The V S Data: Lessons for Health Care Reform

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Vermont Partners for Family Focused Health Promotion

- Vermont Center for Children, Youth, and Families
- VCHIP – Judy Shaw et. al.
- IFS – Melissa Bailey et. al.
- DMH – Biss, McMains et. al.
- DCF – Wolcott et. al.
- DVHA – Simpatico, Berry et. al.
- School systems

Outline:

1. The ACES Study in Vermont
2. How Adversity affects health care outcomes
3. How the Blueprint, VT can use this information to improve the health of all Vermonters and change the economic landscape of Health Care.
4. The Bill
5. The VFBA as 'one' rationale model of health promotion and ACES prevention.
6. Proposal

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Query for children in your state at www.childhealthdata.org

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Open your data briefcase

Your Data ... Your Story

Data Resource Center for Child & Adolescent Health

A project of the Child and Adolescent Health Measurement Initiative

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Browse by State

How to Use This Site

Data at a Glance

At your fingertips–easy-to-read data snapshots for each state

State/Region Nationwide

Browse Data Snapshots

Welcome to the Data Resource Center for Child & Adolescent Health!

Welcome to the newly redesigned DRC website. Take a tour of the site and give us your feedback.

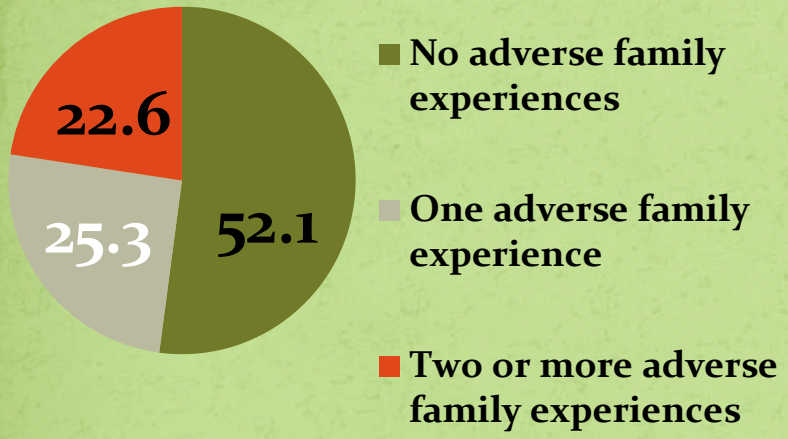
The mission of the Data Resource Center (DRC) is to take the voices of parents, gathered through the National Survey of Children's Health (NSCH) and the National Survey of Children with Special Health Care Needs (NS-CSHCN), and share the results through this online resource so they can be used by researchers, policymakers, family advocates and consumers to promote a higher quality health

Connect with the DRC

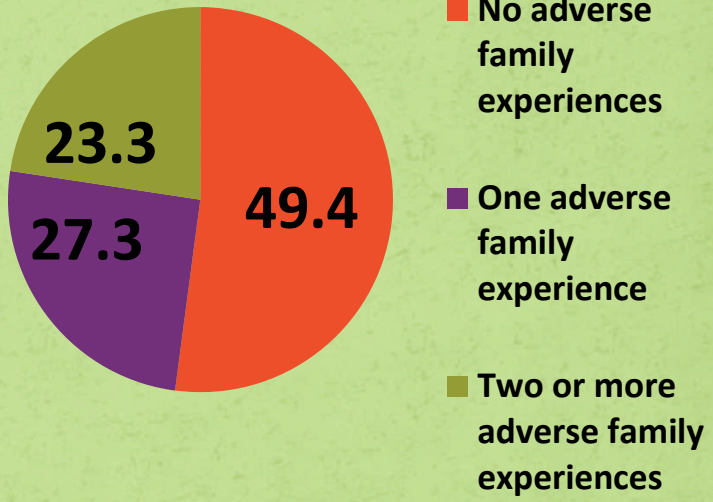
Sign up for email updates

And Now We Have National and State Data on Adverse Childhood Experiences and Resilience FOR CHILDREN (2011-12 NSCH (HRSA/MCHB/CDC)

47.9% of US Children 1+ (of 9) ACEs Age 0-17 years



50.6% of Vermont Children 1+ (of 9) ACEs Age 0-17 years



State Variation In Prevalence of 2+ (of 9) ACES
16.3% (UT) – 32.9% (OK) across states.

