

**Task Force on the Mental Health, Social, and Emotional Needs of Young Children and their Families**

**Friday, April 29, 2011**

**North Carolina Institute of Medicine, Morrisville**

**10:00am-3:00pm**

**Meeting Summary**

**Attendees:**

*Task Force and Steering Committee Members:* Marian Earls (co-chair), Beth Melcher (co-chair), John Thorp (co-chair), Rosie Allen, Karen Appleyard Carmody, Shannon Dowler, John Ellis, Beth Glueck, Catharine Goldsmith, Crystal Hayes, Jill Hinton, Melissa Johnson, Tom Lesniak, Marcia Mandel, Toby McCoy, Judy McKay, Emma Miller, Laura Muse, Deborah Nelson, Susan Perry-Manning, Janice Petersen, William Purcell, Susan Robinson, Kevin Ryan, Jean Smith, Adele Spitz-Roth

*Presenters and other Interested Persons:* Gary Ander, Kate Berrien, Tonita Beverly, Anne Bryan, Laura Edwards, Renee Gibson, Alvina Long Valentin, Merry-K Moos, Katherine Shepherd, Donna White

*NCIOM Staff:* Anna Bauer, Thalia Fuller, Jennifer Hastings, Emily McClure, Sharon Schiro, Pam Silberman, Rachel Williams, Berkeley Yorkery

**Welcome and Introductions**

*Marian R. Earls, MD, FAAP, Medical Director, Guildford Child Health, Inc., Co-chair*

*Beth Melcher, PhD, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, North Carolina Department of Health and Human Services, Co-chair*

*John Thorp, MD, Division Director and Distinguished Professor, Department of Obstetrics and Gynecology, UNC Health Care, Co-chair*

Dr. Melcher welcomed everyone to the meeting.

**Preconception Health: Improving the Care of All Women of Reproductive Age**

*Merry-K Moos, RN, FNP, MPH, Research Professor, Department of Obstetrics and Gynecology, University of North Carolina at Chapel Hill*

Ms. Moos presented information on the health status of a woman before pregnancy and pregnancy outcomes. Prenatal care is unlikely to impact the major causes of infant morbidity

and mortality. The current model of prenatal care begins at the first prenatal visit and ends at the postpartum visit. This model is episodic, disjointed, inefficient and ineffective. A new model of prenatal care focuses on the health of all women of child-bearing age. Women who are healthy before conception have better pregnancy outcomes.

The CDC convened the Select Panel on Preconception Care to address this new model of care. The recommendations resulting from this panel aim to educate men and women on preconception care, provide services to all women of child-bearing age, reduce risks to those with prior poor pregnancy outcomes, and to reduce disparities.

Other initiatives are occurring in other areas that directly affect preconception care and pregnancy outcomes. These include interest in the fetal origins of disease, the life course perspective, and social determinants of health and their impact on disparities.

Ms. Moos presentation can be found here: [Health Status Before Pregnancy and Pregnancy Outcomes](#).

Selected questions and comments:

- Pregnancy is a stress test. What happens during a pregnancy forecasts what will happen when a woman becomes pregnant again and/or when she gets older. It is important to address these issues outside of prenatal care, not just when a woman is pregnant.
- Q: How has the paradigm shift changed strategies for women's health with respect to other specialties other than obstetrics and gynecology? A: The new paradigm is the most developed around endocrinologists with the issue of diabetes. Women who are in good control of their diabetes when pregnant have a reduced likelihood of a child with congenital anomaly. The new paradigm has also engaged people who are not in reproductive health. There is a parallel structure on education of women and providers. In a Canadian study on market research and women showed the effectiveness in changing behavior to be minimal. However, when the marketing was coupled with her provider echoing the message the change in behavior was powerful. We need to empower women and have their providers echo the message.
- Q: It is difficult to get teen moms into prenatal care. What strategies were successful in getting moms into care? A: Emphasizing the pregnancy forecast in relation to life wellness.
  - Being visible in the community, such as in schools or the YMCA, to help teens make life choices to help them improve their own health. Programs such as the Reproductive Life Plan and Before and Beyond make an effort to help people own decisions and move towards more intended pregnancies.
- There is also a mental health aspect. The likelihood of depression is equally great in pregnant and non-pregnant women. The depression may be exacerbated after pregnancy.

There needs to be an effort to do more careful and efficient screenings for depression so at-risk women can be identified and provided with care and interventions. Waiting until the post-partum period to identify depression is not about prevention.

