

## **Strong Connections for Strong Kids: Working Through the Challenges of System Collaboration**

Heather Fitzpatrick: Hello and welcome. Thank you for joining us today for the third and final webinar in the Strong Connections, Strong Kids webinar series, Working Through the Challenges of System Collaboration. This webinar is part of the Head Start National Center on Health efforts to support increased collaboration between Head Start and Early Head Start programs and the healthcare community. My name is Heather Fitzpatrick and I'm on staff at the American Academy of Pediatrics, which functions as the administrative lead for the cooperative agreements for the National Center on Health.

Before we begin today's webinar, I would like to highlight a few housekeeping items. First, regarding the presentations, if you're using Wi-Fi and are not hardwired, you may experience greater lag time during the presentation. The slides will advance automatically throughout the presentation. Attendees will not have control over the slides. All attendees' lines are muted, but if you have a question, we encourage you to type your question in the "Ask a Question" box on your screen. There will be a short Q&A session at the end of the webinar. If we do not have time to address your question during the webinar, we will provide a direct response within a couple of weeks.

In addition, we will post responses to all questions with the materials on ECLKC. If you are listening to the webinar by phone, please click on the "Listen by Phone" button that is just above the "Ask a Question" box. To view the presentation in full screen, please click on the black button at the upper right-hand corner of the presentation slides. After the webinar, you will be redirected to an online evaluation. Please take a few minutes to share your feedback on today's event. Only participants who complete the evaluation will receive a certificate of participation. If you're watching as part of a group, the person who logged in for the webinar will also receive an email with a link to the survey. Please share this link with the rest of the group so that they can complete the evaluation and receive their certificates.

If you need technical assistance during the webinar, please dial 888-205-3438. For those who may need assistance with listening options, please call this number as well. Again the number is 888-205-3438. During today's webinar, our speakers will be sharing their experiences and strategies for overcoming challenges that prevent better collaboration between healthcare and Head Start.

And at this point, I'd like to go ahead and introduce our first speaker. Dr. Anne Edwards is Chair of Pediatrics at Parks Nicollet Health Services in Minneapolis, where she also practices general pediatrics, serving an urban immigrant community. Previously having served on the AAP's Vision of Pediatrics 2020 task force, she now serves as a chair of the American Academy of Pediatrics committee on state government affairs, and as a liaison to the committee on federal government affairs and subcommittee on access. Dr. Edwards is a past president of the Minnesota chapter of the American Academy of Pediatrics, and currently serves as the chapter's policy committee chair. She's also a member of the Kansas chapter of the AAP, and is a member of the section on hospital medicine and the council on community pediatrics. Additionally, she was active with the academy early in her career with the section on medical students, residents, and fellowship trainees. She has served on numerous state initiatives, including the Minnesota Medical Home Advisory Committee, the Payment Reform Working Group for the Minnesota

Legislative Access Commission, the Minnesota Kids Integrated Depression System Advisory Committee, Autism in the Somali Community Work Group, and she co-founded the Minnesota Child Health Improvement partnership. She currently serves on the National CHIPRA Center of Excellence for Quality Measurement Development for Children with Special Healthcare Needs, based out of the University of Washington. Dr. Edwards has received numerous awards, including the 2010 Blanton Bessinger Child Health Advocacy Award.

And with that, I will turn it over to Dr. Edwards.

Dr. Anne Edwards: Thank you. So today we're really here to talk about Bright Futures and how Bright Futures interacts with state Medicaid programs. Also what the Affordable Care Act has to say about preventive care and Bright Futures, and how all of this intersects with Head Start. Well all of us who work with or in government know different programs have different goals, and we are all concerned about the health of children. Oftentimes we have to look at how to align these policies and procedures to ensure the best care for children. And again, today we're really here to talk about preventive healthcare for children. For all of us, preventive care is the hallmark of pediatrics. Pediatrics is not just concerned with the treatment of disease but the promotion of children's health and development throughout the course of their lives. What's called "health supervision" of children has evolved considerably in the past half-century. It first was employed to address areas of nutrition, child rearing, and the prevention of infectious diseases.

Today, preventive care for children also means illnesses caught and treated earlier, developmental and milestones monitored and measured, and the provision of life-saving immunizations. At well-baby and well-child visits throughout the course of childhood, the pediatric medical home takes the patient and family history and conducts measurements to monitor growth, sensory screenings such as hearing and vision and body mass index, behavioral assessments such as screening for developments in autism, physical exams, and scheduled procedures such as a lead screen. In addition, we look at the oral health of a child. Ultimately, all of this is to make sure the child reaches adulthood healthy and sound.

Now as a general pediatrician, many families interact with me quite frequently and very early on in their lives. In fact, every two months, the first year of life. And we really enter in a journey. I can think of many examples where prevention and many of these services have really improved the journey of a child. I have one family who really shared with me. They started to notice some delays in communication, and this was verified by one of the early screenings. We subsequently found through a hearing screen that the child had an acquired hearing loss, something that had not been noted at birth. Through medical interventions but also linkages to other therapies, this child was able to enter kindergarten ready and really has done very, very well both academically and socially, all because of the preventive services early in life.