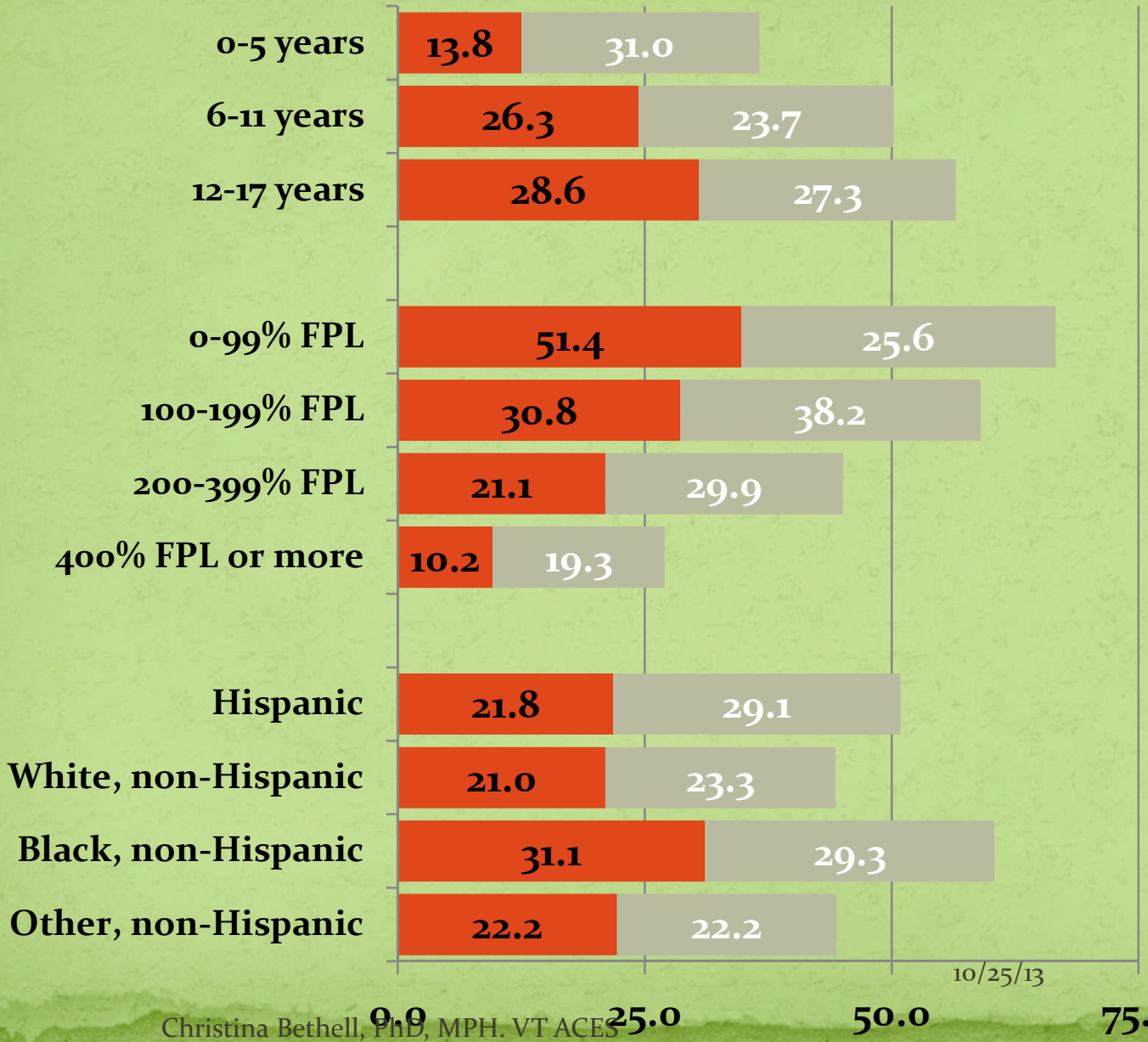
Adverse Child Experiences Included

CAHMI
The Child & Adolescent Health Measurement Initiative

Adverse Childhood Experiences	Vermont Prevalence	National Prevalence	State Range
Child had **one or more** Adverse Child or Family Experiences	50.6%	47.9%	40.6% (CT) - 57.5% (AZ)
Child had **two or more** Adverse Child or Family Experiences	23.3%	22.6%	16.3% (NJ) - 32.9% (OK)
Socioe			MD – 34.3% (AZ)
Divorc			DC) – 29.5 (OK)
Death			T) – 7.1% (DC)
Parent served time in jail	7.9%	6.9%	3.2% (NJ) – 13.2% (KY)
Witness to domestic violence	10.9%	7.3%	5.0% (CT) – 11.1% (OK)
Victim or witness of neighborhood violence	5.7%	8.6%	5.2% (NJ) – 16.6% (DC)
Lived with someone who was mentally ill or suicidal	5.9%	8.6%	5.4% (CA) – 14.1% (MT)
Lived with someone with alcohol/drug problem	1.8%	10.7%	6.4% (NY) – 18.5% (MT)
Treated or judged unfairly due to race/ethnicity	3.0%	4.1%	1.8% (VT) – 6.5% (AZ)

IMPORTANT NOTE:
Questions about child abuse and neglect were not directly asked about in the survey—though are unlikely to lead to substantially different overall rates since ACES are so commonly co-occurring.

Prevalence of Adverse Child and Family Experiences in Vermont, by Age Groups, Household Income Level and Child Race/Ethnicity*



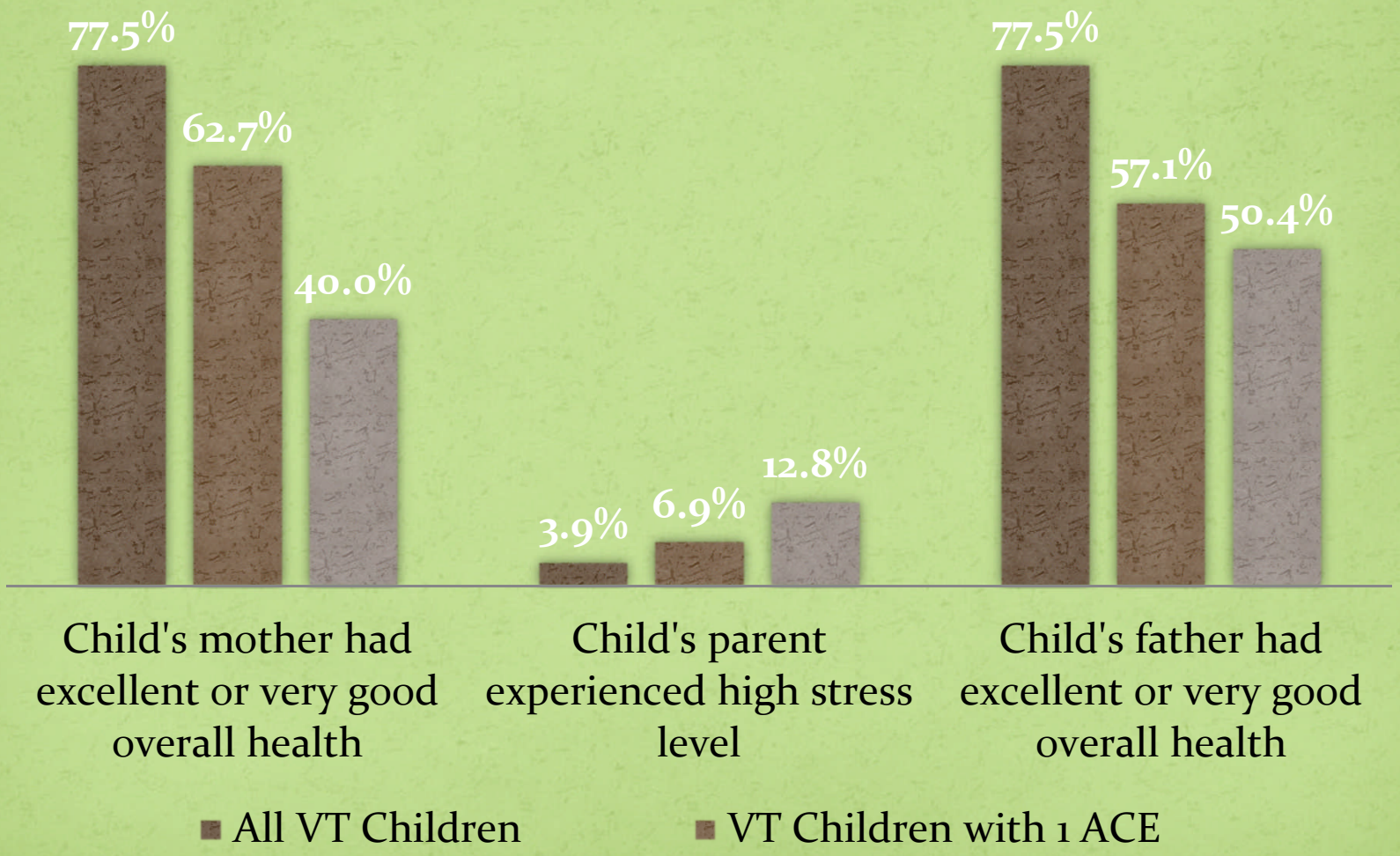
Two or more adverse family experiences

One adverse family experience

*Estimates for race/ethnicity are for US due to small sample size in Vermont

10/25/13

Compounded Risks
ACES and the Health and Stress of Parents



Proportion of VT Children with and without ACES and home, school, and community indicators

