescent well-child visits.

Each CCO is also required to develop a [transformation plan](#) to address the triple aim, as well as develop a community health assessment and adopt an annual community health improvement plan.

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The core functions of public health—assessment, partnership, program and policy development, and assurance—inherently support the success of CCOs and are essential to the successful transformation of Oregon’s health care system.

### Role of Traditional Health Workers

In order for CCOs to meet their goal of improved health, it is essential to address the social determinants of health and work towards eliminating health disparities. To achieve this goal, the Oregon Health Authority has emphasized the role of traditional health workers<sup>1</sup> (community health workers, peer wellness specialists, personal health navigators, and doulas). These traditional health workers may also help CCOs address new state legislation that mandates that the members of CCOs have access to culturally and linguistically appropriate care. The Oregon Health Authority is currently developing a state-wide program to train and certify traditional health workers.

### Coordinated Care Organizations and Local Public Health

Each CCO has a unique relationship with their local public health agency and may have a different approach to improving health for women and children. Malheur County, a rural county in Oregon’s southeast region, is part of the **Eastern Oregon CCO**, along with 12 other counties. Each of these counties has their own community advisory council responsible for conducting a community health assessment and for drafting

a community health improvement plan. The director of Malheur County Health Department is the chair of the community advisory council. Each of these county health assessments and health improvement plans will then feed into Eastern Oregon CCO’s community health assessment and community health improvement plan.

Malheur County has been gathering and examining existing health data, including primary data, through a community mail survey. The survey has been sent to a sample of community members (not just Oregon Health Plan participants) to assess current health care needs and access to health care. Access to early and adequate prenatal care will likely be included in the emerging community health improvement plan. There are not enough local prenatal care providers to serve the population and women often live long distances from their care providers. In addition, there is a large migrant worker population, many of whom are uninsured and are not eligible for Medicaid because of lack of documentation. Undocumented workers will continue to remain uninsured, but the community health assessment does provide an opportunity to highlight the needs of this population and the impact of lack of insurance on the community’s overall health.

Two other CCOs, **Health Share** and **Family Care**, serve Washington County, a suburban and rural area

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Access to early and adequate prenatal care will likely be included in the emerging community health improvement plan. There are not enough local prenatal care providers to serve the population and women often live long distances from their care providers.

west of Portland. Health Share CCO employs an MCH program manager who convenes regular meetings of MCH representatives from the three Portland metropolitan area health departments and the Family Care CCO. These meetings provide opportunities for sharing information and forming new partnerships. This CCO MCH work group has focused on ways to improve the rates of developmental screening for young children, as required by one of the incentive measures. This group is also planning a broader discussion of an MCH model of care that would meet the needs of the diverse populations and communities living within the region.

The **Yamhill County Care Organization** serves Yamhill County in Oregon’s Willamette Valley. The

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<sup>1</sup>Previously referred to as “non-traditional health workers” in legislation.

nursing manager for Yamhill County Health Department serves on the clinical advisory panel for the CCO. This panel is looking at ways to improve access to early prenatal care and is exploring the concept of a maternal medical home using criteria similar to that of patient-centered primary care homes. This nursing manager shared that there has been increased collaboration and communication among community partners as the CCO develops. The manager stated “It’s really been a platform for public health to show what we can offer.” A recent change since the emergence of the CCO is co-locating a public health nurse in a pediatric practice and soon co-locating a public health nurse with prenatal providers as well. The CCO has also been a leader in making connections between the local public health partners and early education partners.

## Conclusion

The first CCOs launched just over a year ago, beginning the transformation of Oregon’s health care system. This transformation requires the involvement and support of many partners in order to achieve the triple aim of better health care, reduced costs, and improved health outcomes. Both the local and state public health agencies play a crucial role in these exciting health care changes. ☺

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## New Publication. . .

### The Affordable Care Act: Goals and Mechanisms

The fall 2013 issue of *Healthy Generations* provides an excellent resource for students and public health professionals who wish to learn more about the Affordable Care Act (ACA), how it will work, and how it will affect vulnerable populations. The important questions addressed in this issue include:

- ◆ What are the goals of the ACA?
- ◆ What are the primary mechanisms through which it will meet its goals?
- ◆ What is the potential impact of the ACA on women, children, adolescents, and immigrant families?

To read it, go to: [www.epi.umn.edu/mch/wp-content/uploads/2012/05/HG\\_Fall20131.pdf](http://www.epi.umn.edu/mch/wp-content/uploads/2012/05/HG_Fall20131.pdf)

*Healthy Generations* is published by the Center for Leadership Education in Maternal and Child Public Health at the University of Minnesota’s School of Public Health, a “sister program” of the University of Washington’s Maternal and Child Public Health Leadership Training Program. These two training programs, along with 11 others in schools of public health around the United States, receive funding from Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration.

Maternal and Child Health Bureau-supported leadership training programs in schools of public health prepare students for careers in maternal and child public health practice, research, planning, policy development, and advocacy. Programs emphasize leadership training, applied research, and technical assistance to communities, states, and regions.

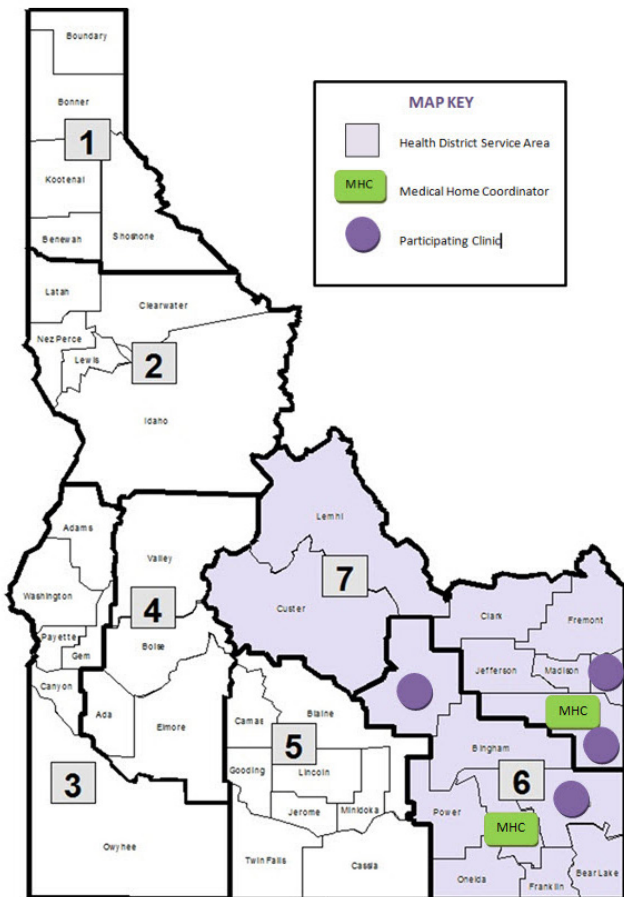
# Medical Home Demonstration for Children with Special Health Care Needs in Rural Idaho:

## A Collaborative Approach

Jacquie Watson

For a relatively small state, Idaho has extremely varied geography, from mountain ranges to large expanses of desert to rich agriculture valleys. Most of the state's land is uninhabitable, consisting of deserts, volcanic wastelands, and mountainous terrains. High mountain ranges and deserts separate a population of 1.6 million into seven population centers. (1) Radiating from these population centers are isolated rural and frontier communities, farms, and ranches.

Idaho's Medical Home Demonstration for Children with Special Health Care Needs in Rural Areas  
A Collaboration Between the CHIC Project, Title V MCH Program, and Local Public Health Districts  
October 2013

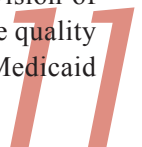


Of Idaho's 44 counties, 35 are rural with no city or urban center of more than 20,000 residents. Rural counties account for 88% of the state's land and approximately one-third of the population. As of January 2013, 97.8% of the state was designated a federal Health Professional Shortage Area in primary care, 95.7% in dental health, and 100% in mental health. (2)

Approximately 426,700 children live in Idaho. (1) Of those, approximately 53,280 are children with special health care needs (CSHCN). (3) Generally, CSHCN have complex, long-term health needs, require care above and beyond that of a typical child, and face many barriers to care due to high costs, lack of access, poor quality, and lack of coverage. When compared with CSHCN living in urban areas, CSHCN living in rural areas are less likely to be seen by a pediatrician and more likely to have unmet health care needs due to transportation difficulties and lack of specialty providers. Families of CSHCN living in rural areas are more likely to report financial hardship due to medical costs and more likely to leave the workforce to provide at-home care to their child. (4)

### Children's Healthcare Improvement Collaborative

In February 2010, the Children's Healthcare Improvement Collaborative (CHIC) was established through the Idaho Department of Health and Welfare's Division of Medicaid with the goal of improving health care quality and delivery systems for children enrolled in Medicaid



and the Children's Health Insurance Program (CHIP). The United States Department of Health and Human Services funds CHIC with a \$10.3 million grant from the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.



In May 2012, CHIC established pediatric patient-centered medical home (PCMH) demonstration sites in Idaho to improve quality and access to care, and coordinate care across specialties and disciplines for children enrolled in Medicaid and CHIP. (5) The PCMH model meets both the medical and non-medical needs of patients by providing primary care that is coordinated, comprehensive, compassionate, culturally-appropriate, and family-centered. (6)

### Innovative Partnership to Address Persistent Health Disparities

The Idaho Division of Public Health's Title V Maternal and Child Health (MCH) Program and CHIC collaborated to develop and implement two PCMH demonstration sites in rural eastern Idaho to address persistent health disparities that exist for CSHCN, regardless of health insurance status. As part of this innovative collaboration, the MCH Program and CHIC coordinated services with two local public health districts: Eastern Idaho Public Health District and Southeastern Idaho Public Health District. The benefits of partnering with these districts are three-fold:

- ◆ The MCH Program currently supports the operation of several specialty pediatric clinics in the region
- ◆ The CHIC has a local pediatric practice

currently participating in the original PCMH demonstration

- ◆ The local health districts are the primary providers of public health services, outreach, and education, and are well-connected, credible resources in their communities

In July 2013, funding from the MCH Program and CHIC supported the hiring of two medical home coordinators, each to be located at one public health district. The medical home coordinator is an integral part of the PCMH model whose purpose is to:

- ◆ Facilitate positive relationships between families and a primary care practice
- ◆ Provide information about continuity of care, identifying patient populations, care plans, care coordination, preventive health, and health education for patients
- ◆ Guide patients and their families through a complex health care system by developing care plans and connecting them to resources

In a traditional PCMH model, the medical home coordinator is embedded in a primary care practice and serves as a member of the team. In rural pediatric and family practices, because of low patient volume and funding constraints, it is often not feasible for a single practice to support a medical home coordinator. For this demonstration project, the medical home coordinator operates primarily from the public health district and travels to multiple independent pediatric or family practices.

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In rural pediatric and family practices, because of low patient volume and funding constraints, it is often not feasible for a single practice to support a medical home coordinator.

By September 2013, each medical home coordinator had recruited two family primary care practices for participation in the demonstration and began identifying a list of target CSHCN patients within each practice. In October 2013, the medical home coordinators will begin working with families and guide practices in developing care plans, coordinating care, providing health education to patients, preventive health practices, and implementing quality improvement strategies through the course of the two-year project. The MCH Program and CHIC



will work closely with the medical home coordinators to monitor implementation, celebrate successes, address challenges, and foster a community of learning.

## Conclusion

This collaboration capitalizes on each party's expertise to make it successful. CHIC laid the framework and provides coaching, Internet-based tracking software, data analytics, and quality improvement training for each medical home coordinator. The MCH Program provides health education tools and prevention strategies to medical home coordinators and access to population health data. The public health districts provide access to local public health services and community resources.

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Goals of the evaluation are to gain a better understanding of the provision of medical home coordination through public health, document successes and lessons learned, and capture components of the demonstration model that are necessary to successfully replicate this medical home collaboration in other public health districts in Idaho

A formal, independent evaluation will be conducted throughout the project. At the end of the demonstration period, a summary evaluation report will be provided to CHIC, the MCH Program, and the public health districts. Goals of the evaluation are to gain a better understanding of the provision of medical home coordination through public health, document successes and lessons learned, and capture components of the demonstration model that are necessary to successfully replicate this medical home collaboration in other public health districts in Idaho. ☉

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# A Public Health and Managed Care Partnership in King County, Washington:

## Innovation in Care Coordination

*Donna Borgford-Parnell  
Crystal Tetrick*

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Through these new and innovative partnerships with managed care organizations, public health continues to assure that children with chronic conditions or special needs are receiving the care coordination they require and connection to a medical home

**A**s a result of the passage of the Affordable Care Act in 2010, the Washington State Health Care Authority consolidated Healthy Options, its Medicaid managed care program, with the state's subsidized Basic Health Plan to form Healthy Options Medicaid.<sup>1</sup> Two years later, the state entered into new contracts with five managed care organizations to provide managed care services for clients of Healthy Options Medicaid, including recipients of Supplemental Security Income (SSI) who are blind.