The home of the AAP's recommendations for preventive care for children is Bright Futures, and this really has become the gold standard of preventive care for pediatricians. So what is Bright Futures? Well we say that Bright Futures is a set of principles, strategies, and tools that are theory-based, evidence-driven, and systems-oriented; that they can be used to improve the health and wellbeing of all children through culturally appropriate interventions that address the current and emerging health promotion needs at the family clinical practice, community health system and policy levels. But what does that really mean? Released most recently in 2008, and updated in 2014, Bright Futures is a book that provides detailed information on well-

childcare for healthcare practitioners. The centerpiece of Bright Futures is the comprehensive set of health supervision guidelines, which is also known as the periodicity schedule of well-child and well-baby visits. This has been developed by multi-disciplinary child health experts ranging from providers and researchers to parents and other child advocates. And it provides a framework for well-childcare from birth to age 21.

These guidelines are designed to present a single standard of care and also a common language based on a model of health promotion and disease prevention. So this is the Bright Futures periodicity schedule. I'm sure everyone can read that, correct? In this form, perhaps it's not the easiest to read, but what is important is this chart offers AAP Bright Futures recommendations for every recommended preventive care visit, from the first pre-natal visit until age 21 years of life. Each child and family is unique, therefore these recommendations are designed for the care of children who are growing and developing well. Additional visits may be necessary if circumstances suggest so. Developmental, psycho-social, and chronic diseases issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. If we blow up the periodicity schedule here, you can see how it is structured, with columns of recommended visit ages and rows of recommended screenings and services for that visit. This captures just part of the schedule, but we wanted you to see the nuances and details that go into each recommended visit and the corresponding service recommendations.

The 2014 update of the Bright Futures periodicity schedule corresponded with a move to a live periodicity schedule. In a sense, this is a real-time version of the schedule, which is available online and will continuously be updated upon notification and publication of a new AAP policy statement or clinical report or endorsement of an external document that might change the schedule's screening or preventive care recommendations. In a sense, this really makes it much more timely. We no longer have to wait for a new edition of Bright Futures to be published to update the schedule. It will change just as clinical recommendations do. We don't really need to go into the weeds in the 2014 update to the Bright Futures, but here you can see the changes that were made, some of them linking to congenital heart disease but also reaching out into adolescent care. Again, the AAP makes new clinical recommendations that affect well-baby and well-child visits. And so now, as you can see, it will be updated in real time. So important for state Medicaid programs will be how quickly they can update their EPSTD periodicity schedules to match current Bright Futures recommendations.

This is something we will talk more about in just a minute. Given the prominence of Bright Futures and the new special attention Bright Futures has received-- sorry about that. Given the prominence of Bright Futures and the new special attention Bright Futures has received because of the Affordable Care Act, we wanted to make sure you were aware of an AAP resource just released this year. It helps policymakers and payers unpack each Bright Futures periodicity schedule recommended visit. It directly described coverage of elements of Bright Futures in the ACA called Achieving Bright Futures, and available at [www.aap.org/AchievingBrightFutures](http://www.aap.org/AchievingBrightFutures). You will find a page dedicated to each recommended visit. When you click on that visit, you are taken to a page that documents all the recommendations for that visit, along with the appropriate billing codes for the screenings and services.

For example, if you click on the one month visit page, you would be taken to a document where the services are broken down by category: history, measurements, developmental behavioral

assessment, physical exam, procedures, and anticipatory guidance. Each visit includes standard language regarding how services should be reported and paid. Listed too are the billing codes used to document these services at each visit. Additional details for the visits are also included, such as when follow-up or referrals are recommended. These documents can be helpful in understanding the Bright Futures periodicity schedule, including all that goes into the well-baby and well-child visit, and how payers can pay for each service provided at these visits. So how do all these moving pieces interact? We have new recommendations to cover Bright Futures in private insurance via the ACA, we have Medicaid's requirements, and then we have Head Start. Let's take a look.

You may have heard a lot about the Affordable Care Act requirement to provide preventive care without cost-sharing. This is something that the academy fought very hard for. To drill down into specifics, the Affordable Care Act requires non-grandfathered, private healthcare plans to provide preventive services free of cost-sharing for families. This slide shows what this means for different populations. For children's, it means that the AAP, ACIP-recommended vaccines and Bright Futures periodicity schedule of preventive visits. But of note, this ACA requirement does not apply to Medicaid plans, only non-grandfathered private plans.

