Children's Hospital of The King's Daughters

Joint Community Health Needs Assessment Overview and Implementation Strategy for CHKD's Three Licensed Facilities

Adopted May 21, 2013 by the CHKD Health System Board of Directors

In early 2013, Children's Hospital of The King's Daughters conducted a community health needs assessment (CHNA) with assistance from Community Health Solutions, a Richmond, Virginia-based health improvement research and consulting firm. The CHNA encompassed the 29 localities in Virginia and North Carolina identified as CHKD's primary service region. The total population of the study region was 1.95 million people, of whom nearly 570,000 were children ages 0-21.

The joint community health needs assessment and implementation strategy cover all three licensed facilities associated with the CHKD Health System: Children's Hospital of The King's Daughters (CHKD) located in Norfolk and CHKD's two Health and Surgery Centers, one at Oyster Point in Newport News (OP) and one at Princess Anne in Virginia Beach (PA).

The CHNA consists of two major components, a Community Insight Profile based on qualitative results from a survey of community stakeholders and a Community Indicator Profile based on quantitative analyses of community health status indicators.

I. Community Insight Profile

- Survey sent to 441 community stakeholders
- 95 respondents (22 percent participation rate)
- Survey asked participants to identify health concerns, service gaps and ideas for improving children's health
- Respondents included 6 school systems, 2 health departments, 9 social services departments, 7 employers, 11 hospitals and health care providers and 11 cities and counties.
- Survey respondents were not asked to assign priority to issues identified as areas of concern; therefore, the rankings are related to frequency of response rather than to magnitude of importance.

Most Frequently Identified Health Concerns

Respondents were asked to identify important health concerns from a list of topics drawn from Healthy People 2020. The 10 most frequently mentioned topics were:

1. Childhood obesity (72% -- 68 responses)
2. Behavioral health
3. Asthma and Nutrition (tied)
4. Autism
5. Child abuse
6. Intellectual and developmental disabilities
7. Physical activity
8. Dental care/oral health
9. Substance abuse – illegal drugs
10. Teen Pregnancy (40% -- 38 responses)

The list above can be condensed based on natural associations among the identified issues:

1. Childhood obesity (nutrition and physical activity)
2. Behavioral health (including substance abuse)
3. Asthma
4. Autism and intellectual and developmental disabilities
5. Child abuse

Most Frequently Mentioned Service Gaps

Respondents were asked to review a list of community services and identify those with gaps in access, availability or quality. The 5 most frequently mentioned service gaps were as follows:

1. Behavioral health services (79% -- 70 responses)
2. Health promotion and prevention
3. Early intervention services
4. Dental care/oral health and Transportation services (tied)
5. Case management services and Crime/violence prevention and support services (tied) (34% -- 30 responses)

II. Community Indicator Profile

Using multiple data sources to evaluate a wide array of community health indicators, a profile of the study region was developed, with the following key findings:

- 0-21 population will remain relatively flat through 2017 with little movement in racial/ethnic distribution and age distribution.
- Compared to the state overall, the study region is more densely populated and has a greater proportionate representation of low income households.
- The death rate for children in all age groups was higher than the state average, with prematurity and low birth weight comprising the largest single cause of death among all age groups.
- The study region's rates of low birth weight, teen pregnancy and infant mortality are higher than the state averages.
- Behavioral health hospitalization discharges were lower than state averages in all but one age group (ages 6-11).
- A significant number of children ages 14-19 are estimated to be overweight or obese, exhibit signs of depression and use alcohol or tobacco products.
- Among children ages 0-18, 8 percent (36,000) were estimated to be uninsured, the majority of whom were at or below 200% of the federal poverty level.
- 26 of the 29 localities within the study region are fully or partially designated as Medically Underserved Areas or Medically Underserved Populations by HRSA.

III. CHKD Implementation Plan

CHKD is actively engaged in internal and external initiatives to improve the health of children throughout its service region. While the community health needs assessment identifies a multitude of health concerns, service gaps and risk indicators, the following four issues fall within the scope of CHKD's core mission, were frequently mentioned by survey respondents and were among risk indicators. These four focus areas are addressed in the implementation plan. CHKD has provided information on four additional items (listed alphabetically) that received a high frequency of responses by survey participants.

Priority Issues

1. Child abuse
2. Childhood obesity
3. Infant mortality/morbidity
4. Health promotion and prevention

Additional Issues

- Asthma
- Behavioral health (limited to services provided for children hospitalized or receiving outpatient care for medical/surgical conditions)
- Case management services
- Intellectual and developmental disabilities (including autism)

Joint Implementation Plan: How to Identify Facilities Involved in Implementation Plan

All CHKD licensed facilities are considered to be part of the implementation plan for each focus area. This is noted by parenthetical abbreviations beside each focus area identifying the licensed facilities (CHKD – Children's Hospital of The King's Daughters, OP – Oyster Point and PA – Princess Anne.) CHKD Healthy System is a highly integrated network of licensed facilities and physician practices, all guided by the same mission and vision. Therefore, patients served by each licensed facility have access to the full resources associated with each focus area.