This is the first time that individuals receiving Supplemental Security Income have been required to enroll in capitated managed care. Prior to these changes, only children and families on Temporary Aid to Needy Families (TANF) were required to enroll in managed care plans. With these new contracts, approximately 120,000 adults and children will need to choose a managed care plan or be assigned to a plan.

Managed care organizations are required to establish and implement an intensive care management program to meet the health care needs of newly enrolled special needs populations. (See criteria for enrollment and ways to identify potential enrollees on page 15.) The establishment of these programs has opened the door for the development of innovative partnerships with public health programs that have extensive experience working with these vulnerable populations.

### Role of the Public Health Nurse

One example of such a partnership is between the Community Health Plan of Washington (CHPW) and the Community Health Services Division of Public Health - Seattle and King County (PHSKC). This partnership builds on the skills and expertise of public health nurses who provide community-based services to children with chronic conditions or special needs. These high-risk and high-needs children often require intensive care coordination services.

The PHSKC public health nurse services support these children and their families, assuring optimal

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<sup>1</sup>Basic Health Plan is a subsidy program for low-income residents of Washington State not eligible for Medicaid. Due to the implementation of the Affordable Care Act, the Basic Health Plan is scheduled to end as of December 31, 2013.



health so they can reach their full potential. This is accomplished by working in partnership with families, providers, managed care plans, schools, and community agencies to create integrated systems of care. Responsibilities of public health nurses include:

- ◆ providing care coordination services in homes, at community visits, or over the phone
- ◆ partnering with pediatricians, hospitals, schools, developmental centers, and other agencies to establish comprehensive networks to support children and their families
- ◆ helping families learn about their child's condition and identifying health concerns
- ◆ helping families understand how to use medical care resources appropriately
- ◆ coordinating directly with hospital discharge social workers on care planning
- ◆ meeting with families prior to discharge to establish a relationship

### Three Levels of Intensive Care Coordination Services

The CHPW has contracted with PHSKC to provide three levels of intensive care coordination services to their pediatric population identified as high-risk and requiring extended network services. The three levels of service include an initial health assessment, transitional health care services and chronic care management. The CHPW provides referrals to PHSKC based on their assessment of their enrollees. All services are voluntary.

The **initial health assessment** involves contacting the family by phone to provide a nursing assessment of health risk factors, health status, understanding of the medical provider's treatment plan and medications, and barriers to care. The nurse also identifies health literacy,

### Identifying Enrollees with Special Health Care Needs

Enrollees with special health care needs must meet the criteria of having two or more chronic conditions, one chronic condition and be at risk for another chronic condition, or one serious and persistent mental health condition. A high number of emergency department visits and primary care provider visits is used to identify special needs populations. Another tool is the Predictive Risk Intelligence System (PRISM). This system was developed by the Washington State Department of Social and Health Services to identify high-risk Medicaid clients who would likely benefit from chronic care management. It is used to analyze the previous 15 months of claims data to determine a quantitative score. A PRISM score of 1.5 or higher is one of the risk factors for determining if a referral for assessment for services is necessary.

cultural and linguistic needs, and basic needs that are not being met. Results of the assessment can be used to identify additional services or the need for chronic care management services.

The goal of **transitional health care services** is to prevent secondary health conditions or complications, re-institutionalization, or re-hospitalization. Children referred for this service are being discharged from a hospital or institution. A public health nurse visits the family within seven days of discharge to conduct a holistic nursing assessment, review the treatment plan, determine caregiver understanding and educational needs, and provide follow through and establishment of a medical home. The nurse also follows up with the caregiver, primary care providers, and other service providers to assure all care needs are being met.

**Chronic care management** services are provided on a month-to-month basis and include a comprehensive health assessment, care planning and monitoring of enrollee status, implementation and coordination of services, ongoing reassessment and consultation, and crisis intervention and case conferencing, as needed, to facilitate improved outcomes and appropriate use of



health services. The public health nurse supports the child and caregiver in identifying barriers to care and developing of a plan of care.

## Conclusion

Through these new and innovative partnerships with managed care organizations, public health continues to assure that children with chronic conditions or special needs are receiving the care coordination they require and connection to a medical home. By working in partnership with providers, managed care plans, and community agencies, public health nurses assure these children get the support and care they need to achieve optimal health in this new era of health care reform. ☺

*Donna Borgford-Parnell, RN, BSN, MBA, Advance Practice Nurse Specialist, Public Health - Seattle and King County, manages the Children with Special Health Care Needs Program. The program has a team of public health nurses who provide care coordination services to families who have children with serious complex conditions, are being discharged from a hospital, or have a newly diagnosed chronic condition. She has worked*

*as a community health nurse for over 30 years, 26 of those years at Public Health - Seattle and King County.*

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*Crystal Tetrick, MPH, Parent and Child Health Manager, Public Health - Seattle and King County, is responsible for overseeing the maternal and child health programs for the 14th largest county in the United States. After receiving her MPH degree through the Maternal and Child Public Health Leadership Training Program at the University of Washington, Ms. Tetrick began her career as clinic support services manager at the Seattle Indian Health Board, a non-profit community health center. Most recently she was the associate director of the Urban Indian Health Institute, a national epidemiology center supporting the health and well-being of urban Indian communities through information, scientific inquiry, and technology. She is a descendant of the Otoe-Missouria and Munsee Tribes. She is a member of the Northwest Bulletin's editorial board.*

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## On-Line Resource. . .

# Evidence-Based Public Health Series

When developing programs and policies, public health practitioners must continually weigh evolving scientific evidence with funding options, politics, and short-term demands. Because resources are always limited, we need a strategic approach for decision making. Evidence-based public health, a framework for integrating science-based interventions and community preferences, is an important tool for the job. The Northwest Center for Public Health Practice offers three one-hour webinars to support decision-making skills:

- **Introduction to Evidence-Based Public Health** Provides an overview of the importance of evidence-based public health and its applications in disease prevention and health promotion

- **Searching and Summarizing the Literature** Provides helpful techniques for searching the scientific literature and other important sources for public health information
- **Return on Investment** Describes the step-by-step processes for calculating return on investment, cost benefit ratios, and social return on investment in public health settings.