So while there's increased attention being paid to Bright Futures throughout the healthcare system, and the academy certainly advocates that all plans public and private follow Bright Futures to ensure seamless, timely coverage for children across plans, this ACA requirement does not touch state Medicaid plans. So what does Medicaid require? Medicaid has a specific and special protection for children through age 21 known as the Early and Periodic Screening, Diagnosis, and Treatment benefit or guarantee, sometimes known as EPSDT. EPSDT is more robust than Medicaid benefits for adults. It is designed to assure that children receive early detection and care so that health problems are averted or diagnosed and treated as early as possible. EPSDT entitles enrolled infants, children, and adolescents to any treatments or procedure that fits within any of the categories of Medicaid-covered services if that treatment or service is necessary to correct defects and physical and mental illnesses or conditions.

Boiled down, EPSDT requires that state Medicaid programs establish a schedule of well-baby and well-child preventive care visits, and that any service or treatment a child is found to need, the 'T' in the EPSDT is provided by Medicaid. This is an extremely important protection for children. And the federal government monitors EPSDT through a specific reporting form at the federal level. Your state may have a specific name for preventative visits under this program. In West Virginia, it's known as health check. In Minnesota – my home state – it's called child and teen check-ups. As stated, each state Medicaid program is required to maintain schedules of preventive visits for medical, dental, hearing, and vision. With respect to medical, the law does not require states to use Bright Futures, as we stated previously.

Federal law requires states to base these periodicity schedules on current practice standards, and the states must "consult with recognized medical and dental organizations involved in child healthcare." However, again this doesn't mean the states have to use Bright Futures. We do know, however, that most states do use Bright Futures for their EPSDT schedule. However, there can be differences between referencing Bright Futures and ensuring that payment is made according to the most recent recommendations. So where does Head Start fit in? Head Start performance measures look specifically at the EPSDT schedule. So if this EPSDT schedule and Bright Futures are not in alignment, this may lead to some discrepancies as to what the

screenings and services are being done at a well-baby or well-child visit. And this may impact the recorded performance of the Head Start program.

There can be some noted discrepancies between a state's EPSDT program and Bright Futures, such as lead screening, which can be a problem for this population. Also, there could be procedural issues at play. As noted in the Head Start performance measures, programs are to make a determination within 90 days as to whether a child has an ongoing source of care and is up to date on the EPSDT preventive care schedule. If the child is not up to date, Head Start must help parents make the necessary arrangements to come up to date. However, a child entering Head Start could be significantly behind on preventive visit schedules and several issues could impact the ability of the child, and therefore the program, to meet the standards. These would include practice scheduling availability, the ability of families to take time off work to take a child to the doctor, the time needed to obtain necessary release forms so that Head Start and a physician's office can ensure progress on the child's care, and making sure documentation of the child's preventive care progress is transferred to the program. I'm sure you can think of other examples.

Medicaid procedures can also impact how preventive care is provided, such as whether preventive visits are bundled. If a pediatrician isn't paid for a specific service, there is a disincentive to provide it, which then could impact whether or not the service is rendered or recorded properly, thus impacting the Head Start performance measure. The goal is really to have everyone using Bright Futures. This may mean aligning systems and practices to make that happen. As pediatricians, we know we have work to do – a lot. Bright Futures still remains the gold standard of pediatric care. And as pediatricians, we should work at all levels to ensure that we are providing preventive care in accord with these recommendations. With respect to our various programs, this means working to ensure that Medicaid covers all Bright Futures recommended services; that if there are discrepancies between Medicaid's EPSDT schedule and Bright Futures, that they're addressed. It also means that issues identified by Head Start with documenting care for children in the program are addressed. Head Start programs can tell pediatricians what issues are with performance measurement and ways we can work together with Medicaid and Head Start to improve.

All of this means we have work to do together and we should look for opportunities to collaborate, dialogue, and address problems so that all children in Medicaid and in Head Start receive the best possible care, which we really know is the goal of everyone here on this webinar. And importantly, our families really expect us to collaborate, to support the optimal future for their children. The AAP Division of State Government Affairs is happy to help with issues related to Medicaid, EPSDT, and Bright Futures. Here's their contact information if you'd like any assistance from the AAP on these issues.

Thank you.

Heather: Thank you Dr. Edwards so much for your presentation. Really helpful information. As a reminder, we'll be addressing questions at the end, but feel free to enter them at any time throughout any of the presentations.

I'd like to go ahead now and introduce our second panelist, Ms. Karen Ayers. Karen Ayers has worked for the Oregon Child Development Coalition for the past nine and a half years in a

variety of positions, and currently she is the Program and Partnership Manager. Ms. Ayers brings a background in nursing and system development to her work, coordinating projects for the Oregon Child Development Coalition's statewide efforts of creating communities of learning. She's an advocate, an active member of numerous statewide committees, with the focus of improving family and health services for children and families throughout Oregon. Karen, I'll go ahead and turn it over to you.

Karen Ayers: So the first thing that I wanted to talk about was overcoming challenges to effective collaboration. So just a little bit about our organization and you can see the depth and how far we reach and some of the real challenges that we face. So our organization, we lie in 13 counties throughout Oregon and we provide services for over 4,000 children and we run five different programs. And so we're in some of the rural and the frontier areas out in Malheur, Klamath, and Jackson, and as well as in the Greater Portland area. So it's pretty diverse when it comes to partnerships and what that might look like and how we might be able to create that.