Issues Not Addressed in the Implementation Plan

Health concerns, service gaps and risk indicators not addressed specifically in the implementation plan are outside the scope of CHKD's mission, expertise, resources or any combination thereof. Many of these items are within the purview of other health care providers and/or community or public agencies. CHKD regularly and routinely offers its expertise and assistance as community resources address a broad range of issues relating to the health and welfare of children.

1. Implementation Plan: Child Abuse (CHKD, OP, PA)

CHKD's Child Abuse Program (CAP) coordinates the region's efforts to accurately identify, treat and protect children who have been abused or neglected. The program provides comprehensive assessment, evaluation and treatment services to suspected victims of abuse and neglect. These services include forensic interviewing, medical examinations and consultations, which include 24/7 coverage of acute sexual assaults of children, and an array of evidence-based mental health services. The program also helps coordinate the efforts of investigative agencies involved in the investigation and prosecution of abuse.

CAP is a Children's Advocacy Center (CAC) accredited by the National Children's Alliance and serves all of southeastern Virginia, including the 7 cities and counties in our local areas as well as the eastern shore, James City County, Williamsburg, Isle of Wight, Franklin, Gloucester, York, Mathews, and counties on the mid-Peninsula. The main office is in Norfolk, but mental health services are provided in the CHKD Oyster Point facility and the program has dedicated space at the Princess Anne CHKD facility, where all CAP services are provided.

Nearly 1,000 children are served annually, and many of these children have multiple visits, including regular psychotherapy appointments. The CAC model provides a safe, child-friendly place for children involved in cases of alleged maltreatment to receive quality services, including forensic interviews, medical evaluations, psychological evaluations, and treatment. The model includes a Multidisciplinary Team (MDT) which brings together the professionals involved in the investigation and prosecution of child abuse as well as intervention and advocacy for the child and family. CAP has 6 city MDTs and 2 military MDTs that review all new cases of child abuse, exchange information among professionals, and make decisions about cases. Working collaboratively in a multidisciplinary team environment to coordinate investigations and interventions is not only financially and operationally more efficient for each locality, but more importantly, this approach seeks to reduce the child's time spent in the legal system by consolidating interviews and questions.

The Child Abuse Program minimizes further stress to these child victims by providing a supportive, child-friendly environment for forensic interviews, conducted by professional interviewers who understand the fears and anxieties of abused children. Interviews are digitally recorded and witnessed by investigators, with the goal of recounting the history of abuse one time only. Victims of abuse and neglect begin the healing process in a program that honors the child's need for safety, dignity and privacy. Board certified Child Abuse Pediatricians, medical fellows, and a roster of Pediatric Forensic Nurse Examiners meet the medical needs of children in maltreatment cases through outpatient clinics, inpatient and outpatient consults, and 24/7 coverage of acute sexual assault of children. Specially trained Clinical Psychologists, Licensed Clinical Social Workers and other mental health professionals provide evidence-based trauma therapy for children. Psychological testing, Brief Clinical Assessments (screening for trauma and other symptoms), and Parenting Capacity Evaluations are also provided. Case Managers provide case coordination, screen and process intakes and facilitate the MDT meetings. The Family Advocate provides support to the non-offending caregiver and psychoeducation

regarding child abuse and the investigatory/prosecutor process; she also links the family to needed community resources. The program's professionals regularly appear in court serving as expert witnesses in criminal and civil cases of alleged child abuse and/or neglect.

In FY12, CAP saw 738 children from the southside, 97 from the Peninsula and 125 from other areas in the region.

FY12 CAP Services	
Service	**FY2012**
Mental Health Visits	3,129
Medical Visits	449
Forensic Interviews	522
Subpoenas Received	271
Court Testimony Provided	65

(Note: The issue of child abuse is being addressed on a number of fronts by a multitude of community providers and agencies, with CHKD providing its expertise and assistance in keeping with the organization's core mission and availability of resources. Therefore, CHKD acknowledges that it neither is nor should be the sole entity responsible for addressing this focus area.)

