

**CCCS Health and Well Being Workgroup
March 24, 2015 3pm Meeting Agenda**

*Board Room, Administrative Office, United Methodist Family Services
3900 West Broad Street, Richmond, VA 23230
Via Conference Call: 866-842-5779 with pass code 4752632705*

- I. Welcome and Introductions

- II. Discussion of Potential Recommendations for Consideration

*Next Health and Well Being Workgroup Meeting: April 14, 2015 at 1pm in the Hanover Room, Virginia
DSS Central Regional Office, 1604 Santa Rosa Road, Richmond, VA 23229 or via conference call 866-
842-5779 with pass code 4752632705*

April 24 - Workgroup Recommendations due to Holly Coy by COB

Next CCCS Meeting: May 4, 2015 at 3pm in the Patrick Henry Building

Recommendations for Discussion
March 24, 2015

General Health

1. Increase access to health insurance coverage, ensuring services during the prenatal, infant, toddler and childhood years (*VBPD*)
2. Coordinate and expand use of medical and dental homes.
3. Reduce disparities by ensuring availability and coordination of services for diverse populations (*VBPD – particularly thriving infants*)
4. Adopt universal screening of all children 0-8 from birth and begin all services as early as possible (*ASCV - particularly early screening for autism*)
5. Provide meaningful autism coverage for Virginia families impacted by autism (*ASCV*)
6. Develop strategies to train child and family serving providers in early identification and referral
7. Single point of entry into healthcare (physical, behavioral, and dental)
8. Continue anti-smoking campaigns and anti-obesity efforts (*VDH*)
9. VFHY partner with VDH on their Thriving Infants initiative specifically supporting and sharing resources to promote preconception health through targeted tobacco prevention messaging to priority populations in Virginia. (*VFHY*)
10. Maintain and support nutrition programs such as school breakfast and lunch (*VDH – nutrition and weight health*)
11. Children who are identified "high risk" should be provided with wraparound services. Families with young children at risk need to have access to supports, including parent peers or family partners as part of the team. (*NAMHVA*)
12. Expand home visiting (funding) for at-risk families who are pregnant or have children under the age of 6 to meet at least 25% of the need statewide. (*HVC*)

Dental Health

13. Identify strategies to educate health care providers about the importance of dental health assessments
14. Increase access to dental care

Maternal/Child Health

15. Continue to support current initiatives – thriving infants, home visiting programs
16. Improve birth outcomes and maternal and child health by supporting the Maternity Care Quality Improvement Collaborative's Five Star Recognition program for hospital implementation of evidence-based best practices to support breastfeeding (*Dr Kellams*)
17. Routine follow-up at 1,3, 6 and 12 months to parents whose children have been in the NICU to ensure that they are accessing early intervention services (if needed) (*VBPD*)

Behavioral Health

18. Use a public health campaign to dispel stigma, increase awareness of early childhood behavioral health needs, and increase awareness of the availability of services
19. Provide professional development re: evidenced-based practices, and social/emotional needs as well as how to manage behavioral issues
20. Mandate core services for all localities
21. Establish quality indicators for the mandated services
22. Continue to support and fund community-based care
23. Provide family support by eliminating the waiting lists for Home and Community Based Medicaid Waivers. (*ASCV*)

24. Early childhood mental health should be screened at an early age. There needs to be mental health training for early childhood professionals, etc. Children who are identified as "high risk" should be provided with early intervention services and healthy family programs in their preschool setting. *(NAMHVA)*

Data Collection

25. Establish consistent data elements across agencies and programs *(VDH)*
26. Use data analytics for decision making

Other

27. Increase funding for early childhood services
28. We should examine the high rates of preschool expulsion rates - is this the result of behavioral challenges of these students? *(NAMHVA)*
29. DMAS should determine criteria that would trigger mandatory case management via home visiting whereby the HV services meet the requirements of an evidence-based or evidence informed home visiting model *(HVC)*
30. Kinship families are most often headed by grandparents. A majority of grandparents are living on a fixed income. When they do not get the help they need to care for the children it is the children that suffer. We get the majority of our kinship calls from grandparents trying to find food resources. We believe that inadequate supports to kinship families living in low-income are not getting the help they need for the children to be healthy. For these families to get the food benefits for the children the entire income of the household is considered and if they aren't below the poverty level they can't get food assistance for the children they are raising. These are families that have worked hard to keep their families together and to keep children out of foster care. It would be great to see some effort made to recommend a Kinship Food Program through TANF or other programs. I understand that TANF has a \$40 million dollar surplus. The children in these families could also use an increase in the TANF child only grant (\$242 for one child does not buy that child much). *(FACES of VA Families)*

Implementation

31. For all of the initiatives: healthcare provider outreach with free online continuing education modules, forms, resource lists etc. (Create a landing page to build on VDH's bfconsortium.org<<http://bfconsortium.org>> that has thousands of registrants) Also engage health commissioner to help keep them informed about the various initiatives and how they can help or access resources *(Dr Kellams)*