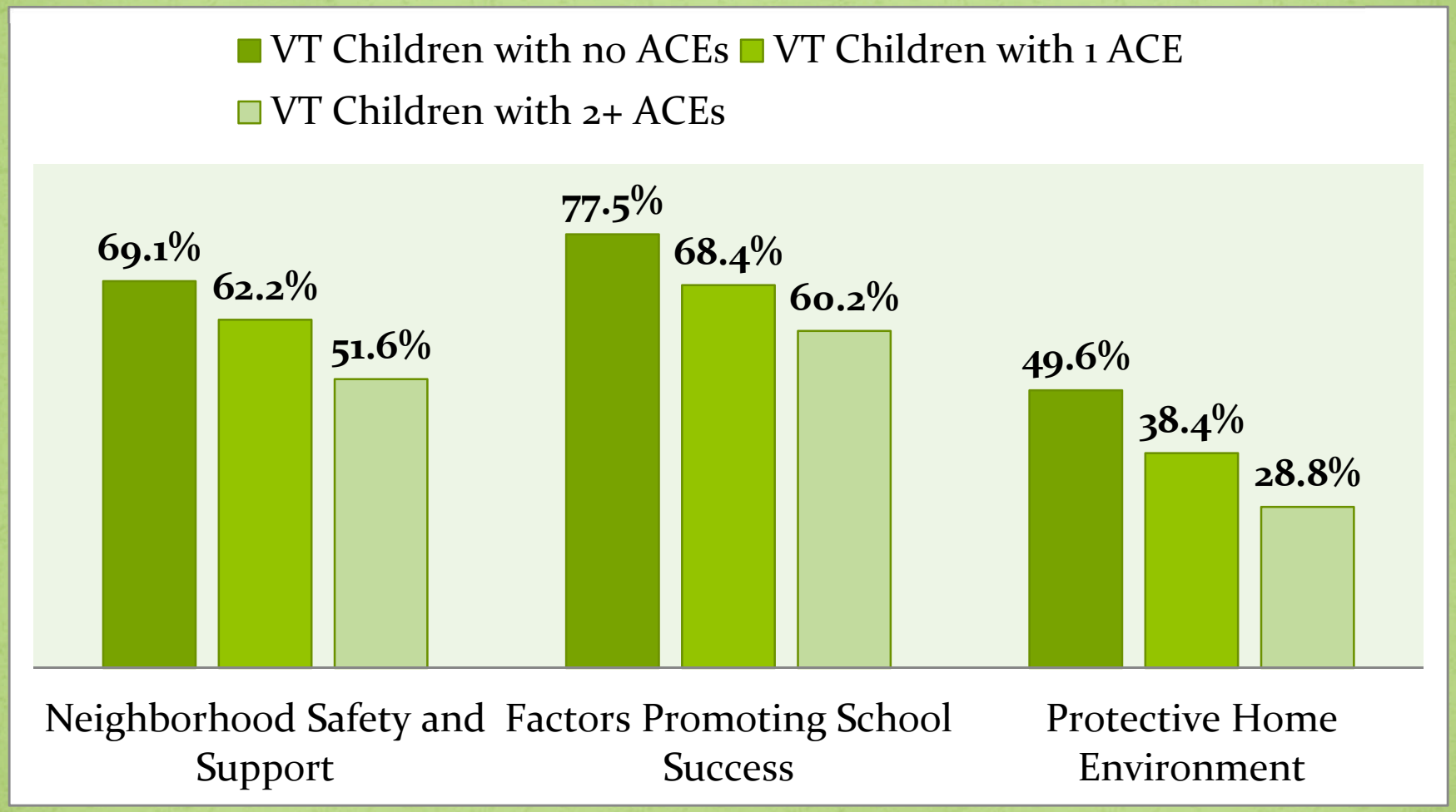


Image Source: Bethel

Likelihood of Medical Home with 1+ ACEs

- **Nationally, compared to children without ACEs, children with 1 or more ACEs are 23% less likely to receive care in a Medical Home (*AOR 0.77 (95% CI: 0.71-0.82).**

- **In Vermont, children with 1 or more ACEs are 50% less likely to receive care in a Medical Home (*AOR: 0.50 (95% CI: 0.37-0.67)**

Geographic Location	Adjusted Odds Ratio	95% Confidence Interval
US	0.77	0.71-0.82
Vermont	0.50	0.37-0.67

*After adjusting for age, sex, race, poverty level, insurance type, and CSHCN status.

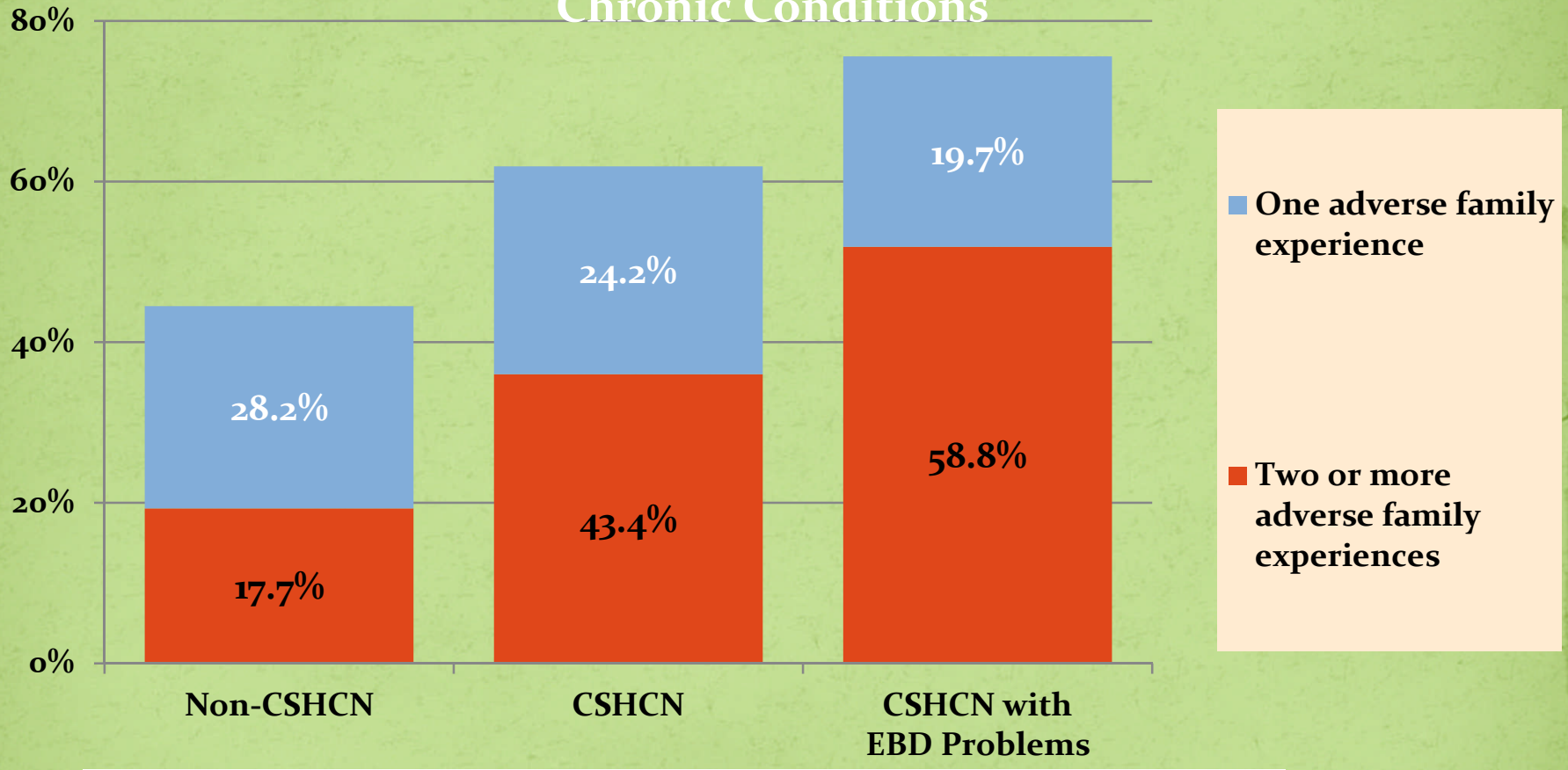
Indicators by presence of Medical Home among children with 1 or more ACEs

- **Nationally, among children with 1 or more ACEs, having a medical home has a positive effect on positive health outcomes (from about 20% increase to 50% increase in odds compared to children without a medical home).**
- **In Vermont, estimates were similar but did not reach significance likely due to small sample size**

Positive Health Indicator	Adjusted Odds Ratio	95% Confidence Interval
Protective Home Environment Index	1.28	1.13-1.43
School Success Index	1.35	1.21-1.50
Mother's health excellent or very good	1.50	1.36-1.65
Family eats 4 or more meals together a week	1.19	1.07-1.33

*After adjusting for age, sex, race, poverty level, insurance type, and CSHCN status.

