Child Fatality Task Force
APPROVED Minutes
October 24, 2011
Minutes Approved January 30, 2012

**Members in Attendance:** William Adkins (by phone), Sen. Austin Allran, Sen. Bob Atwater, Wallace Bradsher, Elaine Cabinum-Foeller, Rep. Dale Folwell, Beth Froehling, Martha Sue Hall, Paula Hildebrand, Bill Keller, Kevin Kelley, Karen McLeod, Gerri Mattson (for Kevin Ryan), Earl Marett, Peter Morris, Sen. William Purcell, Deborah Radisch, Susan Robinson, Angie Stephenson, McKinley Wooten, Rep. Jennifer Weiss.

**Guests:** Tara Bristol, Alan Dellapenna, Kelly Duffy, Janice Freedman, Jinx Kenan, Michael Lancaster, Laura Louison, Amy Mullenix, Belinda Pettiford, Rob Thompson, Rosie Allen Ryan, Jacqueline Simmons, Leslie Starsoneck, Rebecca Troutman, Jennifer Woody

**By Phone**: Tonya Daniels, Miriam Labbok, Laura Sinai, Sherry Troop, Janice Williams

Karen McLeod opened the meeting with a moment of silence for all the children who had passed away since our last meeting.

She then welcomed our newest Senate appointees to the CFTF: William Adkins, the Honorable Wallace Bradsher, and the Honorable William Keller. Senator Wesley Meredith was also newly appointed and sent his regrets. Returning Senate appointees include Senators Allran, Atwater, Bingham and Purcell and Sheriff Welch.

Martha Sue Hall moved and Dr. Elaine Cabinum-Foeller seconded approval of the minutes. They were affirmed.

Dr. Peter Morris was nominated for the position of Co-Chair of the Child Fatality Task Force. Sen. Purcell moved to close the nominations and accept Dr. Morris as Co-Chair. Dr. Morris was unanimously affirmed as Co-Chair.

Ms. McLeod noted that the CFTF was created by the General Assembly for the General Assembly. The CFTF has a track record of using data and research to support recommendations. Indeed, that is part of the reason that the child death rate has declined by more than 35%. Moving forward in these tight budget times, it remains critical to focus on evidence – to make sure that every dollar spent is spent well and to produce results.

**All presentations are available on-line*:***
http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=116&sFolderName=\Presentations

**Evidence Based Programs – Brett Loftis and Michelle Hughes**

Mr. Loftis explained that evidence based programs offer a continuum of evidence about what works for well-informed decisions at every step in the process. Measures should go beyond counting clients served or pencils used to results produced. Some studies have used gold standard methodologies and followed clients for decades and have very solid evidence about what works. Others are newer and may rely on comparison group rather than random sample assignment and may not have the years of follow-up. We should rely on the best possible evidence when making decisions about programs or approaches to take statewide.

Michelle Hughes offered by way of example that the DARE program (officers teaching students in schools about the dangers of drugs) at its peak reached 36 million children. However, randomly controlled studies later showed that there was no difference in behavior for students who had gone through DARE and those who had not. Thus all those dollars and all those hours to serve 36 million students could have been put to much better use.

Ms. Hughes strongly stressed that ***implementation with fidelity matters***. Analysis from the National Implementation Research Network of implementation in health, manufacturing, business, behavioral health and other fields shows consistently that paying attention to how programs are implemented is critical. One time training and then hoping it all works out forever after ("Spray and Pray") fails to produce desired results. Keys include getting and coaching the right staff, organizing with data and appropriate system interventions, and strong and responsive leadership. Indeed, much of the work of the CFTF has been effective because we use data, define the desired outcomes and use evidence in policy-making. In the future, we need to thinking about building and maintaining infrastructure to support successful intervention.

Dr. Morris asked about effective social intervention. Ms. Hughes explained it often had to do with strategies to affect the social environment.

Mr. Loftis noted the importance of process within the program, such as the timing of the budget.

Sen. Purcell reiterated the importance of coaching and using repetition to stress the basic skills needed.