So what is a medical home? A medical home is not a building, clinic, or hospital, but an integrated partnership that provides comprehensive healthcare services to children and families in high quality and cost effective delivery systems. So for those of you that don't know, in Oregon here, we are in the midst of a healthcare transformation and it's been working over the last three years and it is around our Medicaid population. So we have what we call CCOs, so community care organizations, and they're working collaboratively with DCOs, so our dental care organizations. So within Oregon, they have changed the way that they're delivering the services for all of our Medicaid population and expanding some of those services across the state, especially to adults. And in doing that, as we move through that transformation, you can only imagine the bumps that many of our families have encountered.

So it takes a very long time to establish this home and to build partnerships so that our families feel comfortable in going there. And then when they come along and do a complete transformation, what we found is that numerous of our families were now assigned to a new provider. And to even create some challenges, we have families that there might be three or four children in the family, and some of those times that they were actually assigned to different providers. And so as Head Start programs then, we have to work collaboratively with those DCOs in order to help our families be able to navigate both systems and try to figure out what those are for ourselves as they were in the middle of this transformation. But also to then establish a whole new realm of things for families with a new pediatrician, a new dental provider, a new mental health provider, and all of those different areas.

So as we think about establishing that medical home with our providers, and in order for our families to be able to connect them, there's a lot of work for us to be able to do as we move in that direction. So the very first thing that we did here at the Oregon Child Development Coalition is: what is your vision? So as an agency, as you think about all of the things that you're wanting to work through with your families, you have to look at your agency's plan, your strategic plan, and decide: what is our vision here and where do we want to go with that vision? And if you haven't done that, then that should be your first step, to be able to sit down with your management team and talk about what sorts of services are your families needing and where we're going to go from there.

And as a part of the Head Start program, we know that we do things like our community assessment. And within that community assessment, what does it look like within those communities where our Head Start centers lie? And as you can see, with us being in 13 different counties with the Oregon Child Development Coalition, each one of those communities can look very, very different. And so it takes a lot of work for us to work collaboratively with our county staff. And I'm here in our central office in Wilsonville to try to understand what's happening within all of those areas. So how can you enhance what you are doing with your current resources? And who are those partners? So who are those partners that currently exist within those communities? What do they look like? What kind of services are there? And who are those new partners that might be there within that community? And does it align with your mission and your strategic plan? And what is your PIR data telling you? And what is your community assessment telling you? And when we think about: how is your HSAC involved? What does that look like?

So one of the things that I did here at the Oregon Child Development Coalition as we started moving our HSAC forward is that I felt like it was really important to have other players that are at the table besides our medical and our dental services. So I intentionally reached out to establish partnerships with many other different entities and brought them into our HSAC meeting. And one of the things we do a little bit differently here at the Oregon Child Development Coalition is that I oversee health and family services, and those are partnered together. And so we have family and health services supervisors and we have family advocates. So we look at both of those avenues together. So when think about services for families, it's important to bring other organizations in, like your housing, and your food safety net programs, and your WIC, and your food bank, and legal aid, and those different types of things that I was able to bring forward to help have more comprehensive and more collaborative services for our families. So what does that success look like? Well it looks very, very differently for each program and not only for – and agencies. So like I said, we serve five different programs here at Oregon Child Development Coalition.

So we have Early Head Start, home-based, we have a [inaudible] program, we serve migrant and seasonal families, and we have Oregon pre-kindergarten programs. So we have some home-based programs as well as some center-based programs. And so we had to sit and decide: what does that success look like? And each program has to determine what it looks like in the beginning to achieve it in the end. So like I said before, when you're thinking about your vision and your mission and your strategic plans, what does that success look like for you? And what does that success look like for your families? And what we know is that people who share a common direction or vision can achieve their goals more quickly and easily when they share information, activities, and resources.

And by working together, we can achieve common goals that otherwise could not be achieved alone. And one of the things that I think that works really well is it pays to assume new roles and to share leadership, and taking the time to reflect on and to celebrate achievements brings renewed energy and commitment. And so sometimes I think that when we set up our goals, that if we don't look at those small steps as we're moving forward, then I think it's difficult for us to get to the end game. And so some of the examples that we have done, and one of the things that we were looking for here within our organization is bringing those partnerships a little bit closer to our families. And like I said, sometimes thinking outside of the box and thinking around that this medical home or that dental home does not have to exist within a brick and mortar

building. And in one of our counties, what we were able to do is have a partnership with our local FQHC – so our federally qualified healthcare center – and I was able to meet with them numerous times and to set up a contract in place where we actually have an on-site provider in one of our counties.