Chicken and Egg Observations
Adverse Childhood Experiences in Vermont and Health
Children With Chronic Conditions Are More to Experience ACES. Children With ACES Are More Likely to Have Chronic Conditions



CSHCN: Children With Special Health Care Needs
EBD: Emotional, Behavioral, Developmental Problems

Summary

- Adverse Child Experiences (ACES) affect 47.9% of Children Nationwide and 50.3% of Children in Vermont.
- Children who endure ACES:
  - come from all socioeconomic strata.
  - have parents who are less well (both mothers and fathers) and more stressed.
  - Struggle at school, home, and the community.
  - are less likely to be in a Medical Home (ACES children in Medical Homes do better on a number of factors).
- 79.6 % of Vermont Children with special needs & emotional behavioral disorders have endured ACES
- ACES are associated with a wide variety of negative health outcomes that account for the vast majority of the health care costs to our Nation/State.
- ACES are by definition PREVENTABLE.

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Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults

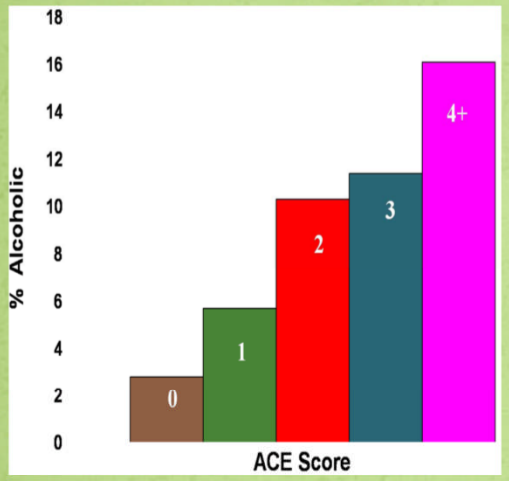
The Adverse Childhood Experiences (ACE) Study

Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS, Dale Nordenberg, MD, David F. Williamson, MS, PhD, Alison M. Spitz, MS, MPH, Valerie Edwards, BA, Mary P. Koss, PhD, James S. Marks, MD, MPH

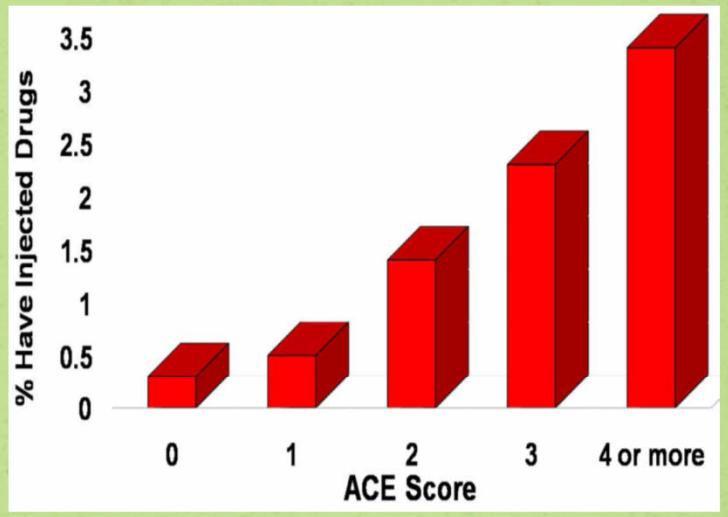
- **Child maltreatment and other adverse childhood experiences are non-specific risk factors for multiple psychiatric disorders, and several health risk behaviors including smoking, overeating, and excessive alcohol and drug use.**
- **Above and beyond the effect of these risk behaviors, adverse childhood experiences predict ischemic heart disease, stroke, respiratory problems, diabetes, and cancer.**

What we have learned from the ACEs:

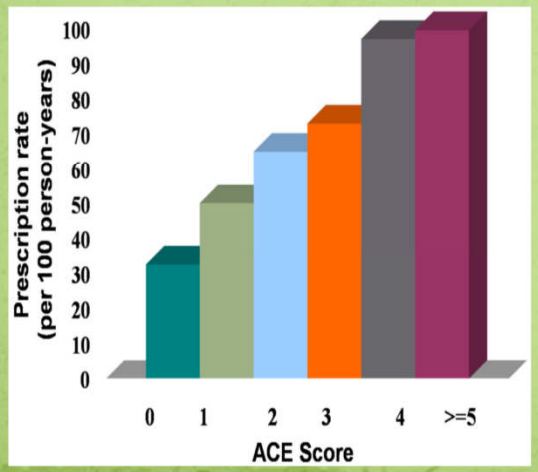
(a) Childhood Experiences vs. Adult Alcoholism.



(b) ACE Score vs. Intravenous Drug Use



(c) ACE Score and Rates of Antidepressant Prescriptions



d) Adverse Childhood Experiences vs. History of STD

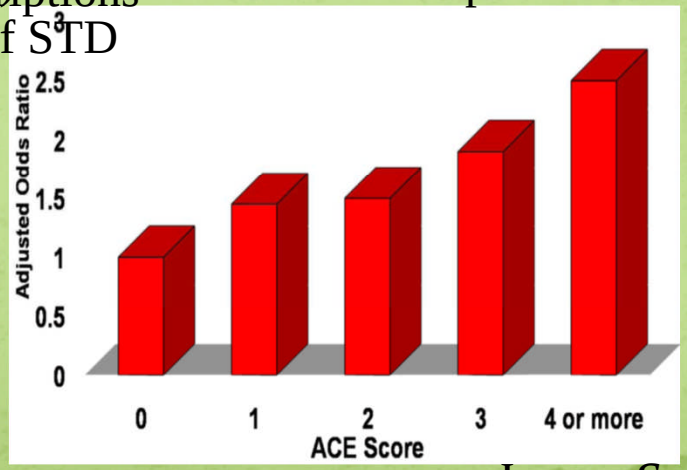
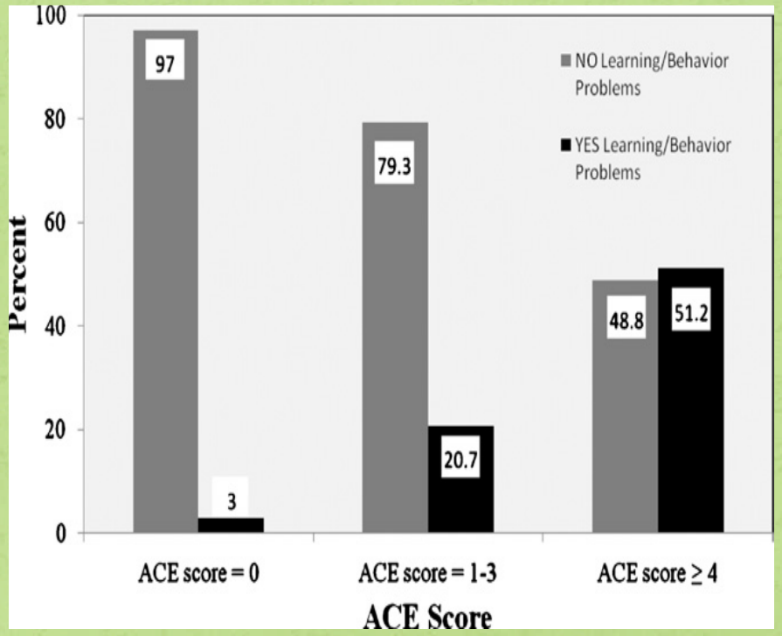