This webinar series is available at [www.nwcp.org/training/opportunities/evidence-based/evidence-based-public-health-series](http://www.nwcp.org/training/opportunities/evidence-based/evidence-based-public-health-series)



# School-Based Health Centers:

## An Important Part of Oregon's Health Care Transformation

Carol Opheikens  
Dawn Creach

The Oregon Legislature established the Patient-Centered Primary Care Home (PCPCH) program in 2009. The program sets standards for what high-quality, patient-centered care looks like. (See box on page 14 for a listing of key standards.) The program also identifies primary care homes, promotes their development, and encourages Oregonians to seek care through recognized primary care homes. The ultimate goal is that 75% of all Oregonians will have access to a primary care home by 2015.

To date, more than 425 clinics across Oregon have been recognized as primary care homes, representing more than 2,400 primary care providers. School-based health centers (SBHC) are one of many types of clinics that the state recognizes as primary care homes. Other types of clinics include family practices, pediatric clinics, community mental health centers, rural health centers, women's health clinics, federally qualified health centers, and tribal medical clinics. School-based health centers are an important part of expanding access to primary care homes.

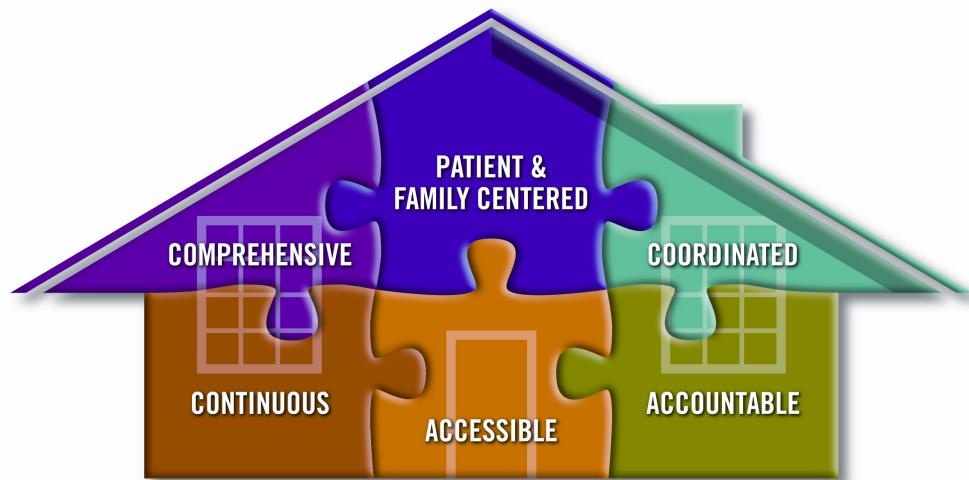
### School-Based Health Centers

School-based health centers offer a unique, evidence-based health care model in which comprehensive physical, mental, and preventive health services are provided to youth and adolescents in a school setting. Ease of access, combined with a focus on health and wellness, creates cost-effective care within

the communities where the students live, learn, and play. The model exemplifies many of the core attributes of the PCPCH model (see figure). In addition, the mission of SBHCs aligns with the Oregon Health Authority's goals of better health care, reduced costs, and improved health outcomes (the "triple aim").

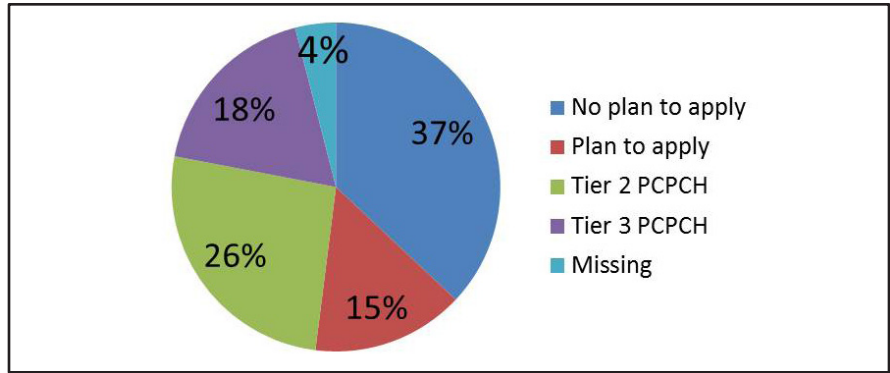
### Statewide Assessment of School-Based Health Centers

To better understand the needs of SBHCs within the context of emerging health care reform practices, an assessment was undertaken by the Oregon Health Authority in partnership with



Core Attributes of Primary Care Homes

the Oregon School-Based Health Care Network. At the time of the assessment, September 2013, there were 24 SBHC systems representing 66 SBHC sites. Seven of the 23 systems had submitted applications and received recognition for 28 sites. Forty-three percent of SBHC sites (28 of 65 sites covered in completed interviews) have received PCPCH recognition. (See pie chart for status of applications.)



Status of school-based health centers applications for Patient-Centered Primary Care Home (PCPCH) recognition (September 2013). N =65. Tier 2: Intermediate primary care home. Tier 3: advanced primary care home.

### Next Steps

It is clear that SBHCs are valued across Oregon. The next steps involve inclusion of SBHCs in the discussions between coordinated care organizations and their partners in order to provide SBHCs with the support and infrastructure they need to remain valued, economically sustainable, and part of the ongoing movement of health care transformation. Recognized patient-centered primary care homes are eligible to receive payment incentives to support the quality, coordinated care they provide Oregonians, which supports the goal of sustainability. ☺

*Carol Opheikens, BSN, FNP, MPH, is the quality assurance coordinator for the Oregon Health Authority’s School-Based Health Centers Program. She has had a long career in public health nursing at the local, county, and state levels. She joined the program in 2008 to provide clinical technical assistance and coordinate the certification of SBHCs across the state of Oregon.*

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*E. Dawn Creach, MS, is a policy analyst with the Oregon Health Authority’s Patient-Centered Primary Care Home Program. She is the program lead for communications, technical assistance, and the application process for clinics seeking recognition as patient-centered primary care home. She joined the program in 2011, bringing expertise in the medical home model, behavioral health integration, evaluation and research, and project management.*

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### Key standards for a patient-centered primary care home

- Accessible** Care is available when patients need it.
- Accountable** Clinics take responsibility for the population and community they serve and provide quality, evidence-based care.
- Comprehensive** Patients get the care, information, and services they need to stay healthy.
- Continuous** Providers know their patients and work with them to improve their health over time.
- Coordinated** Care is integrated and clinics help patients navigate the health care system to get the care they need in a safe and timely way.
- Patient- and family-centered** Individuals and families are the most important part of a patient’s health care. Care should draw on a patient’s strengths to set goals and communication should be culturally competent and understandable.