Plans for FY14 and Beyond:

During the coming year, the program will implement a $1.57 million federal grant, called INVEST (Increasing Virginia's Evidence Supported Treatments). The goal is to reduce the impact of child maltreatment on children in Hampton Roads by creating a trauma-informed network of care and increasing children's access to evidence-based, trauma-informed services. The objectives are: 1) Train CAP staff and community professionals, including child protective services workers, foster care workers, family advocacy program staff, military and civilian law enforcement and attorneys, to become more trauma-informed, understand the different evidence-based treatments, and conduct trauma-informed screening and referral procedures. 2) Train CAP clinicians to deliver three trauma-informed evidence-based treatment(s), including

two treatments that are not currently available in our region (Parent Child Interaction Therapy for traumatized children with behavioral problems and Alternative for Families Cognitive Behavioral Treatment for families with a history of physical abuse, when the child returns home). Results will be measured, monitored and reported. These two models, when added to our current Trauma Focused Cognitive Behavioral Model, should ensure appropriate treatment for all children receiving therapy at the program

2. <u>Implementation Plan: Childhood Obesity</u> (CHKD, OP, PA)

The epidemic of childhood obesity is a long-standing focus area for CHKD. In 2001, CHKD established one of the nation's first comprehensive, multidisciplinary programs designed to help children gain control of their weight to improve their health. Today, the program, called "Healthy You for Life," is offered to children ages 3-16 and provides clinical and psychosocial evaluation and planning as well as classes covering nutrition, exercise and other opportunities for lifestyle management. Clinical follow up extends for one year past completion of the program. The program's staff includes physicians and nurses, registered dietitians, licensed clinical social workers, physical therapists and exercise specialists. The team conducted 811 visits last year. Healthy You for Life participants come from throughout the greater Hampton Roads region:

- 73 % southside
- 22% Peninsula
- 3% NE NC
- 2% western Tidewater, Eastern Shore and upper Peninsula

The exercise component of the program is strengthened by an exercise specialist who conducts personal training sessions as well as group fitness classes for the whole family. Exercise opportunities are available weekdays and weekends around the Hampton Roads region to enhance our patients' ability to embrace a healthier lifestyle. The program established a regional collaboration with the YMCA which offers families a six-week trial membership once they have completed the eight-week lifestyle class.

Healthy You for Life staff members participate in community wide health fairs and conduct family fitness nights at area schools. Furthermore, the program offers professional training sessions on topics related to childhood obesity at a number of conferences and workshops annually. Last year, the program participated in 23 events reaching nearly 3,000 attendees.

The Healthy You for Life program offers individual counseling sessions as well as the use of social media for ongoing support and communication. A Facebook page added this year counts nearly 750 clinic patients and their parents as participants.

The program recently completed research to determine reasons for and methods to overcome attrition by program participants. The following provides a summary of that research:

Purpose

This program transitioned to a revised clinic format ("old" model) to include assessments by the team and pediatrician. Prior to that, patients underwent one clinic assessment with the dietitian, physical therapist, and social worker. Two years later, in response to community feedback, services were added for preschoolers and the team expanded to include additional social workers, physical therapists, dietitians, and exercise specialists. Despite programmatic changes, the program experienced high no-show and attrition rates (70%). Further format changes ("new" model) led to assessment of readiness for change, and focused on the causes of attrition, i.e. engagement, behavioral issues, parental support, and expectations.

Methods

Patients aged 3 to 16 years with a body mass index greater than the 85th percentile-for-age and gender receive clinical assessments and follow-up for 12 months (or 4 visits), lifestyle classes, and access to a team which includes a pediatrician, nurse, dietitians, physical therapists, exercise specialists, social workers, and parent educators. Family-centered classes focusing on fitness, nutrition, and self-esteem provide age appropriate learning environments. In the "new" model the team implements tenets of motivational interviewing, such as reflective listening, asking permission and using open ended questions. Parents speak with the social worker prior to the team assessment. The team conducts weekly care conferences. "New" model also features delivery of therapeutic contacts such as letters, electronic mail, phone calls, and text messages to engage families. The outreach coordinator maintains a database that ensures timely distribution and documentation of contacts by each provider. The program manager communicates with referring physicians when their patient does not schedule an initial appointment within 6 weeks of referral, no-shows, elects not to reschedule, or manifests behavioral issues that preclude continuation. The social workers contact patients who no-show and facilitate outpatient counseling when issues undermine improvements in nutrition and fitness. The physical therapist and exercise specialist complete functional movement and fitness assessments. The dietitian counsels patients on healthy eating and screens for food insecurity. The pediatrician screens
for complications of obesity; engages the referring physician; and makes referrals to specialists (i.e. nephrology, endocrinology), when needed.

Results

Analysis of a retrospective review of clinic schedules and "old" (n=158) and "new" (n=66) model patients aged 10-17 years revealed encouraging results. The no show rate decreased by 50%; compared to "old" (1.9%) more "new" model patients (37.9%) completed 4 visits ($p<0.0001$); and patients with more contacts completed more visits.

Conclusions

The move from "old" to "new" model suggests decreased no-show and attrition rates; increased patient and physician communication; and increased parental support and patient

engagement. Programmatic changes limit attrition, emphasize multidisciplinary treatment, and use innovative therapeutic contact.