Image Source:

Further Evidence:

- Exposure to four or more ACEs associated with increased risk for learning/behavior problems and obesity



Source: Burke et al. (2013)

ACES and Criminal Behavior

Adverse childhood experiences and adult criminality: how long must we live before we possess our own lives?
James a Reavis, PsyD; Jan Looman, PhD; Kristina A Franco; Briana Rojas Perm J 2013 Spring;17(2):44-48

- Adult offenders reported nearly four times as many adverse events in childhood than normative (non-offender) sample
- 8 out of 10 ACES events were found at significantly higher levels among criminal population
- To reduce recidivism, treatment interventions must focus on effects of early life experiences

Table 1. Adverse Childhood Experiences (ACE) Questionnaire scores and comparison with normative sample

ACE score	Current sample (N = 151), %	Normative sample[a] (N = 7970), %	t
0	9.3	38.0	7.22[b]
1	13.2	26.0	3.56[b]
2	13.9	15.9	0.67
3	15.2	9.5	2.36[b]
4 +	48.3	12.5	10.86[b]

[a] Normative sample from the Centers for Disease Control and Prevention[8] based on 1998 male data from Felitti et al.[3]
[b] $p < 0.0001$.

Table 3. Types of Adverse Childhood Experiences (ACE) compared with normative data

ACE type	Current sample (N = 151), %	Normative sample[a] (N = 7970), %	t
Psychological abuse	52.3	7.6	19.58[b]
Physical abuse	41.1	29.9	2.97[c]
Sexual abuse	27.2	16.0	3.70[b]
Emotional neglect	50.3	12.4	13.62
Physical neglect	21.9	10.7	4.37
Household substance abuse	47.7	23.8	6.79[b]
Household mental illness	25.8	14.8	3.75[c]
Mother physical abuse	27.8	11.5	6.15[b]
Criminal behavior in household	20.5	4.1	9.73[b]
Parental divorce	53.6	21.8	8.66[a]

[a] Normative sample data from the Centers for Disease Control and Prevention.[8]
[b] $p < 0.001$.
[c] $p < 0.05$.

Adverse Childhood Experiences (ACEs) study

- Assesses exposure to 10 categories of early childhood trauma or toxic stress.

- In short, ACES lead to:
  - Persistent Psychopathology
  - Antisocial Personality Disorder
  - Substance Abuse
  - Diabetes
  - Hypertension
  - Obesity

Summary:

- Numerous studies show that ACES place us at increased risk for:
  - Obesity, substance use disorders, diabetes, emotional behavioral disorders, hypertension, and criminal behavior.
- We are beginning to understand the basic mechanism by which ACES leads to these negative health care outcomes.
- These outcomes account for the majority of our health care expenditures (and costly State Wide programs).
- ACES are preventable and these disorders are extraordinarily difficult to treat once they have taken root in adulthood.
- Taking an evidenced based, child and family focused approach to health promotion, illness and ACES prevention, and integrated intervention will lead to improved health and decreased costs.
- WE ARE NOT THE ONLY ONE THINKING THESE THOUGHTS.

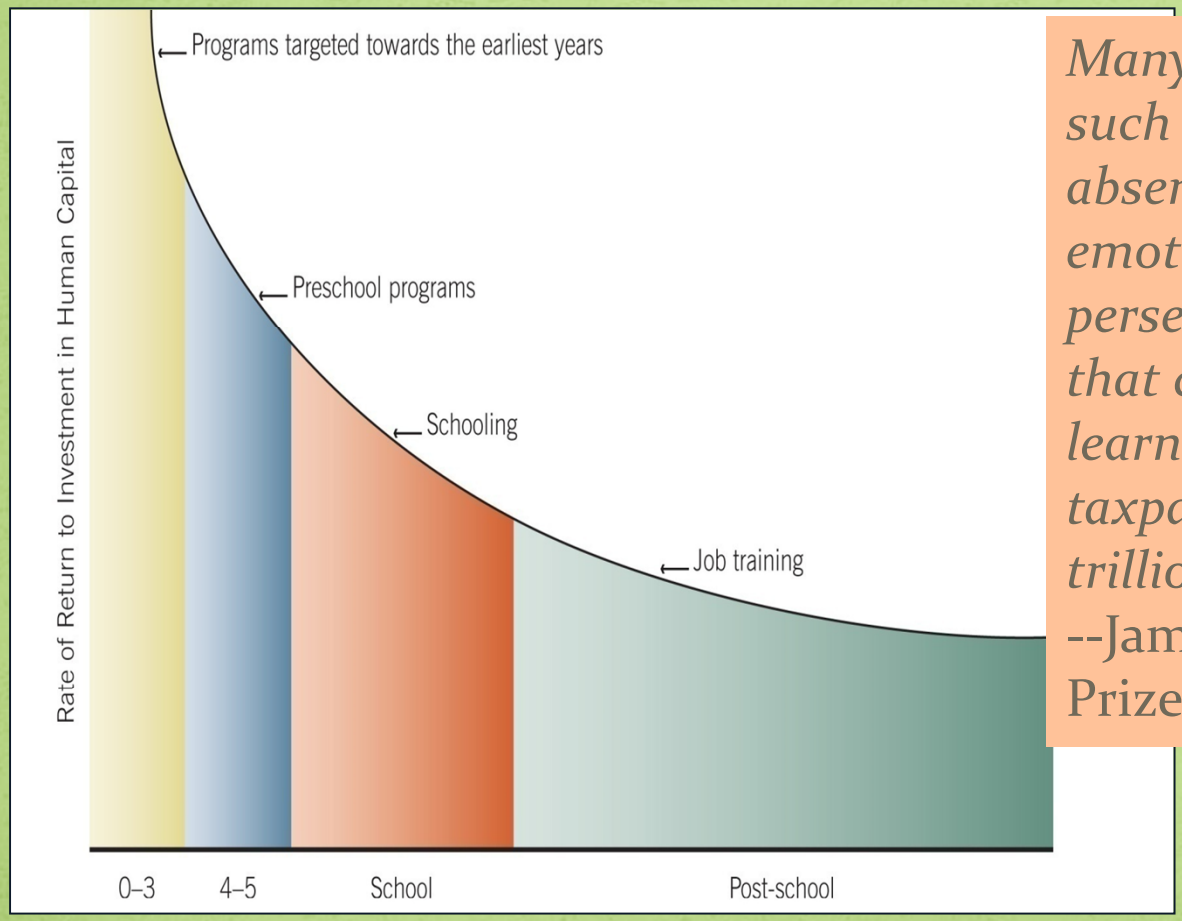
Nobel Prize Winners Agree

"The logic is quite clear from an economic standpoint. We can invest early to close disparities and prevent achievement gaps, or we can pay to remediate disparities when they are harder and more expensive to close. Either way we are going to pay. And, we'll have to do both for a while. But, there is an important difference between the two approaches. Investing early allows us to shape the future; investing later chains us to fixing the missed opportunities of the past. Controlling our destiny is more in keeping with the American spirit."