# Healthy Child Care in Washington State:

## Reestablishing a System of Trained Child Care Health Consultants

*Catherine Dewar Paul  
Peggy King*

Last year, 293,000 children living in Washington State, aged six weeks to six years, attended child care. These children attended one of 2,051 licensed child care centers, 5,075 child care homes, or 70 known unlicensed facilities. These children were cared for by 12,490 child care providers. (1)

Until three years ago, these child care providers relied on a system of child care health consultants (CCHCs). These trained health professionals—nurses, nutritionists, and environmental health specialists—helped child care providers keep children healthy and safe by:

- ◆ serving as a link between child care providers and a child’s medical home
- ◆ ensuring immunizations were up-to-date
- ◆ ensuring that child care providers carried out age-appropriate anticipatory practices
- ◆ ensuring that children received health and developmental assessments along with necessary follow-ups
- ◆ ensuring that children with acute and chronic medical conditions were cared for appropriately
- ◆ ensuring that child care providers follow health and safety policies and practices, including disease prevention

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Washington State, once a leader in child care health consultation, is now one of the few states without a state-wide system for supporting healthy and safe child care.

Three years ago Healthy Child Care Washington, the primary funding source for CCHCs, was terminated. Without it, most licensed child care centers and homes in Washington State now care for children without access to a health professional trained in best practice standards for child care health. The Washington State child care health consultation system, once a role model for the nation, no longer exists.

Currently, the Washington State Department of Early Learning enforces minimal health licensing standards, including a monthly visit from a nurse for licensed centers caring for four or more infants, and a health professional’s review of a child care center’s health policies. However, without a statewide cadre of trained CCHCs, many directors of child care centers scramble



to find a health professional with knowledge of best practices, and either must pay for the service or find someone willing to volunteer, often a parent of a child or a local physician willing to help out. The result is a de-centralized system where many child care providers have no one to go to for advice on health and safety issues.

### Why Trained Child Care Health Consultants are Needed

With thousands of children attending child care in our state, the lack of a strong, coordinated child care health consultation system is a missed opportunity to promote health and safety and to ensure children receive necessary primary and preventive services. Under the Affordable Care Act, [26 preventive services](#) for children are required to be covered by insurers at no cost to parents. The regular presence of CCHCs helps ensure parents are aware of these benefits and children receive these necessary services.

A study recently completed by the University of North Carolina at Chapel Hill evaluated the impact of CCHCs in the child care setting. The study found that child care health consultation by trained health professionals has a positive impact on health and safety policies and practices, and resulted in "...improvements in children's access to a medical home, enrollment in health insurance, immunization status, and documented oral, developmental, vision, and hearing screenings." (2)

In addition, CCHCs help providers understand how to deliver safe and effective care to an increasing number of children with chronic and acute medical conditions, such as asthma, diabetes, severe food allergies, and mental health issues. Finally, CCHCs are a critical component of the provider-parent partnership, educating child care providers on how to communicate with parents the health services their children need.

### Making Child Care Healthy in Washington State

The Coalition for Safety and Health in Early Learning (CSHEL), a small group of CCHCs still practicing in the state, voluntarily continue to advocate for best practice standards in child care (see box). However, in order to make child care healthy in Washington State, we cannot depend upon volunteers alone. A system of trained CCHCs must be reestablished. This can begin with the two state agencies that most impact child care in Washington State.

The Washington State Department of Health is the lead



The Coalition for Safety and Health in Early Learning is composed of health, safety, and early learning professionals committed to quality early childhood care and education for all children in Washington State. The coalition recognizes health and safety as key indicators of high quality child care and early learning settings. It works with community partners and other agencies to provide a forum for networking for early childhood professionals and others interested in promoting health and safety in early learning settings. The coalition disseminates health and safety information through a web site, policy papers, and quarterly meetings. Its goal is to achieve consistency on health and safety issues statewide and to promote evidence-based best practices in the care of young children.

state agency responsible for the protection of the health of children throughout the state. Currently, attention to child care issues is fragmented within the department. Appointing one person with sole responsibility to oversee all issues related to child care would promote a systemic approach to these issues and ensure consistent messaging of best practices for all projects and work. This person's ability to link experts within the Department of Health and other state agencies, in particular the Department of Early Learning, could help ensure that state policies and rules meet best practice standards and that the use of CCHCs is promoted.

The Washington State Department of Early Learning's [Early Achievers](#), a child care quality rating and improvement system, and their [infant-toddler regions](#) provide excellent opportunities to utilize trained CCHCs to provide health and safety coaching, and consultation and training to both education specialists and child care providers. Currently, the few nurses involved with regional projects are either not consulted or are used as generalists whose focus is not health.



Washington State, once a leader in child care health consultation, is now one of the few states without a state-wide system for supporting healthy and safe child care. Washington can now use other states, such as Pennsylvania, Iowa, and Alabama, as models for reinstating a Healthy Child Care Washington program.

## Conclusions

Parents trust child care providers to ensure healthy and safe environments for their children, including those with chronic medical conditions. They trust child care providers to recognize when a child is ill or having a life-threatening reaction and know what to do. They trust child care providers to administer medications safely and to prevent accidents to the best of their ability. But child care providers cannot do it without the support and guidance of child care health consultants. ☺

*Catherine Dewar Paul, RN, MPH, is past chair of the Coalition for Safety and Health in Early Learning in Washington State. She has worked as a child care health consultant for the past 20 years with Head Start, Early Childhood Education and Assistance Program, and private child care.*

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## Agencies Open Doors for Future MCH Professionals

The Graduate Student Epidemiology Program (GSEP), sponsored by the Maternal and Child Health Bureau, promotes student internships at state and local health agencies. Interns obtain experience with addressing specific data or analytic issues while states and agencies get help with data collection, data analysis, and program evaluation.