And especially during our migrant and seasonal program when we have a lot of families who are coming in. And in this one particular county we serve about 344 children in a very, very short period of time. And so we were able to have an on-site provider from this FQHC, and they were able to – they're there for 24 hours a week, and so she comes on site in the morning and then starts being able to triage all of our children. Because within this one particular county, we have three different centers that we provide services to, and she travels around the centers and is able to assess children. She has her laptop so the FQHC and this county is where most of our families are – this is their medical home to begin with. And so she's able to pull up their records and see the history on children to be able to work closely with them, as well as then they will send someone – as a part of their outreach program – will then move into migrant housing or where families are, and we'll do home visits with them. Or we'll triage the child and then be able to get the child an appointment. And then the Head Start program works closely with the families to be able to ensure that they keep the appointments. We've done the same thing with another FQHC La Clinica in the Hood River and the Dallas area, where we have on-site providers out there during our summer programs and through our peak programs. And then one of the other areas that we've been able to do is that I've been working across the state, but specifically in Multnomah County, and I'm negotiating and putting a contract together with a public health nurse.

And I think those are some of the areas within your health department – and if you're like Oregon, a lot of our health departments, staff, the numbers have been cut and cut and cut. And so at Head Start programs, we all need nurses and we all need public health nurses. And so what I'm trying to do is I'm trying to pull together other Head Start programs and see how we can piece together a 0.5 or a 0.75 FTE for a public health nurse. And then this public health nurse will be on-site in our building for eight hours a week.

And within the center, we have several home-visiting programs, so the nurse will be able to go on home visits with our family advocates. They're there to answer any questions for parents. They're there to help us with our medication administration and our delegation process, as well as training staff and training our family advocates in regard to any sorts of things around a tube feeding or an EpiPen or any of those other different types of things. I think one of the biggest things that I think about as I think about collaboration is that moving it from cooperative into collaborative, it's much like in Head Start programs where we have our 18-month-olds and our two-year-olds, and they do what we call parallel play. And I think we all play nicely together with a lot of our partners and we're all in line with each other.

And what I really try to do is I try to get them to move into collaborative play and cooperative play, which is what – instead of us playing alongside of each other, we're actually working together, much like children do, where they're actually not all playing with the same toy lined up next to each other but they're all playing with one toy or pretending to do something together. So how to make it work. For Head Start programs across the country, collaboration poses both an opportunity and a challenge to get people in organizations to work together in new ways.

The road to collaboration is neither straight nor easy. It involves changing the way people work and think. When people collaborate, they move from competing to consensus building; from working alone and including others; from thinking mostly about activities, services, and programs to thinking about the big picture; and from focusing on short-term accomplishments to achieving long-term results. The difference between the symptom and determining the diagnosis. What are the things that we do here too is that we have a Parent, Family, and Community Engagement statewide committee, and our parents are very involved in our decision-making. And so lots of our partnership building, as well as our systems and our processes, start out of the Parent, Family, and Community Engagement committee as well as the HSAC committee. And many of our parents who are on our Health Services Advisory committee are also a part of our Parent, Family, and Community Engagement.

And so I think that those things – having parents involved from the very beginning I think is very successful. And a lot of times having parents in the very beginning, as well as bringing those partners together, around our medical providers and our dental providers and our mental health providers, and we have parents at the table from the very beginning, then I think that helps in establishing those relationships. Establish roles of who will do what and how, does enhance the work that is already being done. And then think about all the possibilities. As we were talking early about lead, that's been a huge challenge in Oregon, as Oregon really has a waiver in place and that they were just using a questionnaire rather than actually providing the services at 12 months and 24 months and doing the blood draw for our infants and for our toddlers. So one of the things that I was able to do is that I was able to build a relationship with Barb Zeal, who was the head of our Early Childhood Lead Prevention team here in Oregon.

And then I was asked to sit on part of her committee. And then bringing those things forward around EPSDT in Oregon and some of the requirements around Head Start programs, what we were able to do was to meet with DMAP, who is the provider of Medicaid services here in Oregon, and we were able to talk about the questionnaire and talk about what Head Start is requiring us to do through EPSDT. And then we were able to put a question on this questionnaire that says: Is this child enrolled in Head Start? And with this questionnaire in Oregon, if it's "yes" or "I don't know," then they move forward and then they actually will do the venedraw and look at the lead levels. And so those are some of the things that I think that individuals can do. When you think about your vision, you think about your gaps and where those gaps may lie within your organization. And then what I do in building those partnerships is that I intentionally plan for those.

So one of the strategies that I have is that whenever I'm at a conference or whenever I am at a workshop – whether it's here in Oregon or nationally – is that I intentionally seek out and listen during introductions, and then I go introduce myself to two new people that I don't know and ask them some questions about their organization and what they do, and then I take their cards. And then when I get back, I shoot them an email and follow up with them, and then from there, then I start asking them more questions and spending either time on the phone with them or doing those different types of things. I start building those relationships with them because I know that somewhere in the future that I might be needing the organization to be able to support our families or to be able to enhance some services that are there in Oregon. One of the other things that we have done too is that we've done some things around food security, and we've worked collaboratively with WIC and asking two questions around food security. And then

we have now been able to train some of our WIC staff, and now WIC in Oregon is actually asking some of those questions as well.