-James J. Heckman (2011)

The Economics of Inequality: The Value of Early Childhood Education

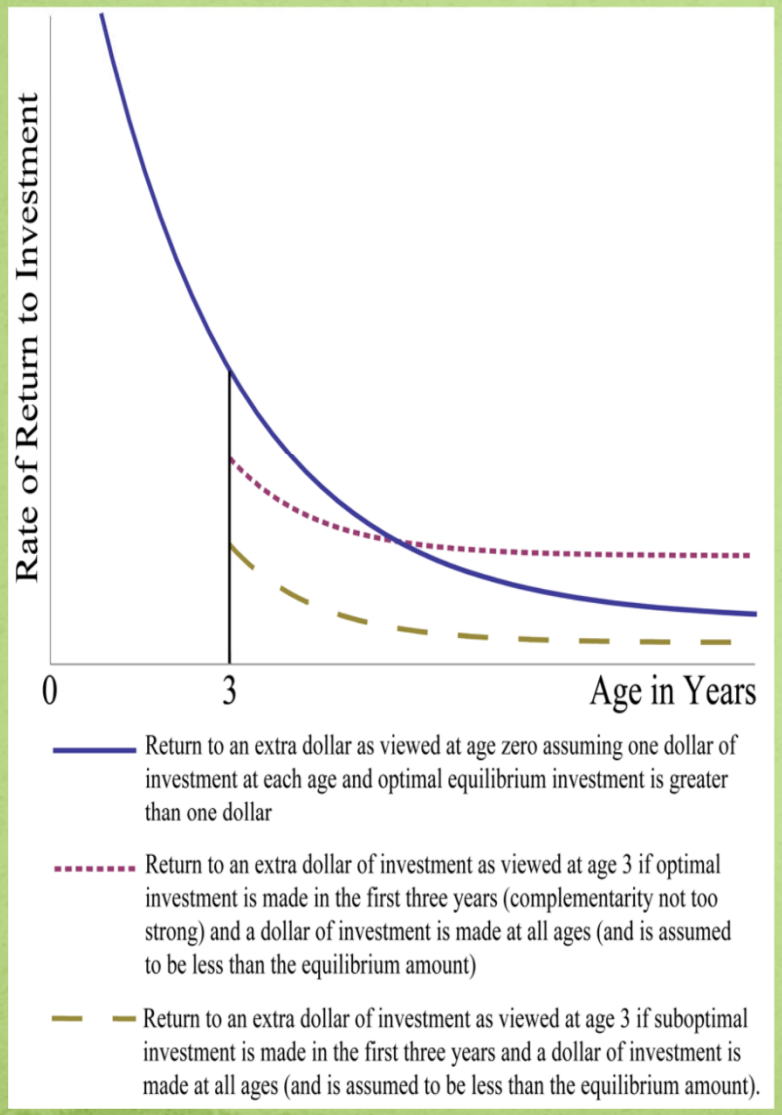
Why Intervening Early Matters:



Many of our social problems, such as crime, are traced to an absence of the social and emotional skills, such as perseverance and self-control, that can be fostered by early learning. Crime costs taxpayers an estimated $1 trillion per year.
--James Heckman, Nobel Prize Winning Economist

Image Source: Heckman & LaFont

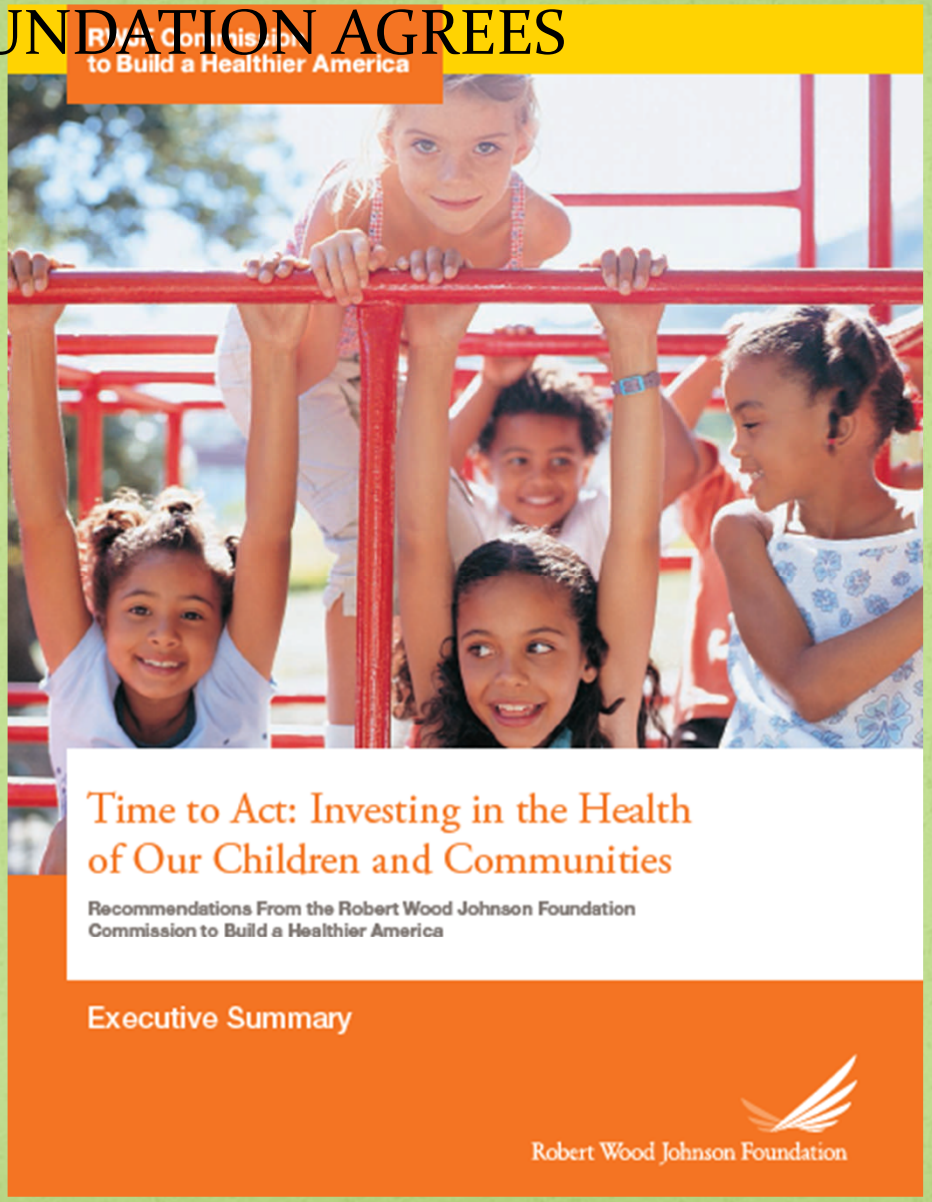
Return on Investment:



Returns to a Unit Dollar Invested.
(a) Return to a Unit Dollar Invested at Different Ages from the Perspective of the Beginning of Life, Assuming One Dollar Initially Invested at Each Age
(b) Returns to One More Dollar of Investment as Perceived at Different Ages, Initially and at Age 3

Image Source: Heckma

ROBERT WOOD JOHNSON FOUNDATION AGREES



Losing Ground in Health:

- "Americans like to think that we are healthier than people who live in other countries. That is a myth".
- In 1980 the US was ranked 15th among affluent countries in Life Expectancy (LE), by 2009 we have slipped to 27th.
- "To become healthier and reduce the growth of public and private spending on medical care, we must cerate a seismic shift in how we approach health and the actions we take. As a country, we need to expand our focus to address how to stay healthy in the first place."