CHKD is also home to a comprehensive diabetes education program, a complementary program to Healthy You for Life. The CHKD diabetes program helps approximately 1,300 local children who live with the chronic disease. Two certified diabetes educators, a social worker, nurse and department coordinator help patients and families at the onset of the disease and until adulthood. The Diabetes Center provides inpatient and outpatient clinical management, diabetes education, support groups, and professional and community education programs. A transition program helps the older teens and young adults begin transferring care to adult providers in the community.

(Note: The issue of childhood obesity is being addressed on a number of fronts by a multitude of community providers and agencies, with CHKD providing its expertise and assistance in keeping with the organization's core mission and availability of resources. CHKD acknowledges that it neither is nor should be the sole entity responsible for addressing this focus area.)

Plans for FY14 and Beyond:

- Demand for the Healthy You for Life Program is greater than current capacity, with wait times approaching six months. Therefore, CHKD is working to expand the availability of and access to the Healthy You for Life program in the coming years.
- Research findings related to program attrition will be applied to the program design, and studies will be conducted determine the short-term and long-term effects of the program on BMI and on psychosocial factors affecting participants. Specifically, CHKD is comparing change in BMI from referral to the last documented visit to see if there is a difference between old model patients (limited contact in between visits), new model patients (different forms of therapeutic contact), and those included in the gym-in-a-bag protocol (new model plus bag). The program is also attempting to document and analyze whether there is a difference in wait time (months from referral to initial visit) among old or new models.
- The program will participate in obesity summit at East Carolina University (NC) as well as Weight of the State in Richmond, VA.

3. Implementation Plan: Infant Mortality/Morbidity (CHKD, OP, PA):

CHKD works collaboratively with Eastern Virginia Medical Schools Maternal Fetal Medicine program as well as the hospital's neonatology division, with many efforts aimed at preventing or minimizing preterm births while promoting optimal health for mothers and their unborn babies via evidenced-based practice.

An important program in CHKD's work in the area of infant mortality/morbidity is the hospital's Maternal Neonatal Transport Review (MNTR) program**.** These programs are conducted several times each year at every hospital that refers neonates to CHKD, home of the region's only subspecialty neonatal intensive care unit. CHKD operates a 62 bed NICU with 7 additional step-

down neonatal beds. As the regional perinatal/neonatal referring hospital for southeastern Virginia and Northeastern North Carolina, CHKD serves patients from:

- Albemarle Hospital, Elizabeth City NC
- Chesapeake Regional Medical Center, Chesapeake, Va.
- DePaul Medical Center, Norfolk, Va.
- Sentara Leigh Hospital, Norfolk, Va.
- Maryview Medical Center, Portsmouth, Va.
- Mary Immaculate Medical Center, Newport News, Va.
- Sentara Obici Hospital, Suffolk, Va.
- The Outer Banks Hospital, Outer Banks, NC
- Riverside Regional Medical Center, Newport News, VA
- Roanoke Chowan Hospital, Ahoskie, NC
- Riverside Shore Memorial Hospital, Nassawadox, Va.
- Southampton Memorial Hospital, Franklin, Va.
- Sentara Princess Ann Hospital, Virginia Beach, Va.
- Sentara Williamsburg Regional Medical Center, Williamsburg, Va.

CHKD leads and organizes the team for each MNTR, ensuring that a CHKD neonatologist and EVMS perinatologist offer a thorough analysis to the referring hospitals' obstetricians, pediatricians and obstetrical and neonatal/nursery nurses. The sessions are intended to highlight current therapies or changes in treatment modalities to ensure the best possible outcomes from the transfer of high-risk newborns to CHKD. CHKD provides CME Category 1 credits at each review.

CHKD provides annual financial support to the EVMS Maternal Fetal Medicine (MFM) program to ensure its availability throughout greater Hampton Roads to provide consultation, assessment, emergency and continuing care services for high-risk pregnancies. CHKD's continued investment in the accessibility of MFM physicians throughout the region is to ensure that comprehensive evidence-based care will be delivered to high-risk obstetrical patients in an effort to reduce infant mortality and low birthweight deliveries. In part through CHKD's support, MFM is able to continue offering specialized services such as:

- Diabetes in Pregnancy Program
- HIV in Pregnancy Program
- Fetal Surgery Program
- Specialized Ultrasound Technologies
- Prenatal Diagnosis and Genetics Program
- Perinatal Research
- Fetal Cardiovascular Program
- Teenage Pregnancy Program
- Maternal Transport

In its ongoing pursuit to decrease preterm birth, MFM has advocated for the use of 17-hydroxy progesterone, proven to decrease preterm labor in mothers who have previously delivered

prematurely. In addition, MFM is developing new therapies to determine cervical length, tied increasingly to the likelihood of preterm birth.

CHKD's NICU utilizes cutting-edge therapies including High Frequency Jet Ventilation, Hypothermia Therapy and Donor Human Milk, all aimed to prevent common premature maladies of chronic lung disease, intraventricular hemorrhage, and necrotizing enterocolitis.