The deadline for agency proposals is November 22, 2013 for a summer 2014 project. Student applications open January 6, 2014.

Two students in the University of Washington MCH Program—Tess Abrahamson-Richards and Avanthi Jayasuriya—participated in the 12-week program for summer 2013. Tess Abrahamson-Richards worked on two projects with the Oregon Public Health Division's Maternal and Child Health Section. One was to create reports that described the prevalence of 23 maternal and child health factors for five of Oregon's nine tribes. The other was to analyze PRAMS data for an upcoming publication on the relationship between stressful life events and postpartum depression among American Indian and Alaska Native women in Oregon.

Avanthi Jayasuriya worked with the Nebraska Department of Health and Human Services' PRAMS team. A poster based upon her experiences was accepted for the 2014 annual conference of the Association of Maternal and Child Health Programs (AMCHP). The poster describes how community and statewide stakeholders were included in the process of data analysis and usage.

[More information for agencies](#)

[More information for students](#)

State Reports . . .

# New Federal Grants Improve Health Care for Vulnerable Populations

Alaska Department of Health  
and Social Services

Cheryl Prince

New federal grants awarded to Alaska have led to the implementation of four programs: Maternal, Infant and Early Childhood Home Visiting (MIECHV), Healthy Start, Health Promotion and Emergency Preparedness for Vulnerable Populations, and Pediatric Medical Home. Below are brief descriptions of three of the grants. For more information about the MIECHV grant, see the [spring 2013](#) issue of the *Northwest Bulletin*.

## Healthy Start

The Healthy Start grant, funded by the Health Resources and Services Administration, enables the Division of Public Health Perinatal Health Program to plan and implement activities to reduce the risk of infant mortality in the Bering Straits Region. The only birthing center in the region is located in Nome, which is 100 to 300 air miles away from the fifteen villages comprising its service area, and 540 air miles from the state's only level III neonatal intensive care unit in Anchorage.

In the Bering Straits Region, as elsewhere in Alaska, specially trained community health aides provide most routine medical care in villages, and licensed medical providers staff delivery hospitals located in hub communities, such as Nome. Access between villages and hub communities is often limited to air and river transport. Inclement weather often dictates travel schedules. Consequently, the plan of care for all women living in remote villages is for them to move to a birthing center at 36-weeks gestation. These services may be paid for by Medicaid, Indian Health Service, or private insurance.

Because of Nome's distance from services for high-risk pregnant women, there is an ongoing concern around their transportation to a larger medical center for obstetrical and neonatal care. The Healthy Start program tracks the location of births in rural areas and examines issues related to appropriate transport of pregnant women for the birth of very low birth weight babies. Norton Sound Regional Health Corporation was retained to deliver this

program in Nome starting in March 2013.

## Health Promotion and Emergency Preparedness for Vulnerable Populations

Alaska is also ensuring that necessary health promotion and disease prevention services are provided to vulnerable families throughout the state. The new Health Promotion and Emergency Preparedness for Vulnerable Populations grant, funded by the Centers for Disease Control and Prevention, will improve emergency preparedness for MCH populations especially vulnerable during times of disaster: pregnant women, women with infants, and children and youth with special health care needs. The goals of this program are to 1) increase community awareness of health care needs, and 2) promote access to essential health services.

## Pediatric Medical Home

The Pediatric Medical Home state implementation grant, also funded by Health Resources and Services Administration, established a care coordination position in a rural community health center located 80 miles north of Anchorage. The coordinator's role is to encourage families to enroll their children and youth with special health care needs, especially those with chronic conditions, in health services. The program focuses on assuring up-to-date immunizations, having an asthma action plan at the school, assisting families with children with a diagnosed chronic condition, and integrating the Ages and Stages Developmental Screens into well-child visits. ☺

*Cheryl Prince, PhD, MPH, MSN, is a maternal and child health epidemiologist for the Alaska Department of Health and Social Services, Division of Public Health. She also serves on the editorial board of the Northwest Bulletin: Family and Child Health.*

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# Idaho State Receives State Healthcare Innovation Planning Grant

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Idaho Department  
of Health and Welfare

*Dieuwke Dizney-Spencer*

In April 2013 the Centers for Medicare and Medicaid Services awarded Idaho up to three million dollars to develop a [State Healthcare Innovation Plan](#) (SHIP). The grant is sponsored by Governor Otter and managed by Idaho Department of Health and Welfare. Idaho is one of 16 states that received model design funding this year. The grant is funded through the Affordable Care Act and supports initiatives to accelerate the development and testing of new payment and service delivery models. Two other states in the Northwest Region have received an innovation grant: Washington is in the pre-implementation phase and Oregon is in the implementation phase.

## Re-design of Idaho's Health Care Delivery and Payment System

The SHIP will be used to re-design Idaho's health care delivery and payment system. The main goal is to transform the system from a fee-for-service, volume-based system to a value-based system focused on improving health outcomes. The re-design will address Idaho's complete health care system, not just its Medicaid program. A steering committee and four work groups have led the planning process. They will make the recommendations and policy design decisions that will make up the SHIP. The focus is on four key elements of health care delivery systems: network structures, health information technology, clinical quality improvement, and multi-payer strategies.

Participants in the health care system throughout the state (professionals, other services providers, and consumers) have provided feedback for the SHIP. At least 56 focus groups and five "townhall" meetings have been held.

## Building on Idaho's Current Successes

The SHIP will build on Idaho's current successes and strengths. A statewide assessment of Idaho's current health care delivery and payment system has identified existing programs and initiatives that can be incorporat-

ed into the new system. Through the process, we hope to integrate public health and MCH with primary care using the patient-centered medical home model (see article on page 12). How this will be accomplished and what it will mean for the MCH population will be more apparent when the SHIP is published.

The planning process began on June 6, 2013, with a project kick-off event attended by more than 90 stakeholders from across the state. Following review of a draft and publication of the SHIP, the next step will be to apply for implementation funding for Idaho's State Healthcare Innovation Plan. ☺

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# With Health Care Reform, Oregon MothersCare Reassesses Services

Oregon Department  
of Human Services

*Lesa Dixon-Gray*

For the past twelve years, the MCH system in Oregon operated a statewide program called [Oregon MothersCare](#), whose sole purpose has been to ensure early access to prenatal care. Recent changes in health care reform have created the opportunity for Oregon MothersCare to assess its role in women's health.