### **Preconception Health Promotion Efforts in North Carolina**

*Alvina Long Valentin, RN, MPH, Women's Health Branch, Division of Public Health, North Carolina Department of Health and Human Services*

Ms. Long Valentin discussed programs addressing preconception health in North Carolina. The NC Preconception Coalition released its strategic plan in 2008. Four workgroups, consisting of members from DPI, DHHS, local health departments, universities, community-based organizations, non-profits, and consumers meet regularly to discuss ways to put the strategic plan into action. The four workgroups are Increase Consumer and Community Awareness about Preconception Health, Ensure Quality Preconception Care and Practice among Health Care Providers and Community Outreach Workers, Expand Access and Affordability of Preconception Care, and Advocate for Environmental and Policy Changes that Support Preconception Health.

There has also been incorporation of preconception health into Title V and Title X programs. The Healthy Beginnings project, a Title V program, has incorporated reproductive planning, healthy weight, folic acid consumption, tobacco cessation, breastfeeding, safe sleep and well childcare. Title X programs are incorporating smoking cessation using the 5 A's method. North Carolina is also working to create a state plan amendment to make the current Medicaid Family Planning Waiver permanent beginning in June 2011.

Current North Carolina programs for preconception health include the NC Preconception Health Campaign, the Post Partum Plus Project, the Mother's Matter Project, Baby Love Plus, and the pregnancy care medical home. Future preconception health initiatives should include tracking women's health indicators during reproductive years, implementing the NC Preconception Coalition's action steps, seeking funding opportunities, and sharing findings and best practices.

Ms. Long Valentin's presentation can be found here: [Preconception Health in NC](#).

Selected questions and comments:

- Q: Are there any evaluations for any of these programs, especially the Healthy Beginnings project? A: Healthy Beginnings was evaluated for a two-year period. A new team of evaluators have been added to the project this year from UNC-Greensboro. Some components, such as reproductive life planning, have not been evaluated yet since they are new. Evaluations have shown a decrease in infant mortality. However, many

programs don't evaluate using random control studies but still have strong evaluations behind them because results are compared to statistics in similar counties.

- Q: Is Healthy Beginnings a national project? A: No, the project was developed in North Carolina. It was originally state funded but now it is also Title V funded.

### **Related NCIOM and HNC 2020 Recommendations**

*Berkeley Yorkery, MPP, Project Director, North Carolina Institute of Medicine*

*Laura Edwards, RN, MPA, Prevention Specialist, Division of Public Health, North Carolina Department of Health and Human Services*

Ms. Yorkery and Ms. Edwards went over recommendations made in the past that are related to this task force's purpose. Ms. Yorkery discussed previous NCIOM task force recommendations. Most of the recommendations came from the Prevention Task Force, Health Reform workgroups, Adolescent Health Task Force, Substance Abuse Task Force, and the Child Maltreatment Prevention Task Force.

Ms. Yorkery's presentation can be found here: [NCIOM Task Force Related Recommendations](#).

Ms. Edwards discussed Healthy North Carolina (HNC) 2020 objectives that relate to the purpose of this task force. HNC 2020 objectives are based on the social economical model of health and cover 13 topic areas. Relevant objectives are highlighted in red in her presentation. Topic areas with relevant objectives include Tobacco Use, Sexually Transmitted Diseases/Unintended Pregnancy, Maternal and Infant Health, Substance Abuse, Social Determinants of Health, and Cross-Cutting Issues.

Ms. Edward's presentation can be found here: [HNC 2020 Objectives](#).

### **Perinatal Health: Challenges and Barriers to Providing All Women with High-Quality Care**

*John Thorp, MD, Division director and Distinguished Professor, Department of Obstetrics and Gynecology, UNC Health Care*

Dr. Thorp explained the pitfalls and opportunities in prenatal care interventions. The two pitfalls of prenatal care interventions are the influence of status and the perinatal funnel. Status is the most powerful indicator of health outcomes. Status is affected by individual factors, family, neighborhoods, intergenerational factors and traditions. Risk factors from every layer can clump together and cause poorer and poorer health. Epidemiologists tend to focus on one risk factor

and assume causality. This focus can lead to few universal remedies, many false starts and creates a need for excellence in epidemiology.

The perinatal funnel demonstrates the need to identify problems early instead of identifying problems late in pregnancy or after birth. Applying unnecessary interventions universally is expensive and patients and clinicians can become skeptical of universal advice. Also, applying interventions universally can skew the results of effective treatments by diluting the effects.

Tailored interventions overcome both of these pitfalls. These interventions identify a mother's status and modifiable risk factors to create a proper treatment plan. Tailored interventions require five requisites: understanding of biology, observational data to identify and validate risk assessment, design interventions base on biology and observational data, test the effectiveness of an intervention in clinical trials, and implementation if effective.

Dr. Thorp's presentation can be found here: [Prenatal Care Interventions and Child Health](#).