CHKD also conducts a NICU Follow-Up Clinic to provide ongoing evaluation and guidance to parents of neonates during the first three years of life. The clinic is offered at three locations spread within the service region for easy access by all graduates and is attended by a neonatologist and developmental pediatrician. The purpose of the follow-up program is for early identification of medical or developmental issues associated with prematurity, resulting in the ability to offer early intervention to optimize outcomes.

(Note: The issue of infant mortality/morbidity is being addressed on a number of fronts by a multitude of community providers and agencies, with CHKD providing its expertise and assistance in keeping with the organization's core mission and availability of resources. CHKD acknowledges that it neither is nor should be the sole entity responsible for addressing this focus area.)

Plans for FY14 and Beyond:

- Facilitate education of community physicians on medical and technological advances in the causes and prevention of prematurity and low birthweight deliveries.
- CHKD will continue to monitor and measure outcomes related to infant mortality and morbidity and to work collaboratively with physicians and community agencies to address the causes and prevention of preterm births.
- In collaboration with the American Academy of Pediatrics, CHKD will host a statewide obstetrical and neonatal conference to provide obstetricians and pediatricians with the latest information on a variety of topics related to maternal and neonatal care.

4. <u>Implementation Plan: Health Promotion and Prevention</u> (CHKD, OP, PA)

CHKD's community outreach program provides preventive education and resources to improve the health and well-being of children and families throughout Hampton Roads. In collaboration with Children's Medical Group, Children's Surgical Specialty Group and Children's Specialty Group, plus multiple departments in the hospital (Hospital School Program, Social Work, Transport, NICU, Volunteer Office, Chaplaincy Services, Child Life, Care Connection for Children, etc.) more than 399 outreach activities have been conducted serving close to 46,920 parents, professionals, and students in FY12.

The community outreach program provided 57 school-based programs and 122 community programs. In addition, the department launched a pilot Kohl's Steps To Fitness Assembly Program in area schools with great success.

Programs and Services Provided:

- Parent and professional programs in the community, schools, daycares, churches, conferences, social services, parks and recreation centers, foster care agencies, etc.
- CHKD special events/programs: open houses, Baby Expos, conferences, sideline sensibility, health fairs, etc.
- Leadership for the Hampton Roads Parent Education Network (HRPEN)
- Co-chair of the Virginia State Wide Parent Education Coalition (VSPEC) Organization structure subcommittee

Collaborations:

- Bon Secours Family Focus
- Catholic Charities of Eastern Virginia
- Chesapeake Community Services Board
- Chesapeake Bureau of Community Programs
- Chesapeake Council on Youth
- Chesapeake Public Schools
- Children's Harbor
- CHIP of Southampton Roads
- Fleet and Family Support Centers
- Hampton Department of Human Services
- Hampton Healthy Families Partnership
- Hampton Roads Youth Partnership
- KidsPriorityOne
- Lutheran Family Services of Virginia
- Mediation Center of Hampton Roads
- National Counseling Group, Inc.
- Newport News Healthy Families Initiative
- Norfolk Ready by 5- Norfolk Department of Social Services
- Old Dominion University
- Planned Parenthood of Southeastern Virginia
- Prevent Child Abuse Hampton Roads
- Project Link, Virginia Beach Department of Human Services
- Seton Youth Shelter
- Smart Beginnings of the Peninsula
- Suffolk Publics Schools
- The Planning Council
- The UP Center

- Virginia Beach Public Schools
- Virginia Premier Health Plan
- Virginia Beach Student Health Advisory committee
- YMCA Community Services

Program Area Served

- The program serves all 7 cities and occasionally extends to a few areas outside of CHKD's service area. The following is a breakdown of the 46,920 people served in each city:
    - Chesapeake – 18%
    - Elizabeth City/nags Head –3%
    - Gloucester- < 1%
    - Hampton – 10%
    - Newport News- 5%
    - Norfolk – 34%
    - Portsmouth- 3 %
    - Suffolk – 3%
    - Virginia Beach – 21%
    - Williamsburg/York –1%
    - Other cities – < 1%

CHKD's Division of Community Health and Research has focused on conditions and issues impacting children's health with an emphasis on health disparities in the cities of the Hampton Roads region, western Tidewater, and the rural Eastern Shore. Current areas of emphasis include childhood obesity, asthma, immunization, infant and child passenger safety, teen alcohol abuse, and autism. During the 2011-2012 academic year, approximately $1.43 million in extramural grants supported this work with additional funding from CHKD and EVMS.

In FY12, CHKD hosted 62 individual continuing medical education events in various locations throughout the region, helping child health experts in our region keep up with their skills and their accreditation.