**Medical Homes – Leslie Starsoneck and Dr. Elaine Cabinum-Foeller**

Medical homes represent an approach to health care that emphasizes accessible, family-centered, coordinated, comprehensive (preventive, acute and chronic), quality health care. It uses a single point of entry to a system of care that facilitates access to medical and non-medical services. In NC, the medical home model emphasizes the use of a multidisciplinary team that links with a network of services that has historically been used to provide care to Medicaid eligible children and adults.

The medical home approach goes back to 1967 and NC has been in the forefront. Medical homes may be accredited. There are six different standards to meet, each with a variety of measures.

NC tends to rate particularly well on accessibility and comprehensiveness. Research shows a variety of positive outcomes, including fewer hospitalizations and substantial dollar savings. Children with special health care needs may especially benefit:

- Fewer illnesses and symptoms of chronic conditions
- Higher scores on mental health after four years
- Decrease in days of missed school
- Fewer visits to the emergency department
- Fewer hospitalizations and less time when hospitalized
- Improved access to mental health services in rural areas (based on parent reports)

Careful evaluations across the country have shown that well-implemented medical homes can save millions of dollars in cost. North Carolina specific data shows close to half a billion in savings. The savings are due to factors such as deterred hospitalizations through sound condition management. For example, hospitalizations for asthma decreased 40% under CCNC.

Medical homes are a proven program with benefits that cut across interest area for all CFTF committees. They can improve maternal health before and between pregnancies; they can increase child preventative visits and opportunities for pediatricians to talk about injury-prevention strategies; and they can provide more comprehensive care for children who have been traumatized and are part of the child welfare system.

There was discussion about scoring specifics.

Brett Loftis asked about medical homes for foster children, an especially vulnerable population for whom it can be challenging to keep track of medical records and treatment. For example, foster children are often immunized each time they change placements if records are not available to demonstrate the shot has already been received.

It was noted that only 40% of foster children were medical home (CCNC) enrolled even though all foster children were Medicaid eligible. Dr. Morris asked if all foster children are automatically eligible, why are so few children in medical homes? Rep. Weiss wondered if part of the problem was that there were not enough medical homes for the children who needed them. Kevin Kelley noted that the state was seeking a State Plan Amendment (SPA) so that county Department of Social Services would automatically place a child in CCNC are unless they actively sought to opt a foster child out of a medical home. This means that the default would be to assure that the child was attached to a medical home. (The current default to opt the child *out* of the medical home with special action needed to opt the child in.)

Honorable Bradsher asked how long the SPA would take. He suggested that judges could incorporate medical homes part into their court orders on placement. He asked if there would be a downside to that approach. Mr. Kelley noted that the decision often happened at the DSS level rather than the court order level.

Ms. McLeod asked why so many local DSSs were not opting-in already. Mr. Kelley speculated that it might be an awareness issue.

Ms. Starsoneck noted that a foster parent may want to use their trusted family pediatrician and not drive five counties over to see the child's previous doctor.

Sen. Allran asked about the impact of extra vaccines on children. Sen. Purcell noted that it was unpleasant for the child (who had been traumatized and recently removed from the home) and incurred additional costs.

Dr. Cabinum-Foeller, who sees many traumatized children in her practice, noted that medical homes offer a continuous healing relationship with the doctor. She also underscored the importance of data back to the provider and quoted her mentor saying "no one is going out there to practice mediocre medicine."

Dr. Gerri Mattson added that medical homes are a nationally recognized model. While they have been Medicaid focused in North Carolina for decades, two private providers (the State Health Plan and Glaxo Smith Kline) are moving toward the medical home model as well. Blue Cross/Blue Shield has been providing incentives for providers to use a medical home model for several years.

Rep. Folwell noted that many providers were investing in new (expensive) facilities or equipment and then feeling compelled to use them. Could that be in conflict with the goal of preventing ED visits,

hospitalizations or other ways of using the new facilities and equipment and facilities? Dr. Cabinum-Foeller could not respond to any specific case but noted that the studies repeatedly showed decrease usage of high end services in the real world environment.