Created by Oregon law, the Oregon version of accountable care organizations, coordinated care organizations (CCOs), provide Oregon residents access to health insurance plans through Cover Oregon ([www.coveroregon.com/](http://www.coveroregon.com/)), the state's marketplace. For newly pregnant, uninsured women, Cover Oregon offers opportunities for coverage that previously had been patch-worked together. With coverage for pregnant women becoming universal, and insurance enrollment processes standardized, Oregon MothersCare decided to reassess its design and the services it offers. Using a quality planning approach, Oregon MothersCare reviewed Oregon data regarding births and insurance coverage, and its own internal data regarding program services and populations.

Cover Oregon partners with community assisters to help individuals enroll and is encouraging the public health community to act in that capacity. Likewise, Oregon MothersCare has an interest in ensuring that pregnant women enroll early, as that allows early access to prenatal care. However, the program was reluctant to require all sites become assisters without first assessing how the sites were operating and their future plans for clients. Following standard quality planning practices (1), Oregon MothersCare brought together external and internal stakeholders to brainstorm the effects of health reform changes. The program asked for input on the current goals, objectives, benchmarks, design, and funding. Suggestions ranged from including preconception health screening to coordinating closely with both Cover

Oregon and Oregon's CCOs. Using that information, the program developed a survey that was sent to the larger Oregon MothersCare community.

Oregon MothersCare staff used the survey results to assess a variety of issues, including 1) participation in health insurance enrollment, 2) whether serving a population of largely insured individuals will require changes in Oregon MothersCare and MCH services, 3) the greater impact of health reform on women and vulnerable populations, 4) whether Oregon MothersCare and MCH services will need a greater focus on populations not able to access health care insurance, and 5) whether access to prenatal care

will become harder to obtain due to a lack of workforce resources when more people are insured.

In the next two years, as the landscape that intersects health care and MCH changes, Oregon MothersCare will be assessing, evaluating, and changing to respond to the new environment. ☺

*Lesa A. Dixon-Gray, MSW, MPH, is the women's health programs coordinator, Oregon Public Health Division, Center for Prevention and Health Promotion, Maternal and Child Health Section. There she leads several initiatives, including a patient navigation program to ensure early access to prenatal care called Oregon MothersCare, development of a birth anomalies registry, and preconception health strategies.*

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## REFERENCE

1. Juran J. Juran on Planning for Quality. New York, New York: The Free Press, 1988



**Oregon MothersCare**  
supporting healthy pregnancies



# Enrolling Uninsured in State Health Insurance Marketplace

Washington State  
Department of Health

Patty Hayes

Washington State is one of 17 states<sup>1</sup> that elected to launch a state-based health insurance marketplace. Our state's marketplace, WAHealthplanfinder ([www.wahealthplanfinder.org/](http://www.wahealthplanfinder.org/)), provides a seamless experience for users, whether they qualify for Medicaid or low-cost insurance. Despite the challenges of the first week of operation, over 25,000 enrolled in just the first two weeks. WAHealthplanfinder is being held up nationally as one of the best health insurance marketplaces.

## Certified In-Person Assisters

Just how do our state's uninsured enroll using the WA-Healthplanfinder? Certified in-person assisters play a key role, providing face-to-face customer service for those who need it. Funded through a federal grant, ten in-person assister organizations lead outreach and enrollment efforts in their service areas in partnership with networks of local organizations. These lead organizations provide training, developed by the exchange, to certify in-person assisters. In-person assisters must attend these trainings, either online or in person, and pass a test to receive certification.

Enrollment goals have been set for each lead organization based on the number of uninsured and local population data. As people enroll, these lead organizations will report to the exchange on a range of measures, including number of enrollment events, race/ethnicity and age of enrollees, and geographic and population enrollments.

## Lead Organization for King County

Public Health-Seattle and King County is serving as the lead organization for King County. The county is using

data and community engagement to reach and enroll an estimated 180,000 people eligible for either the subsidies through the exchange or Medicaid expansion. An in-person assister network, consisting of 23 city-based organizations, serves as the basis for outreach planning. In one month, more than 300 in-person assisters were trained.

To broaden the network and engage community partners, Public Health-Seattle and King County has partnered with libraries, local fire departments, other county agencies, social service agencies, faith-based organizations, and health care provider groups. The network has staff from diverse backgrounds speaking at least 34 languages.

An additional boost came when Dow Constantine, County Executive, made this effort a top priority and established a leadership circle of representatives from business, labor, education, health care, and community and faith-based organizations. Members of the leadership circle are ambassadors at community events and in social marketing efforts. ☺

*Patty Hayes, RN, MN, Director, Community Health Services Division, King County, oversees the development of programs and services for low income and homeless individuals as well as families in the county. She has over 25 years of experience in public health, policy development, and advocacy. She is a former member of the Northwest Bulletin's editorial board.*

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<sup>1</sup>As of May 28, 2013. Seven planning for partnership exchange, 27 defaulting to federal exchange. <http://kff.org/health-reform/state-indicator/health-insurance-exchanges/>



## Maternal and Child Public Health Leadership Training Program

The Maternal and Child Public Health Leadership Training (MCH) Program is now accepting applications for fall 2014 for the two-year, in-residence interdisciplinary Master in Public Health degree program. Deadline for application is December 1st for the Department of Epidemiology or January 1st for the Department of Health Services. For more information, go to <http://depts.washington.edu/mchprog/admissions>. The following students were admitted for the 2013 academic year:

**Tiffany Beck** has a Medical Degree from the Virginia Commonwealth University, Richmond. While in the MCH Program, she will also be obtaining training in the field of gynecologic oncology. She is interested in outcomes research to improve cancer care for women with gynecologic malignancies, as well as comparative effectiveness and cost effectiveness of cancer treatment. Her thesis will examine the cost and effectiveness of delivering end-of-life care for women with ovarian cancer utilizing the Surveillance Epidemiology and End Result (SEER) database.

**Emily Freney** has a Bachelor of Arts degree in public health from the University of Washington, Seattle. One of her first jobs was as a recruitment coordinator at a women's clinic and research center, where she worked with women interested in becoming involved with clinical research. She is interested in contributing to women's health by improving delivery of health care services and women's understanding of their health options.