So what are the challenges? Well within our organization, because we're so large and because we lie across the state, we have numerous, numerous challenges. And again, if we can go back and we can use our data to help us with those challenges and we can look at our PIR data in regard to: are we struggling with immunizations? Are we struggling in establishing those medical homes? Are we struggling with the treatments for some of those dental services? And being in 13 different counties, it looks differently in lots of places. In one of our counties, we actually had a mobile medical unit that was run by Providence and the local FQHC nurses were a part of it. And they actually came and they sat across from our building in Odell and then in Parkdale. And then the funding went away, and so now this medical unit is not up there, which again was an extension of that medical home, because it was the nurses from the local FQHC that were actually on the medical unit that was there.

And so now it has created some challenge for us and for families because before, they were able to come to our center and access that medical entity that was sitting right across the street from them. And so now it's around building those partnerships. How can we get those nurses and another medical unit within that community to help support those families? Because then otherwise they have to go all the way down to Hood River, where before it was coming up to Parkdale. So all collaborations face challenges. Depending on how the challenges are handled, they can either cause the collaborative to lose momentum and collapse or it can be a springboard for creativity and revitalization.

One of the things that I always think about is think way outside the box and just think about what that might look like, and then just start bringing those things forward into the table and as you're talking around with partners. Because you don't know what they might be willing to do unless you're willing to ask the question. Some of the challenges that we face here are the resource times and how to make them stretch and how to make enough time for that. And transportations for families is a huge issue for our families, especially for our migrant and seasonal families who are here in Oregon. And a lot of our population we serve are monolingual Spanish-speakers.

So ensuring that translation is in place and interpretation is in place for our families as well. And then for us, it's just trying to understand how to navigate the healthcare system. As in Oregon, we're in the middle of the transformation, and so it's changing. So we have to strategically ensure that we have our local staff as well as those of us that are here in central office sitting on committees so that we can ensure that we have a voice at the table for Head Start families, as well as all low-income families in Oregon.

Heather: Thank you so much Ms. Ayers. I appreciate your presentation and some great examples there.

And we'll move now quickly through our final speaker, Dr. Danette Glassy. For 25 years, Dr. Danette Swanson Glassy has been a primary care pediatrician at Mercer Island Pediatrics, near Seattle. For the American Academy of Pediatrics, she is a member of the executive committee of the Council on Early Childhood, and a member of the Head Start National Center on Health advisory committee. She is co-editor of the third edition of *Caring for Our Children: National*

Health and Safety Standards for Out of Home Care, Third Edition, and the spin-off, Stepping Stones to Caring for Our Children. She also serves as the chapter childcare contact in Washington state and mentors other chapter childcare contacts.

Dr. Glassy advocates for quality environments and experiences for young children by lobbying, tweeting – and she can be found at @glassyMD – and facilitating community projects. Much of this work is in collaboration with the Washington chapter of the American Academy of Pediatrics, as the early learning committee co-chair, with the Coalition for Safety and Health in Early Learning, and as a board member of the BestStart Washington. And I'll turn it over to Dr. Glassy.

Dr. Danette Glassy: Great. Thank you so much. And thank you all for joining this webinar, and to Dr. Edwards and Ms. Ayers for their information. I am happy to be here and bring you some examples and suggestions for your practices on the ground level there. I wanted to start by reminding you about Caring for Our Children.

There are many influences on your practice as Head Start providers, and one of the things that's an influence through people nationally and in your state, but also for you as a resource, is Caring for Our Children: National Health and Safety Performance Standards. You can find this entire compilation of what the experts around the country think is best practices in early learning settings right there at [cfoc.nrckids.org](http://cfoc.nrckids.org).

You can also pick up a print copy of the book from the American Academy of Pediatrics, at their website. It's national standards, best evidence, expertise, and experience came together to say, "Here's your health and safety practices for your early learning settings." It's quality information. And a reason to go look at this is all the resources that are there for you to be able to implement these things in your organization. Each standard has the standard written out. Here's what you should do. The rationale for that: why were the experts saying this for you?

Comments. And often the comments have resources or recommendations for implementation. It goes into what type of facility it might be important for. It tells you what related standards are so you can look to it too, and then references. In the back of Caring for Our Children or at the end of the website that has this whole thing, are the appendices. And again, rich with resources that may help you. There is reference on the NRC website also for Head Start Performance Standards and state licensing rules. And also, Caring for Our Children influences the development of Head Start Performance Standards and your state licensing rules. You heard mention of Stepping Stones. The experts that came together and wrote Caring for Our Children said, "What if we distilled down those over 600 standards to the ones that we think are going to prevent the most harm?"