RWJ Executive Summary Published Jan 2

Robert Wood Johnson Foundation

- Nationally one in three children is overweight or obese
- Three in four Americans ages 17-24 are ineligible to serve in the U.S. military, primarily because they are inadequately educated, have criminal records, or are physically unfit.
- More than one fifth of all Americans live in unhealthy neighborhoods that are marked by limited job opportunities, low-quality housing, pollution, limited access to healthy food, and few opportunities for physical activity.
- By 2043, the majority of U.S. residents will be people of color, who are disproportionately low-income and living in disadvantaged communities

RWJ Executive Summary Published Jan 2014

RWJ Recommendation 1:

1

Make investing in America's youngest children a high priority. This will require a significant shift in spending priorities and major new initiatives to ensure that families and communities build a strong foundation in the early years for a lifetime of good health.

- Create stronger quality standards for early childhood development programs, link funding to program quality, and guarantee access by funding enrollment for all low-income children under age 5 in programs meeting these standards by 2025.
- Help parents who struggle to provide healthy, nurturing experiences for their children.
- Invest in research and innovation. Evaluation research will ensure that all early childhood programs are based on the best available evidence. Innovation will catalyze the design and testing of new intervention strategies to achieve substantially greater impacts than current best practices.

RWJ Recommendation 2:

2 **Fundamentally change how we revitalize neighborhoods, fully integrating health into community development.**

- Support and speed the integration of finance, health, and community development to revitalize neighborhoods and improve health.
- Establish incentives and performance measures to spur collaborative approaches to building healthy communities.
- Replicate promising, integrated models for creating more resilient, healthier communities. Invest in innovation.

RWJ Recommendation 3:

3

The nation must take a much more health-focused approach to health care financing and delivery. Broaden the mindset, mission, and incentives for health professionals and health care institutions beyond treating illness to helping people lead healthy lives.

- Adopt new health "vital signs" to assess nonmedical indicators for health.
- Create incentives tied to reimbursement for health professionals and health care institutions to address nonmedical factors that affect health.
- Incorporate nonmedical health measures into community health needs assessments.

Recommendations

Efforts to improve health have often focused on changing how health care is delivered or reimbursed. But changes to health care alone will not lead to better health for most Americans. As a Commission, we have learned that there is far more to health than health care. Other factors such as education, income, job opportunities, communities, and environment are vitally important and have a bigger impact on the health of our population. We must address what influences health in the first place.

To improve the health of all Americans we must:

- **Invest in the foundations of lifelong physical and mental well-being in our youngest children;**
- **Create communities that foster health-promoting behaviors; and**
- **Broaden health care to promote health outside of the medical system.**

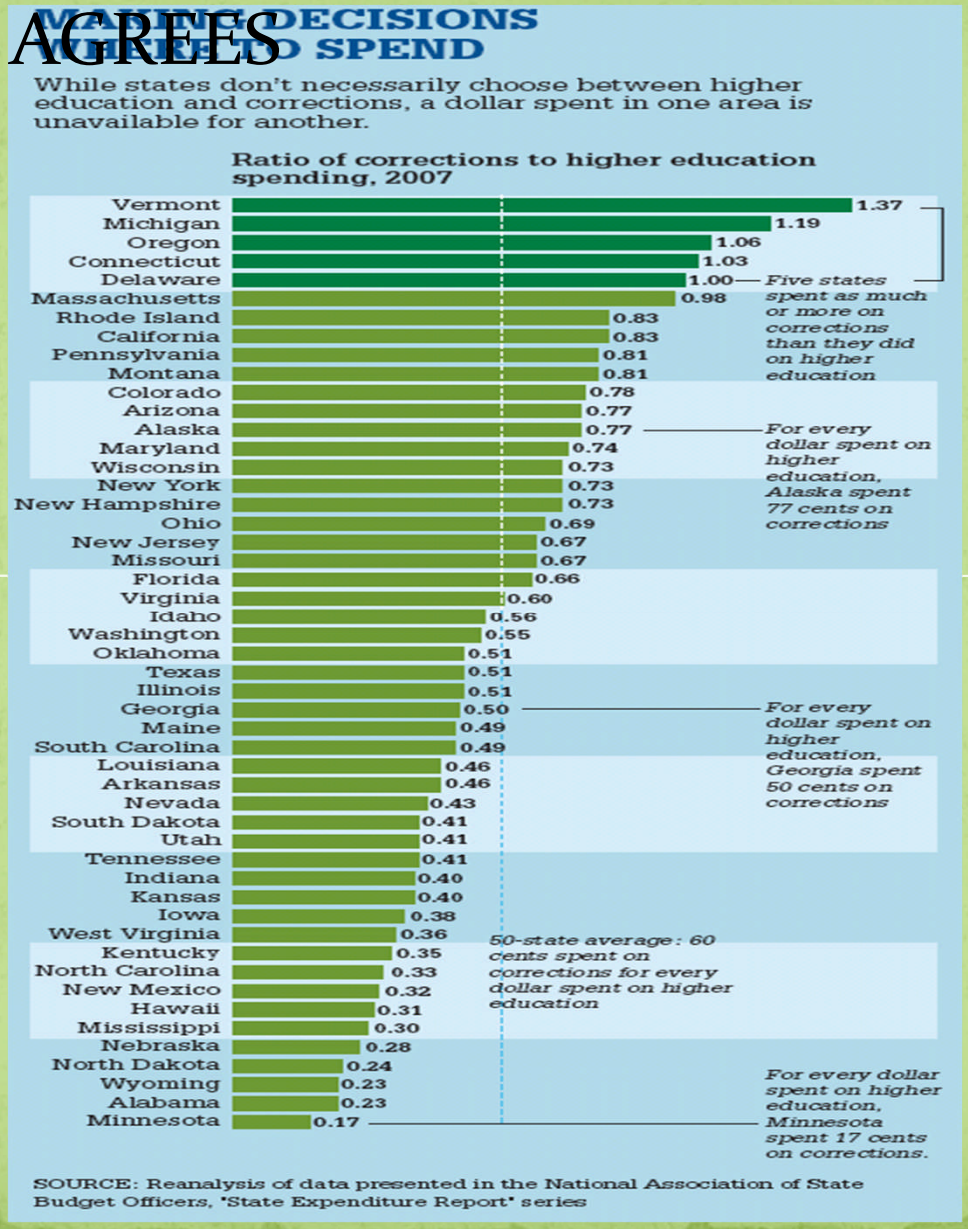
HARVARD AGREES

- Growing evidence of the extent to which toxic stress can disrupt developing brain circuits, other maturing organs, and metabolic regulatory systems underscores the need for new interventions focused on reducing or mitigating the consequences of significant adversity.