**Annie Hoopes** has a Medical Degree from Ohio State University, Columbus, and is an adolescent medicine fellow at the University of Washington School of Medicine and Seattle Children's. While in medical school, she developed an interest in prevention and global health. She worked at the Centers for Disease Control and Prevention as a tuberculosis epidemiology fellow with the outbreak investigation team. Building on a long-standing and growing interest in adolescent health, she chose to continue her education at University of Washington as an adolescent medicine fellow.

**Kate Doughty** received a Master of Science degree in nutritional sciences from the University of Connecticut,

Storrs. With a full research assistantship, she had the opportunity to work on a randomized controlled trial aimed at increasing exclusive breastfeeding rates among overweight and obese low-income women utilizing the peer counselor model. Her main area of interest is improving access and acceptability of healthy foods—namely fruits and vegetables—to underserved populations.

**Alison (Ali) Ojanen-Goldsmith** is a concurrent degree student in the University of Washington School of Public Health and School of Social Work. She has over 15 years of experience working with maternal and child health populations. Her research and professional interests include reproductive and environmental health disparities, abortion care for marginalized populations, and investigating the relationships between birth experiences, breastfeeding, and postpartum wellness. Through policy advocacy and community relationships, she seeks to normalize abortion in the range of reproductive health experiences, increase access to abortion and postpartum care for low-income people, and bring a critical social justice perspective to her public health work.

**Elise Sarvas** has a Doctor of Dental Surgery degree from the University of North Carolina at Chapel Hill. She is pediatric dental resident and a concurrent degree student in the School of Public Health and School of Dentistry. Her goal is to gain the knowledge and experience necessary to treat the dental needs of children and adolescents, especially those with special health care needs. Her research interests include management of medically complex patients, prevention of dental decay, and the association between oral and respiratory biology.

**Paige Wartko** graduated with a Bachelor of Science degree in health sciences from Clemson University, Clemson, South Carolina. She completed an internship with the Hormonal and Reproductive Epidemiology Branch of the National Cancer Institute, National Institutes of Health. Her work at National Institutes of Health with endometrial cancer encouraged her to pursue further research in women's reproductive cancers with the ultimate goal of obtaining a Doctor of Philosophy degree so that she can eventually lead research in reproductive and women's health. ☺

## Resources . . .

Affordable Care Act. Georgetown University Health Policy Institute Center for Children and Families.  
<http://ccf.georgetown.edu/aca/>

Affordable Care Act, State by State.

[www.hhs.gov/healthcare/facts/bystate/stateby-state.html](http://www.hhs.gov/healthcare/facts/bystate/stateby-state.html)

The Affordable Care Act: How Will it Work and How Will it Affect MCH Populations? University of Minnesota Leadership Education in Maternal and Child Public Health. Fall 2013.

[www.epi.umn.edu/mch/wp-content/uploads/2012/05/HG\\_Fall20132.pdf](http://www.epi.umn.edu/mch/wp-content/uploads/2012/05/HG_Fall20132.pdf)

Critical Issues in Health Care. *JAMA*. 2013;310(18).

Health Insurance and Access to Care for Children and Adolescents. Knowledge Path. MCH Library.

[www.mchlibrary.org/KnowledgePaths/kp\\_insurance.html](http://www.mchlibrary.org/KnowledgePaths/kp_insurance.html)

Health Insurance Marketplace. Centers for Medicare and Medicaid Services.

<http://marketplace.cms.gov/>

Health Insurance Marketplace by State. The Commonwealth Fund.

[www.commonwealthfund.org/Maps-and-Data/State-Exchange-Map.aspx](http://www.commonwealthfund.org/Maps-and-Data/State-Exchange-Map.aspx)

Health Reform. Association of State and Territorial Health Officials.

[www.astho.org/Programs/Health-Reform/](http://www.astho.org/Programs/Health-Reform/)

Health Reform. The Henry J. Kaiser Family Foundation.

<http://kff.org/health-reform/>

Health Care Reform: The ACA and Children with Special Health Care Needs. Catalyst Center.

<http://hdwg.org/catalyst/publications/aca>

National Center for Health Reform Implementation. Association of Maternal and Child Health Programs.

[www.amchp.org/Policy-Advocacy/health-reform/Pages/default.aspx](http://www.amchp.org/Policy-Advocacy/health-reform/Pages/default.aspx)

National Health Law Program.

[www.healthlaw.org/](http://www.healthlaw.org/)

New Perspectives on Transforming States' Health and Human Services. Practical Commentaries on the First Year of the Work Support Strategies Initiative. Olivia Golden, ed. The Urban Institute. June 2013.

[www.urban.org/UploadedPDF/412833-New-Perspectives-on-Transforming-States-Health-and-Human-Services.pdf](http://www.urban.org/UploadedPDF/412833-New-Perspectives-on-Transforming-States-Health-and-Human-Services.pdf)

New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act.

[www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501%28c%29%283%29-Hospitals-Under-the-Affordable-Care-Act](http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501%28c%29%283%29-Hospitals-Under-the-Affordable-Care-Act)

Patient Protection and Affordable Care Act Resources for Families. MCH Library.

[www.mchlibrary.org/families/frb\\_ACA.html](http://www.mchlibrary.org/families/frb_ACA.html)

Patient Protection and Affordable Care Act Resources for Professionals. MCH Library.

[www.mchlibrary.org/guides/ACA.html](http://www.mchlibrary.org/guides/ACA.html)

Preventive Services Covered Under the Affordable Care Act. 26 Covered Preventive Services for Children.

[www.hhs.gov/healthcare/prevention/children/index.html](http://www.hhs.gov/healthcare/prevention/children/index.html)

Preventive Services Covered Under the Affordable Care Act. Improvements for Women.

[www.hhs.gov/healthcare/prevention/women/index.html](http://www.hhs.gov/healthcare/prevention/women/index.html)

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### Health Insurance Marketplaces, Region X States

Health Care.gov (Alaska)  
[www.healthcare.gov/](http://www.healthcare.gov/)

Your Health Idaho  
[www.yourhealthidaho.org/](http://www.yourhealthidaho.org/)

Cover Oregon  
[www.coveroregon.com/](http://www.coveroregon.com/)

Washington Healthplanfinder  
[www.wahealthplanfinder.org/](http://www.wahealthplanfinder.org/)