### **Role of Medicaid in Women's Health**

*Tonita Beverly, RN, MSN, Nurse Consultant, Practitioner and Clinical Services, Division of Medical Assistance, North Carolina Department of Health and Human Services*

Ms. Beverly reviewed Medicaid coverage available for women of childbearing age. Several Medicaid programs offer full coverage for eligible women and children including Medicaid for Infants and Children/Health Choice (MIC), Medicaid Aid to Families with Dependent Children (MAF), Medicaid Aid to the Blind (MAB), Medicaid Aid to Disabled (MAD), and the Work First Program. Other programs offer less coverage including Medicaid for Pregnant Women (MPW) and the Family Planning Waiver.

The Family Planning Waiver is designed to reduce unintended pregnancies, improve the well-being of children and families, and extends eligibility for family planning services to those with incomes up to 185% federal poverty level (FPL). DMA has decided to push forward in making the waiver a state plan option in order to expand coverage to teens and offer additional services such as transportation. DMA plans to roll out the amendment in July 2011.

Ms. Beverly's presentation can be found here: [Medicaid and Women's Health](#).

Selected questions and comments:

- Q: What substance abuse and mental health services are covered by different levels of Medicaid before, during, and after pregnancy? A: With regular Medicaid, coverage for substance abuse is offered throughout pregnancy. The MPW program coverage ends once the mother is no longer eligible for services, or 60 days postpartum.

- Q: The waiver promotes interconception care, but what if a person has not had children?  
A: That person would also be eligible for the family planning services waiver.

## **Pregnancy Medical Home**

*Kate Berrien, RN, BSN, MS, CCNC Pregnancy Home Project Coordinator*

Ms. Berrien gave an overview of Community Care of North Carolina's (CCNC) Pregnancy Home. CCNC consists of 14 networks across the state to provide a population management approach to the Medicaid population. CCNC pregnancy homes aim to improve birth outcomes through evidence-based and quality care. Each local CCNC network has an obstetrics team consisting of an obstetric coordinator (a nurse) and an obstetric clinical champion (a physician). The team educates practices, works with providers and agencies to make necessary system changes, and provides technical and clinical support to participating pregnancy homes.

Providers are eligible to become a part of a pregnancy home if they are enrolled in Medicaid as a private practice, federally qualified health center/rural health clinic, local health department, nurse practitioner, or a nurse midwife. Participating in the pregnancy home has been shown to improve outcomes. Participating providers also receive an increased match rate and other financial incentives.

The pregnancy home provides pregnancy screenings for risk factors such as previous premature deliveries, chronic disease, and substance abuse. If a patient's screen is positive, she will be referred to have a pregnancy assessment with a case manager. Case manager services are need driven, which means women at higher risk will receive more intense services.

The Perinatal Quality Collaborative of NC (PQCNC) is a UNC-Chapel Hill project to improve in-patient quality improvement. Initiatives the program offers include the 39 Weeks Project and supporting intended vaginal birth and breastfeeding.

Ms. Berrien's presentation can be found here: [CCNC Pregnancy Medical Home](#).

Selected questions and comments:

- Q: Is obesity considered a chronic illness in the prenatal assessments? A: It potentially could be. The chronic disease category was intentionally left broad.
- Q: Are the obstetric clinical settings affiliated with hospitals and the teams? A: There are 14 networks and 10 have identified an obstetric champion. About half of the teams are fetal medicine and hospital based and the other half are obstetricians in public health settings. Some are academically oriented, others are practice oriented.

## **Discussion**

The workgroup discussed potential recommendations which are listed below.

### Potential Recommendations:

- Ensure issues are identified during the post-partum assessment are addressed
- Enable clinicians to know how to screen to pick up risk factors that affect early childhood mental health
- Improve care transitions through improved communication between pediatricians, family practitioners, and obstetricians/gynecologists.
- Improve communication between the obstetric practice and the delivery site
- Improve care transitions for women between prenatal care, obstetrician, the hospital, and community outpatient services
- Address making Medicaid more streamlined such as simplifying enrollment
- Promote programs such as Bright Futures and adolescent care to family physicians and pediatricians to improve preconception health
- Link the mother-baby dyad to empower pediatric providers to consider the mother's well-being (i.e., education, ideal inter-pregnancy intervals, asking about post-partum visitations, etc.)
- Improve reimbursement for depression screenings of the mother during pediatric and prenatal visits
- Increase resources to provide treatment, competency and capacity
- Improve the ecologic framework (i.e., community partners such as faith organizations, support systems)
- Use social marketing, life course and health education in schools to promote healthy behaviors
- Link data systems to give a more comprehensive view of risk (i.e., CCNC case management system, electronic health records, health information exchange)
- Consensus between providers and public health officials on how to measure social-emotional needs of young children and families
- Build in a reproductive life planning tool into adolescent health screening

### **Next Meeting—May 20 at 10:00am**

The next meeting will focus on mental health and substance abuse during pregnancy and post-partum.