CHKD pediatricians have a long-standing commitment to not only assessing developmental milestones during patient visits but also to addressing a key issue that will have a life-long effect on children – literacy. CHKD established the Reach Out and Read program at its pediatric practices in 2001. Developed by pediatricians and endorsed by the American Academy of Pediatrics, Reach Out and Read makes literacy promotion an integral part of pediatric checkups for children ages six months to 5 years old. Pediatricians encourage parents to read aloud to young children and give them a free, age-appropriate book during well-child visits.

Research findings from 14 peer-reviewed studies clearly show that pre-schoolers served by the program score significantly higher on vocabulary tests than their peers. And, in a statewide test

that measures literacy among children entering kindergarten, Hampton Roads has performed better than every other region in Virginia since 2005. Reading is a skill that holds profound importance in the lives of children. Learning to read well is vital for children's success in school.

By distributing 70,479 books in 2012 through our 26 pediatric practice locations, CHKD remained Virginia's largest participant in Reach Out and Read, a role it has held since its inception at CHKD. Additionally, 96% of CHKD's pediatric providers completed annual Reach Out and Read training to ensure optimal results with the program.

CHKD's Reach Out and Read program collaborates with many members of the community, including: the CHKD/EVMS pediatric residency program, Barnes and Noble, UPS, Primrose Preschool – Chesapeake, St. Patrick's Catholic School – Norfolk, Calvary Christian School – Norfolk, Larchmont United Methodist Preschool – Norfolk, Greenwood Elementary and John B. Dey Elementary – Virginia Beach.

(Note: Health promotion and prevention are being addressed on a number of fronts by a multitude of community providers and agencies, with CHKD providing its expertise and assistance in keeping with the organization's core mission and availability of resources. CHKD acknowledges that it neither is nor should be the sole entity responsible for addressing this focus area.)

Plans for FY14 and Beyond:

Community outreach continues to extend its reach by utilizing CHKDs medical groups and other department staff. The Kohl's Cares for Kids annual grant for FY14 will change the program's focus from the prevention of child abuse to addressing the prevention of obesity more directly in large-scale community events. Continued use of community collaboration will be utilized for outreach to prevent child abuse. Program participants will be asked to evaluate the quality and effectiveness of all programs offered through CHKD community outreach. Evaluation results will be used to improve the programs health promotion and prevention offerings in the future.

For the Reach Out and Read Program, plans are underway to educate all participating pediatricians and support staff on new developmental milestones guidelines as they pertain to literacy education. The CHKD program will also assist the state-based program in building a stronger coalition to enhance support for the program throughout Virginia. And, CHKD's program will expand into local pre-K programs to encourage reading aloud and literacy education and will encourage public schools' library/media centers to participate in local book drives.

Additional Issues

Implementation Plan: Asthma (CHKD, OP, PA)

CHKD's allergy and immunology clinic provides evaluation, diagnosis and treatment of symptoms related to allergies and immunological deficiencies, asthma, sinusitis, hives, chronic infections, skin rashes caused by allergies, food allergies and drug allergies.

Allergy and immunology physicians tailor each child's treatment plan according to his or her unique needs.

The allergy and immunology program at CHKD serves more than 14,000 patients per year at CHKD, Oakbrooke in Chesapeake, Princess Anne in Virginia Beach and Oyster Point in Newport News.

(Note: The issue of childhood asthma is being addressed on a number of fronts by a multitude of community providers and agencies, with CHKD providing its expertise and assistance in keeping with the organization's core mission and availability of resources. CHKD acknowledges that it neither is nor should be the sole entity responsible for addressing this issue.)

Plans for FY14 and Beyond:

To address access to care and availability of services, a new physician will be added to the practice and a new site will open in the Harbour View area of Suffolk. Physicians will continue their participation in multidisciplinary clinics, including those for patients with Eosinophilic gastroenteritis and in community health programs, including the "Healthy Homes" initiative for children with asthma.

CHKD physicians participate in the *Consortia for Healthy Homes in Norfolk (CHHN)* project, a HUD initiative aimed at protecting children and families from housing-related health and safety hazards. The focus of is asthma, air quality, and household safety. The project seeks to decrease children's exposure to (1) dust and dust mites, (2) mold and moisture intrusion, (3) insect (cockroaches) and rodent infestations, (4) combustion products of heating and cooking utensils, (5) unintentional fires, (6) poisonous household products and (7) accidental falls. The program objectives are to: (a) coordinate efforts to improve indoor environmental quality and safety in the targeted housing communities by partnering with organizations to form the *Consortia for Healthy Homes in Norfolk* (CHHN) (b) involve low-income and minority populations in program activities; (c) ensure that the CHHN is integrated into a much larger, collaborative, community-based and capacity building approach that involves organizations, stakeholders and opinion leaders; and (d) develop and implement a pragmatic evaluation plan that reflects the level of indoor environmental hazards in the target population and evaluates the effectiveness of CHHN. Pediatric asthma clinic patients from low-income homes will receive clinical testing using pulmonary function tests to determine the extent and severity of asthma and skin prick tests to detect level of sensitivity to indoor allergens. Housing interventions will be performed according to outcomes of the assessments.