Dr. Morris questioned if it was a medical home issue or a certificate of need issue. Dr. Mattson noted that EDs would be part of overall savings when there were shared savings. Dr. Purcell reminded members that rural considerations were important as well.

**Community Care of North Carolina (CCNC), Dr. Mike Lancaster**

CCNC has 14 provider networks all across North Carolina with 4000 doctors and 500 case managers participating to serve about 1 million Medicaid enrollees. CCNC has demonstrated a 15% lower cost for treating Medicaid clients than traditional approaches to care. In large part that is because a strong focus in data-driven practices results in better care, which has the side benefit of saving money by deterring hospitalizations and other high end services.

Dr. Lancaster talked about various initiatives of CCNC. One focus was on chronic pain and has implications around prescription drug abuse. CCNC has used data driven practice to develop procedures that result in less prescription drug abuse *and* improved satisfaction rates for emergency departments.

A+ Kids focuses on antipsychotic medications in children. Use of antipsychotic medication in children, including children ages 7 to12, has increased by more than 20% in the past several years. (More than 10,000 NC Medicaid eligible children under 12 received at least one antipsychotic drug in both 2009 and 2010.) These medications are often not tested/proven safe for children and sometimes not tested for the specific condition for which they are being prescribed. (Off label use is common and not *per se* dangerous. For example, 17-P to prevent preterm birth was an off-label use until earlier this year.) These drugs represent substantial cost with just two of them – aripiprazole and quetiapine -- costing more than $100 million each year. These drugs are often being prescribed for Attention Deficit Hyperactivity Disorder (ADHD) which is not an antipsychotic condition.

Potential overprescribing of drugs unproven for the condition or the age is especially concerning since children are more susceptible to adverse effects. Too often, medications are being overused and under-monitored for children. CCNC recently began looking at this issue when NC legislation allowed them to become involved with mental health drugs when they are prescribed outside their FDA approved usage. CCNC has just begun its analysis of prescription of such drugs for children 12 and under. It seeks to reduce the incidence of prescription of multiple anti-psychotic medications for children, reduce cases where dosages exceed FDA limits (which are often set to adult bodies), and improve safety monitoring. CCNC will ask providers to register the drugs prescribed and monitor outcomes, such as lipid levels and weight gain. Doctors would still prescribe as their judgment dictated. CCNC is starting with monitoring for the children ages 7 to 12 and then will seek to expand their analysis to older children.

Dr. Morris wanted to clarify that the drugs were being prescribed for ADHD and not autism spectrum disorder. Dr. Lancaster confirmed.

Sen. Allran asked why such powerful drugs were being prescribed for such young children. Dr. Lancaster said that the drugs would control behavior.

Dr. Morris added this could be a substantial benefit especially in a community were there were no step-down medical care options. Controlling behavior can keep a child at home and in the classroom. He

gave the real life example of a child who was medicated to stay at home but recently punched out his sister and had to be institutionalized. The drugs were away to keep kids out of facilities for which there was already high demand, especially in the absence of step down facilities.

Rosie Allen asked if the information was disaggregated by age. Dr. Lancaster noted that there were about 10,000 children in each the 7 to 12 and 13 to 17 ranges and 400-500 were for children less than age 5.

Sen. Purcell noted that ADHD drugs have gotten a bad wrap. When they work well, they can change lives and strengthen families. Children who were struggling in school become strong students.

Rep. Weiss asked if the information was for children on Medicaid or overall? Dr. Lancaster clarified that his data reflected children who received Medicaid.

Brett Loftis that for abused and traumatized children, medications are often used to treat behavioral oppositional disorder instead of treating the underlying trauma.

Sen. Allran asked why the problem was getting worse. Dr. Elaine Cabinum-Foeller noted that she often encountered parents who wanted a pill to keep their children quiet. Lack of support and training for parents, as well as a range of options for helping with challenging children are all part of the problem.

Dr. Lancaster noted that the American Academy of Pediatrics recently issued new guidelines for treating ADHD and CCNC will be training on those guidelines.

