

STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE
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November 29, 2013

SENT VIA HARD COPY AND ELECTRONIC MAIL (sim@ct.gov)

The Office of the Healthcare Advocate
Attention: Victoria Veltri, Healthcare Advocate
PO Box 1543, Hartford, Connecticut 06144

Re: State Innovation Model Draft Proposal Comments

The Office of the Child Advocate is appreciative and supportive of the tremendous effort and expertise that was invested in creating the State Innovation Model (SIM) proposal. The importance of the enthusiastic leadership provided by the Lieutenant Governor and her team to improve access, quality and sustainability of health care for our citizens cannot be overstated. We are truly on the precipice of exciting and necessary health care innovation that will improve the starts and futures of Connecticut's children and families. This Office agrees that the SIM drivers of transformation—the advanced medical home, community health improvement and consumer empowerment—will be essential components of an effective working health care system. Within that framework, it is essential that we embrace the implications and opportunity for improved child health systems, to ensure family-centered, continuous, affordable and accountable care for our youngest and most vulnerable citizens. With that spirit, OCA offers the following comments and recommendations.

Highlighting Implications of SIM for Children's Well-being Care

Much of the SIM proposal rightly focuses on improving health care delivery and outcomes through better prevention or management of chronic disease or costly health issues. It is imperative that we consider and fully optimize the SIM framework to improve children's health outcomes, beginning with pre-natal development and infancy. "A Statistical Portrait of Infants and Toddlers in the United States," published November 2013 with funding from Robert McCormick Foundation and Child Trends, reports compelling demographics that must guide our vision for health care delivery.

According to this recent report:

- Nearly half of infants and toddlers live in low income families;
- One in eight lives in deep poverty;
- Nearly twenty-five percent of infants and toddlers had one immigrant parent;
- Black and Latino infants and toddlers experience worse health outcomes;
- More than sixty percent of infants and toddlers do not receive developmental screening.¹

¹ Murphey, D., Cooper, M., Forry, N., The Youngest Americans: A Statistical Portrait of Infants and Toddlers in the United States (Nov. 2013), support from R. McCormick Foundation, Child Trends, pp. 1-3, p. 101. Connecticut data
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It may be useful to embed in the descriptions of the primary drivers of transformation the importance of each driver for children's population health, including increasing parental capacity, and supporting the developmental and social-emotional well-being of infants and toddlers.

Community Health Improvement and Implications for Prevention and Treatment for Children

As the SIM proposal notes, Connecticut is home to an array of evidence-based services that support children and their caregivers. Connecticut has a spectrum of effective home visiting services that have been shown to strengthen caregiver capacity, reduce incidence of child abuse or neglect, reduce racial birth disparities, improve developmental outcomes for young children and improve clinical prognosis for caregivers. These home visiting services exist along a continuum of care ranging from the Nurturing Families Network for first time or at risk mothers to the dyadic clinical model created by Connecticut's own Child FIRST program. The challenge for these programs is replication or expanding capacity to reach all of the children and families that need them. Given the implications of Adverse Childhood Experiences data for health and well-being,² our infrastructure development should include focus on dramatic expansion of access to a therapeutic continuum of pre-natal and home visiting services. By considering these programs as Community Health Providers within the SIM framework, an opportunity is created to further develop and bring to scale critical and cost-efficient early intervention partners.³

Home visiting programs can help ensure that our most needy families are linked to the medical home and that care is well coordinated to meet families' needs. Home based supports described above should be covered under public and private insurance plans, available to all pregnant and post-partum mothers, with specialized training and quality assurance control. Home visiting can also work to ensure developmental screening of young children, a cost efficient and effective mechanism for identifying children in need of additional support services. National data confirms that many children eligible for early intervention services do not receive them.⁴

Connecticut also provides evidence-based programs for children with more serious mental health challenges through a combination of state and federal funding. Chronically, there are not enough of these programs available in our systems of care to meet the increasing need for supports. We should consider how capacity building dovetails with the SIM framework. Key challenges lying ahead are increasing screening capacity in pediatric settings (including schools and community health agencies) to better identify children who can benefit from these services, and ensuring timely and continuous access wherever needed.

Primary Care Transformation and Pediatric Well-Being Care

It will be essential that pediatric care providers have the resources to facilitate screening so that

suggests that screening rates are increasing; however it is difficult to say what percentage of infants and toddlers receive developmental and social-emotional screening at this time. See Honigfeld, J., Meyers, J., The Earlier the Better: Developmental Screening for Connecticut's Young Children (Oct. 2013) pp. 16-18.

² Shonkoff, J. P., Garner, A. S., and the Committee on Psychosocial Aspects of Child and Family Health. (2012). The lifelong effects of early childhood adversity and toxic stress. American Academy of Pediatrics Technical Report. Retrieved from <http://pediatrics.aappublications.org/content/129/1/e232.full.pdf>

³ "Medicaid Financing of Early Childhood Home Visiting Programs: Options, Opportunities, and Challenges," The Pew Center on the States, June 2012 (describing how to fund home visiting services under state EPSDT or preventative service plans; or through braiding Medicaid and MIECHV and other grant funding.)