Implementation Plan: Behavioral Health (for Children Hospitalized or Undergoing Outpatient Care for Medical/Surgical Conditions) **(CHKD, OP, PA)**

A team of licensed clinical social workers (LCSWs) under the direction of Dr. Peter Dozier, Director of Behavioral Pediatrics at CHKD, provides the hospital's first line of assessment for patients who are medically compromised and have a known or suspected behavioral health management issue, including those who experience the effects of alcoholism or substance abuse. Next year, CHKD expects to see more than 500 patients with a connection to a behavioral health or substance abuse issue. This year, the hospital implemented an initiative to require screening by an LCSW of all hospitalized patients to assess risk to self-harm or harm to others. This standardized LCSW assessment will optimize patient safety in this important area.

CHKD's Behavioral Health Committee, a multi-disciplinary team, is actively engaged in updating current practices and policies, improving the process of transfer and transport to inpatient psychiatric facilities, implementing evidence-based practices for risk assessment and monitoring behavioral health-related patient safety through increased staff involvement.

CHKD's department of social work is instrumental in fulfilling the bio-psycho-social and emotional needs that may arise when a child is hospitalized. The 22 social workers on staff, along with 3 per diem evening social workers, work with children in our outpatient specialty clinics, especially those catering to children with chronic illnesses. CHKD social workers are available in the hospital from 8 am to 11 pm including weekends. The social work department:

- conducts comprehensive psychosocial history assessments and child and adolescent mental health assessments to stabilize crisis situations and to collaborate with the medical teams to develop comprehensive treatment plans
- coordinates referrals to and ongoing communications with community resources to plan for behavioral health follow-up and/or treatment after the patient's discharge from CHKD. CHKD remains involved to ensure adherence to medical care plans
- collaborates with community agencies and resources including, but not limited to: region-wide Departments of Social Services, Community Services Boards, child mental health inpatient facilities, local Public Health Agencies, Eastern Virginia Medical School's art therapy internship program, Logisticare transportation services, etc.
- facilitates a variety of educational and therapeutic support groups for CHKD families dealing with new diagnoses or chronic illness management as well as grief or loss issues
- facilitates the Family Advisory Council for the Neonatal Intensive Care Unit for the promotion of relationship-based care

- works with families and CHKD's eligibility workers and Health Benefits Advisors to facilitate the application process for health care coverage for Medicaid and FAMIS as well as for prescription coverage
- fulfills quality and outcomes-driven initiatives for the organization, a recent example being participation in the process that led to approval of CHKD's Craniofacial Program as a Cleft Palate-Craniofacial Team (CPT, CFT) with the American Cleft Palate-Craniofacial Association and Cleft Palate Foundation

(Note: Behavioral health is being addressed on a number of fronts by a multitude of community providers and agencies, with CHKD providing its expertise and assistance in keeping with the organization's core mission and availability of resources. CHKD acknowledges that it neither is nor should be the sole entity responsible for addressing this issue.)

Plans for FY14 and Beyond:

- Develop a sustainable plan for the Licensed Clinical Social Work team to ensure coverage during critical events and peak times.
- Ensure full implementation by LCSWs of inpatient screenings for risk of harm to self or others. The assessment helps guarantee the safety of every hospitalized child who may be at risk.
- Conduct a suicide prevention community workshop aimed at professionals as well as parents, fall of 2013. The initiative is aimed at identification, prevention and intervention. This workshop is being organized by an inter-agency planning committee with members from local mental health facilities, the Department of Public Health, Norfolk State University and the Virginia Department of Behavioral Health and Development Services. The keynote speaker will be Richard McKeon, Ph.D., MPH, Chief Suicide Prevention Branch, SAMHSA (Substance Abuse and Mental Health Services Administration). This conference is expected to accommodate up to 400 participants. This regional conference will result in published research looking at the attitudes of mental health provider's pre and post conference attendance. Publication is expected in the Journal of Public Health and Social Work.
- Continue support groups that allow patients and families to connect with others in the community who share their challenges. CHKD offers support groups for cardiology, diabetes, Turner's syndrome, Prader-Willi syndrome, cancer, sickle cell and NICU & PICU patients and families as well as SibShops, a recreation-based group for brothers and sisters of children with special needs.
- Increase support of the Halo Fund at CHKD. The department of social work manages the Halo Fund, established to assist parents and patients with the cost of transportation, meals, medications and specific needs while hospitalized or upon discharge. These

donated funds are also used to assist with urgent needs. Urgent needs may involve payment of a utility service that is vital to the care of the discharged patient and the purchase of medically ordered equipment needed to improve their health where insurance coverage is not available (for example, hearing aids, bath chairs, blood pressure cuffs). The HALO fund helps more than 600 families each year.