And that was Stepping Stones. And so if you really wanted to distill down to the most important ones, you can also see Stepping Stones to Caring for Our Children online in full text at that NRC website. So there are many things that influence your practice. One is the evidence-based practice, such as what's in Caring for Our Children. There are your Head Start Performance Standards. If you're not following these, you are held to that standard to continue to get your grants. You know more than I do probably about how to look up the standards and read them and interpret them. And of course, this is a little reminder that a rich resource for you is through the Head Start technical assistance program. And for health and safety, I've given the website

there for going to it. As you know, the American Academy of Pediatrics is the lead agency that provides that resource. But look to that when you're having questions about your Performance Standards. You also are influenced by your state licensing rules. Many states really require you to look at those and integrate those into what you're doing. If you're not quite sure about your state licensing rules or want to learn more, you can go to the NRC Kids and click on your state and find out what your state licensing rules are for childcare. And I wrote out – if you didn't have a link there – how to get to it directly.

Before I go on to the challenges though, the other thing that's coming up in our state are so many Head Starts and child cares are collaborating now with school districts. And some of the rules that school districts have may not be completely in line with what your state licensing rules are, which are not in line with the Performance Standards, which maybe Caring for Our Children says something else. So the challenges, of course, include all of those influences through your best practice. The other challenge though are the pediatric providers. You heard Dr. Edwards say about the consensus that came together that said, "This is best practice in a pediatric provider's office for when children should have a well-child visit and what should happen in that well-child visit." And indeed, the studies show that when children have a regular source of care and that care is comprehensive and culturally sensitive and continuous, and many other words that start with "c," that that child has better health and better outcomes for all of the reasons that she talked about.

But reality is not necessarily that. There are all kinds of pediatric practices, and many people who are the lead of those. And as Ms. Ayers told us, sometimes you don't even have that as an option and you have to be creative in how you can get an ongoing source of healthcare to the child. So pediatricians, there's family practice, there's general practice, physician's assistants, and nurse practitioners. And they all have variability in their training. Did they even have much pediatric-specific training? Are they board certified? Something that's becoming more and more important to states as they license, but not across the board. The other one that, of course, is a challenge to the pediatric practice is the reimbursement for the care that they're giving. Dr. Edwards mentioned that to us. She gave the example of sometimes a pediatric practice is given a set amount of money. And when your particular student needs more care than they budgeted for, that's a big problem. And many states, including my own, still do not completely reimburse for the care that is provided in our pediatric homes, the children who are covered by Medicaid. So it's the stance of the money as well. Other is the variability in state requirements.

You heard from Dr. Edwards a complete discussion of this. You have: how often are well-child checks covered? What and how often are tests covered? And sometimes have these requirements and they don't enforce them. And so you can have a practice that's not, again, incentivized to even follow what they're supposed to be doing. So that's another challenge. There is variability in diseases and conditions. Ms. Ayers pointed out that in Oregon and Washington likewise, we don't have the same lead exposure and lead poisoning problems that other parts of the country do, so our primary care doctors are reluctant to do a blood test on everybody. Yet we know that there are population-specific problems for diseases and conditions. And then there's the challenge of the program understanding.

And again, I urge you to always contact your T/TA systems for the health component at the AAP, through an email, website, or online. Timing was mentioned. You have 90 days to require that. But I can tell you in my office in August, I sometimes get 40 requests for writing up a

confirmation that someone had a well-child visit for whatever program. So it can take me a couple of days to work through those piles at the end of a busy day. So the timing can be difficult. I didn't want to leave us without solutions. And so I wanted to talk through some of those. One of them is training. Training for programs and for all the people who participate; maybe training for your Head Start advisory committee people who may only have a peripheral understanding of Head Start, but are rich in partnerships and resources for you. So there are the Regional Health and Safety Conferences. And encouraging as many of your health staff, teachers, program supports to be able to attend these, including your volunteers.

There is now specific training for Orientation for Health Service Managers. And again, making sure that your health service managers are up to date on what is the latest in best practices, including the resources and support for linking medical homes and your program. There are state and local program trainings as well. And these are especially important to highlight the local disease-specific issues and conditions, such as the lead screening program. So in Washington State, the Washington chapter of the American Academy of Pediatrics is partnering with our department of health to begin that process to get a waiver for our EPSDT requirement for lead screening of every child. Yes, you heard me right. It might be official some-day. But it's a process. And so in the meantime, we still should be checking for lead poisoning in children, especially in Head Start.

Another solution I think is the support, getting more support for your health service managers and your health by providing them with training and linking them to programs, encouraging them to reach out. Also your health service manager networks. There is a move so that every state and region has manager networks that can share tools and solutions, and that can be very helpful, again, on a local basis. And your childcare health consultants. If you don't know who your local childcare health consultants might be, you can go through the AAP's website, [healthychildcare.org](http://healthychildcare.org), and click on your state and find out links to find these people in your community. Tools: I think systematic tools are really the key.