Sen. Allran encouraged Dr. Lancaster to help legislators figure out ways to address the issue of appropriate prescribing of antipyschotics. Dr. Lancaster noted of the top prescribed 15 drugs, 10 are used to treat behavioral health. Last years legislation has been very helpful at allowing CCNC to look at quality issues around these drugs. Sen. Allran asked about only allowing psychiatrists to prescribe them. Dr. Lancaster noted that often general practitioners were continuing a psychiatrists' prescription and were hesitant to take a patient off a medication started by a specialist. At the same time, it is often hard for a patient to see a psychiatrist.

Karen McLeod noted the important of treating underlying trauma. Sen. Purcell reflected that drug manufacturers often give money both to doctors and to legislative campaigns. Rep. Weiss stressed that we need for young people to have access to the treatment they need. Are there enough places for them to get good care? Dr. Cabinum-Foeller added that there was a need for on-going treatment and assessment, as children may disclose abuse or other trauma for the first time well into the treatment process.

**Pregnancy Medical Homes, Kate Berrien**

Pregnancy Medical Homes seek to improve birth outcomes in North Carolina by providing evidence-based, high-quality maternity care to Medicaid patients. They are outcome driven and practices must adopt all parts of the model. Unlike other medical homes models, pregnancy is by nature episodic and thus it is not a primary care model.

A number of provider types can participate, including ob/gyns, rural health clinics, health departments, nurse practitioners and nurse midwives. They must sign an agreement with the local CCNC network. About 275 practices have signed up. The pregnancy medical team includes a variety of professionals such as nurse and a physician with access to the broader CCNC team (social workers, pharmacist, psychiatrists, etc.)

Pregnancy medical homes use data and research to determine best practice and set targets. In NC targets include reducing preterm births by 5% and keeping the primary c-section rate at or below 20%. In fiscal year 2011, the C-section rate was below 20% and the rate of low birth weight was about 11%.

Furthermore, financial incentives are linked to desired outcomes. Rather than paying more for c-sections, which are not always medically necessary, payments are the same for c-sections and vaginal births to prevent perverse incentives. Doctors also get paid for key screenings and have more flexibility on referring women for ultrasounds. The postpartum visit includes depression screening using a specific validated tool.

Key performance measures are linked to proven best practices:

- No elective deliveries <39 weeks
- Offer and provide 17P to eligible patients
- Reduction in primary c-section rate
- Standardized initial risk screening of all OB patients.

Data is critical and provided in real time so that professionals can assess how they are doing and adjust as needed. Ten key medical and psychosocial indicators (such as tobacco use, history of preterm or low birthweight, and unsafe living conditions) are used for priority risk factors to focus on prematurity and low birthweight. It's based on a risk stratification model.

Flexibility and partnership are other key components of the model.

Ms. Berrien also acknowledged the two elephants in the room: 1) undocumented immigrant women who are not eligible for Medicaid but who will be giving birth to a US citizen (who will be eligible for Medicaid) and 2) the need for insurance and medical treatment across the lifespan – not in various 9 month increments. Approximately two-thirds of women who are Medicaid eligible while pregnant are not eligible for public health insurance outside of pregnancy. Yet the health of the mother before conception is a critical component of a healthy pregnancy and birth.

**Maternal, Infant, and Early Childhood Home Visiting Programs, Laura Louison**

Ms. Louison reported on the proven model of home visiting to strengthen families and improve child safety and well-being. Research shows that well-implemented home visiting programs are among the most effective strategies for preventing child abuse and neglect. They also decrease injuries and improve family income.

There are four main programs used in NC: Nurse Family Partnership, Healthy Families America, Parents as Teachers and Early Head Start. They differ in who provides the services and which families can be served. For example, Nurse Family Partnership is designed to serve first time parents with home visits from nurses while Health Families America model is proven to work with families who may already have children in the home and uses various professionals, not just nurses, for the home visits.