- With the region's substantial military presence, further emphasis will be given on coordinating with military installations to involve deployed members of the armed forces in the care of their sick children. CHKD social workers help families navigate the maze of emotional, financial and logistical challenges that arise when children are ill. Whether a child is hospitalized or undergoing outpatient treatment for a chronic illness, our social workers coordinate community-based aspects of a child's care, provide compassionate support to families in crisis and collaborate with medical providers on treatment programs that address children's emotional and medical needs.

Implementation Plan: Case Management Services (CHKD, OP, PA)

CHKD is home to the **Care Connection for Children** (**CCC**) program, one of six sites in Virginia for this Title V program that provides community based comprehensive care coordination, information and referral for children and youth with special health care needs and funding for health care needs of children and youth ages 1 to 21 with chronic health care conditions. Approximately 12,000 children with special healthcare needs reside in our region's 21 cities and counties (VA only). In FY12, CCC provided comprehensive case management services to more than 620 families. Financial assistance was provided for 86 children who were uninsured or underinsured and 204 families were assisted in applying for state health programs.

The staff at CCC provided several training sessions for families and providers on Medicaid waiver services and EPSDT benefits, Family Centered Care, medical legal partnerships, emergency preparedness, use of portable medical summaries, medical home, transitions of care, educational advocacy, and other topics specific to children and youth with special healthcare needs. The CCC provides a unique educational experience for pediatric residents with the "Families as Educators" program. This program involves families, trained as community educators, to teach residents about the challenges and joys of living with a child with chronic, complex, health care needs. 18 residents participated in this program.

CCC is funded through the Title V Maternal Child Health Block Grant funds, matched and allocated through the Virginia Department of Health. CHKD offers its charity care program to participants to offset the costs of lab work, diagnostic testing, therapies and hospitalizations.

The CCC program at CHKD is in its 10th year and is seen as a model for the other programs across the state.

(Note: Case management issues are being addressed on a number of fronts by a multitude of community providers and agencies, with CHKD providing its expertise and assistance in keeping with the organization's core mission and availability of resources. CHKD acknowledges that it neither is nor should be the sole entity responsible for addressing this issue.)

Plans for FY14 and Beyond:

For next fiscal year, the focus will be to improve transition services for youth aging out of the pediatric health care system, which occurs at age 21.

Children's Hospital of The King's Daughters has also launched an assessment of its case management structure (i.e. position in organization, caseload and workload numbers, deployment and work hours, etc.) and processes (relationships with key departments, especially MDs and finance, utilization review and discharge planning, information handoffs, assessment and documentation, effectiveness of rounds, etc.), to determine its precision for meeting several key organizational goals listed below.

- Achievement of patient safety and quality goals
- Assessment of risk and provision of adequate education and support for families
- Reduction in LOS where possible
- Correct staffing mix and roles for RN case managers and social workers
- Prevention of unplanned readmissions and ED revisits within 30 days of discharge
- Provision of safe, smooth, and sustained transitions to the best levels of care for recovery, including handoffs to primary care and the medical neighborhood, potential ACO, and health plan case managers
- Identify opportunities to build responsive relationships with community providers

Implementation Plan: Intellectual and Developmental Disabilities (including Autism) (CHKD, OP, PA)

Developmental pediatric specialists provide developmental consultations for the evaluation and diagnosis of children with developmental disabilities, such as developmental delays, speech/language disorders, motor disorders, cerebral palsy, intellectual disability, autism, learning disorders and attention deficit disorders. Children referred to CHKD developmental pediatrics include premature infants, children with birth defects or syndromes such as Down Syndrome, and those who are not talking or walking, are motor delayed and are failing in school. Developmental pediatric physicians currently see 3,500 patients per year at CHKD and at CHKD's Health Centers at Oakbrooke in Chesapeake and Princess Anne in Virginia Beach. Developmental pediatricians also participate in the NICU follow up multi-disciplinary clinic.

(Note: Intellectual and developmental disabilities are being addressed on a number of fronts by a multitude of community providers and agencies, with CHKD providing its expertise and

assistance in keeping with the organization's core mission and availability of resources. CHKD acknowledges that it neither is nor should be the sole entity responsible for addressing these issues.)

Plans for FY14 and Beyond:

In order to address ongoing demand and meet future needs, an additional physician will join the practice this summer. And, to address access and availability for our region, services will be offered at Oyster Point in Newport News and Harbour View in Suffolk beginning this summer.

The department is planning to collaborate with the Virginia Department of Health to provide interdisciplinary assessments for children with autism and other developmental disabilities.

A research study will be conducted this summer to identify markers of stress and resiliency among caregivers of children with special needs. The results will be used to direct interventions in coordination with the social work department.