I want to share with you one of my patients. And we're just going to call him Patient D. That's not his picture but it's a delightful picture I wanted to include. He goes to a Head Start program through Puget Sound Educational Service District. So that's a loose affiliation of many school districts in our area that run quite a few Head Start programs. And he moved to Washington State from Iowa. He was four and a half when that happened. And he enrolled this fall in a Head Start program in his community. They immediately asked his mom, of course, "Who is your primary care doctor?" She gave them my name, and they sent me a packet. And I want to share that with you. One of the things that was in the packet was our state's EPSDT form for what is a complete well-child check. And you probably can't see the specifics on here, but many states have these. And if I didn't know anything about EPSDT or about the requirements of EPSDT, this is a pretty simple form to look at, see if it matches what I'm doing, or to fill out or try to fill out. So they gave this to me as an example, but they know that I could include my own.

The other thing that was in that packet was this letter. And it was a very nice letter that reminded me what they would need to enroll this child. Head Start regulations require that every child have a well-child exam within 90 days of enrollment. Now that's not quite true. Remember what we said? Well-child visits at three and four especially are usually yearly. But that they have documentation of a well-child exam within 90 days.

If a child has had such an exam within the last 12 months, they go on and explain a report of that exam fulfills this requirement until the next well-child exam is due. So they're telling me, "Hey, there you go. You did one six months ago. Fine." They tell me that the parents of my Patient D and his birthdate has enrolled in their Head Start, and that they indicated that such an exam had occurred within the last 12 months. Well, for my Patient D, it occurred in Iowa, but this was a chance for us to get better acquainted. They then wrote by hand – which is always brings it right to your face – please include the test results for any blood work for lead or hematocrit or hemoglobin. If these tests were not recommended by the provider, please indicate that. So they're telling me, "You know what? You have to not only show us what you did, but on these specific tests, you have to give us the results or tell us why and sign your name off on that," so that they are covered for their requirements.

I thought this was the most clever thing I had seen. And of course in the packet also came my HIPAA and FERPA and all those other things where the parents said I could talk to the family. So I know we're running out of time, but I would challenge all of you, through your health services advisory committees maybe, to create these communication tools that are state-specific: a letter explaining what you need, a copy of the form that your state uses for their use, a release of information from the family, and include that extra note about your problem areas, lead, hemoglobin. Maybe it's vision and hearing. Maybe this is an office that just does not feel comfortable doing vision or hearing on three and four-year-olds. Again, I told you there are many kinds of pediatric providers that may not have that expertise.

But again, tell them that's what you need, and developmental screening of course. So I hope these tools have been helpful for you. I challenge you to partner, as Ms. Ayers told you to, with all kinds of people, including your state's chapter of the American Academy of Pediatrics, who is most knowledgeable about all of these things and can work with you to help you meet your requirements; and to reach out and keep striving for that best practice. Thank you so much for staying online and listening to my part.

Heather: Dr. Glassy, thank you so much. And thank you to all the presenters again for sharing your experiences and your expertise. I know we're running over but we do have a couple of – they're always good questions but – just a couple of good questions, which I think might be helpful. So I'm going to turn the first one over to Karen Ayers to see if she can tell us how parental consent and HIPAA is secured with the FQHC doctor that comes to see the children on-site at the Head Start centers there in Oregon.

Karen: Well, and especially because they're there to provide mostly services to our migrant and seasonal families. And so during our enrollment process, we already know who it is that's going to be on-site. So as we're enrolling our families into our program, we're getting a consent to treat, and we specifically break it down to well-child exams, hearings, visions – because we do OAEs on all of our children as well. And so we get the consent for the parents to do that, as well as filling out a release of information, ROI, that specifically says that this provider is going to be on-site and is going to be providing services to your child, and that we're able to talk to them.

Heather: Great, thank you. And the final question that we had, which we'll address today, is about one participant noted that as we were moving between speakers, we started taking up a greater focus on some of the social, economic, and cultural challenges that our children face. And this person asked if Bright Futures will be working on expanding the content, the line that's

in there currently, on psycho-social and behavioral assessments to talk about identifying toxic stressors, looking at parenting skills, executive function in children. And then the second part of that question: would insurance be moving towards funding services to develop family coping and resilience? And I can answer as a staff person that Bright Futures is developing actually a new theme. And thank you to whoever set up this question, that's great. But it will actually address a lot of those issues around social determinants of health, looking at the strengths of each family and maybe some potential risks as well in how we can address those in the medical home. And certainly as those things come online, I think the academy would work to advocate with and educate our insurance providers, as well as Medicaid and states as well around those issues so that hopefully we can get the financial support needed to support those efforts in practice. So thank you again very much for those questions.

Again, thank you to our presenters today. Very excellent information that you provided. If anyone has further questions about collaboration between Head Start and the medical home, please don't hesitate to contact the Head Start National Center on Health. Our phone number is 888-227-5125. You can also reach us by email at [nchinfo@aap.org](mailto:nchinfo@aap.org). And when the webinar ends, there will be a survey poll again that you can take immediately. And there will be a follow-up email sent to everyone who watched live with instructions about how to share the SurveyMonkey link to everyone who may have been in your group who watched today's webinar.

So again, thank you very much and we appreciate your time, and look forward to you on future webinars.

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