These programs are being expanded in NC due to new federal dollars ($2.2 million in FY11 and $3.2 million in FY12). This allows for expansion of existing home visiting infrastructure in NC. Great attention is being paid to providing technical assistance, data collection and dissemination, coaching and other supports. (They are actively avoiding the "spray and pray" approach.)

Maternal, Infant and Early Childhood Home Visiting is part of continuum of services and can be complimentary with medical homes, child trauma program, etc. While long-term savings are substantial, upfront costs can be quite high, so it important to serve family at the appropriate place within a continuum of proven programs.

Leslie Starsoneck noted that research had shown that severe domestic violence can wipe out the benefits of Nurse Home Visiting. She asked if DPH was looking at that concern. Ms. Louison noted that NC will conduct extensive data collection to meet federal benchmarks, and will be able to assess the efficacy of the model with families experiencing domestic violence. Additionally, the state was also seeking to identify where gaps may exist, such as services for domestic violence or treatment for substance abuse, and develop cross-model trainings to address these challenges. On a national level, Nurse Family Partnership is looking at possible adaptations to serve families where severe domestic violence is present.

**Director Report**

Elizabeth Hudgins announced that new co-chairs will be elected for each of the committees at the January 30th meeting. Committee co-chairs may consist of one CFTF member and other committee participant (or two CFTF members). Ms. Hudgins urged people to contact her with nominations.

She also reported on a workgroup convened by Senator Bingham looking at the recent ban of synthetic drugs, such as synthetic cannabinoids. After hearing about the implementation issues at the last CFTF full meting, Senator Bingham pulled together a group of experts including panelists from our earlier meetings, plus others to discuss possible solutions to improve safety and enforcement.

**Committee Reports**

***Perinatal Health*:** Elizabeth Hudgins reported for Dr. Verbiest who sent her regrets for being unable to attend. Exciting work continues around the issue of improving equity in birth outcomes, with the first meeting of the North Carolina Partnership to Promote Equity in Birth Outcomes on October 20th. The NC Child Fatality Task Force is co-convening this meeting in partnership with the UNC Center for Maternal and Infant Health along with the UNC Gillings School of Global Public Health, the NC Preconception Health Campaign and the Women's Health Branch of the NC Division of Public Health. This work is funded by a grant from the Eunice Kennedy Shriver National Institute of Child Health and Human Development to the UNC Center for Maternal and Infant Health.

At the last PHC meeting, participants learned about the impact of cuts for the ECU High Risk Maternity Clinic and the Office of Minority Health and Health Disparities as well as positive steps taken by hospitals to support breastfeeding.

***Intentional Death Prevention:*** Brett Loftis reported that the group had met in October to learn more about the issue of suicide. The presentations were outstanding but since there was not much time for discussion, an additional meeting on the topic has been scheduled for December 12 at 10AM. The November 14th meeting will maintain its original focus of youth violence.

***Unintentional Death:*** Dr. Peter Morris that the August meeting of the group had focused on prescription drugs and it was decided to stay our course of supporting drug-take backs and other efforts to reduce child access to unneeded medications but likely not to pursue legislation. The November 21 meeting has been RESCHEDULED to January 23rd. (There were concerns it was too close to Thanksgiving and attendance might fall off.) The January 23rd meeting will likely focus on tanning beds. A subcommittee of UDC is meeting to look at strategies for improving teen road safety. That group will present to the full CFTF on January 30th to update the Task Force and receive guidance

going forward. UDC will finalize its recommendations on teen road safety to the full CFTF for the April meeting.

The next meeting of the full CFTF is January 30th at 10AM. The next meeting of the Intentional Death Prevention Committee is November 14th at 10AM. The next meeting of the Unintentional Death Committee is January 23rd. All meetings are in room 1027 of the Legislative Building in Raleigh. The Perinatal Health Committee thanks everyone who is participating with North Carolina Partnership to Promote Equity in Birth Outcomes and encourages people to attend the free all day conference on Biological Consequences of Chronic Exposures to Social at Economic Disadvantage at the Stone Cultural Center at UNC-Chapel Hill.