⁴ See N. 1, *supra*, citing Rosenberg, S. A., Zhang, D., & Robinson, C. C. (2008). Prevalence of developmental delays and participation in early intervention services for young children. *Pediatrics*, 121(6), e1503-e1509.

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every child is appropriately matched to specialty providers and community health improvement programs. Screening should address (but not be limited to) infant mental health, early childhood development, pediatric behavioral health, and caregiver depression. The pediatric home may require access to an array of specialty consultation to assist with administering or interpreting screening and creating follow up recommendations for families.

The SIM draft rightly emphasizes the need for care coordination within or linked to the medical home to engage with individuals and assist with access to appropriate services. Data confirms the critical value of well qualified and carefully provided care coordination for improving health care outcomes and reducing cost.⁵ It will also be essential to recognize key differences in the care coordination services for children and adults. Moreover, the care expectations and skill set of care coordinators who are assisting families who have a child with significant mental health challenges may be unique from services provided in a more traditional medical model home. Nationally, for example, the most effective examples of intensive care coordination for children with serious mental illness, in terms of quality and cost control, employ highly educated staff who are experienced working with children in public systems and who have much lower case loads than adult care coordinators.⁶ Research has shown that investment in this model results in better health outcomes for children and reduced costs through reduced use of institutional care.⁷

Implications for School Based Health Care

The SIM proposal presents an opportunity for strengthening our school based health center infrastructure. According to Child Health and Development Institute of Connecticut, “despite the enhanced array of community-based and in-home mental health care options, children receive mental health services in school more frequently than any other setting.”⁸ Under the current proposal, there may be an opportunity for a school based health clinic to develop as a medical home or as a community health entity or even as a provider who is a bridge in between.⁹ Moreover, there is an opportunity to scale up community agency efforts that bridge families, mental health interventions, pro-social activities and school personnel to help children that might otherwise fall through the cracks.¹⁰

Workforce Development

The SIM proposal recognizes the critical role of workforce development in building a responsive healthcare delivery system. OCA would emphasize that as part of this process we must examine our workforce resources and its capacity to meet the variable and interdisciplinary needs of children and their caregivers. For example, as we work to strengthen and build upon our early childhood screening and intervention system, we must ensure that we have a robust and knowledgeable workforce that is trained to identify and meet the needs of young children in a developmentally-appropriate way, including supporting social-emotional development and infant mental health. Likewise, we may inventory our capacity to provide culturally and developmentally appropriate services to adolescents with serious mental health challenges. Finally, workforce development

⁵ Pires, S., Human Service Collaborative, Customizing Health Homes for Children with Serious Behavioral Health Challenge, Prepared for: U.S. Substance Abuse and Mental Health Services Administration (March 2013).

⁶ Id. pg. 12.

⁷ Id. pg. 12-13.

⁸ Bracey, J., Arzubi, E., Vanderploeg, J., Franks, R., CHDI Report: Improving Outcomes for Children in Schools: Expanded School Mental Health (Aug. 2013), pg. 4 (emphasis added).

⁹ “School-Based Health Centers and Pediatric Practice,” by Stephen E. Barnett, MD, Mandy Allison, MD, MSPH, Pediatrics Vol. 129 No. 2 February 1, 2012, pp. 39-391.

¹⁰ Examples of such programming in Connecticut include Valley Kids Belong, and Family School Connection.

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efforts must consider the need for dramatic increase in the number of school-based mental health professionals that can work with children, families and educators on school-wide and individualized interventions.

Concurrent Efforts Related to Children's Mental Health

It will be important to consider implications of SIM for children's mental health system development and connections between the draft model and other inter-agency developed system plans. For example, several agencies are coordinating efforts to implement the provisions of Public Act 13-178, An Act Concerning the Mental, Emotional and Behavioral Health of Youths. Per the requirements of this Act, DCF is required to develop a comprehensive plan to meet children's mental health needs. The Office of Early Childhood is charged with providing recommendations on coordinating and maximizing services offered by home visitation programs, and developing a public information campaign on children's mental, emotional and behavioral health issues. The Act also requires the development of memoranda of understanding between system crisis management services (Emergency Mobile Psychiatric Services) and school districts to better link school personnel with community supports for children.

All current efforts share the same goals of maximizing identification of children with health care needs, ensuring access to continuous care, and improving accountability for care actually provided. In light of the concurrent activities to the SIM working group, it may be necessary to spell out how the developing children's mental health blue print fits in with the innovation model.

Further Planning and Implementation Efforts May Include Broad Base of Child Well Being Experts

OCA respectfully suggests that the terrific health care innovation work in Connecticut will further benefit from inclusion of critical voices for children at the table, including advocates, Office of Early Childhood, DDS, DCF behavioral health experts, and representation from the school-based health clinics, public school community and/or State Department of Education. In this way, we will ensure maximum benefit and infrastructure development to meet children's multi-disciplinary well-being needs and connect statewide reform efforts under the umbrella of health care innovation.

Respectfully submitted,



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