- "The time is long overdue for the scientific community to clarify the evidence base for early childhood investment. Generic statements about program impacts that do not link specific interventions to specific outcomes have limited meaning. Effects on parent behavior are not the same as impacts on children, and changes in child behavior are not proxies for academic achievement. Significant progress will require the disciplined development of enhanced theories of change that are grounded in science and drive the design of explicit strategies focused on specific causal mechanisms to produce breakthrough gains on important outcomes."

Source: Shonkoff
Changing the Narrative for Early Childh

THE RAND CORPERATION AGREES



Research Facts on Behavioral Health and Juvenile Corrections

- Prison population has tripled from 1987 to 2007 in the U.S.
  - 2.3 million total, or 1 in every 99.1 adults
- US prisons hold more people with mental illness than do psychiatric hospitals and 4x greater than general population.
- Mental health problems affect 1:5 young people at any given time
- An estimated 66% of all young people with mental health problems are not getting the help they need
- Educational disparities caused by mental illness persist through life

Does it work?

How do you pay for it?

Cost Comparison- Juvenile Justice & Incarceration

- **Cost of Juvenile Justice**
  - 2007-2008 in the State of California
    - $216,081 per person per year for youth and young adults incarcerated by the Department of Juvenile Justice
    - $12,804 for each person under DJJ parole supervision
- **Cost of Incarceration**
  - Average per prisoner operating cost was $23,876 in 2005(feed, clothe, house & supervise)
  - Some reports indicate the total cost to be around $150,000 per inmate per year when all cost factors are considered

Summary:

- The current intervention focused approach of health care is not working in our country.
- Well respected think tanks around the world have identified the need to move towards health promotion and prevention using an early childhood, family focused approach.
- Potential areas for benefits include changes (reductions) in health care costs, reductions in incarcerations, improved school performance and community health.
- We have a model to do this work in Vermont.
- Focusing on ACES prevention is an ideal model to do this work.

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VERMONT Blueprint for Health

Smart choices. Powerful tools.

"program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management."

-Advanced primary care practices that are recognized as **patient centered medical homes (PCMHs)** by the National Committee for Quality Assurance (NCQA)

-Multi-disciplinary core **Community Health Teams (CHT)** and additional specialized care coordinators, which support PCMHs and provide the general and target population access to multi-disciplinary health services

-Evidence-based self-management programs to help citizens adopt healthier lifestyles and engage in preventive health services

-Multi-insurer payment reforms that fund PCMH transformation and community health teams

-Implementation of health information technology (HIT)to support health information exchange, guideline-based care, population management, and comparative evaluation

-Multi-faceted evaluation system to determine the impacts of health care reform initiatives

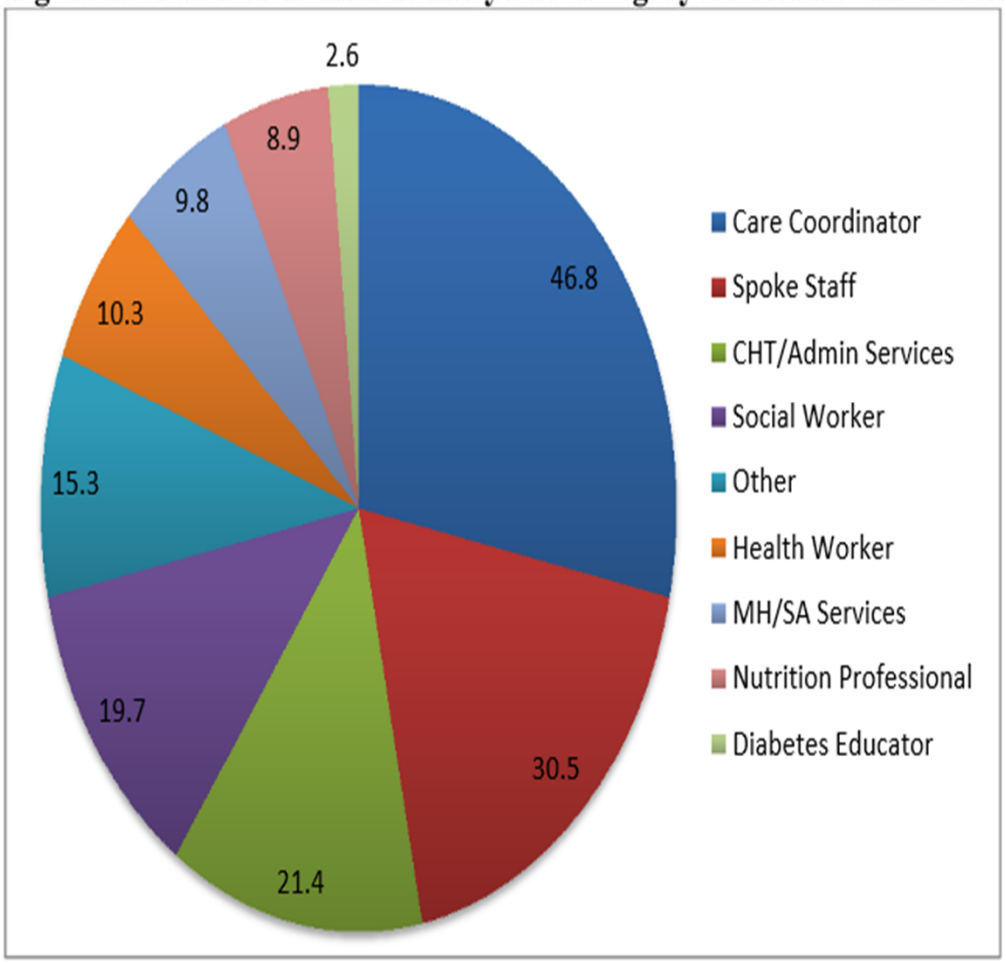
-A Learning Health System that helps practices and community health teams plan and implement PCMH operations, and supports ongoing quality improvement and innovation

Source: VT Blue Print for Health Annu

VERMONT Blueprint for Health

Smart choices. Powerful tools.

Figure 19. Number of CHT Staff by Job Category Statewide – All funding Sources



Source: VT Blue Print for Health

"Community Health Teams (CHTs) are perhaps the most important innovation in the Vermont Blueprint. Recognizing that efficient and effective coordination of services has not been readily available to the general population or well integrated across primary care and human services, the CHT staff act as

promotion and prevention at the Child and Family level.

- If we truly want to effect broad health care reform in Vermont we must embrace health promotion and prevention (including ACES) with a focus on children and families.
- The Blueprint needs to be more child and family focused.
- We have had early discussions with CHT (PJ) about training Blueprint Team Members (Care Coordinators, Nursing Teams and others) as Family Wellness Coaches engaged in family based health promotion, ACES and illness prevention, and integrated intervention.
- In the ACO era family based assessment, health promotion and prevention can be achieved and lead directly to reductions in health care costs.
- We can achieve these results by reducing obesity, emotional behavioral problems, hypertension, substance abuse, diabetes and criminal behavior.
- Each of these is preventable if the focus is the child and family. Once a person is affected by these illnesses they are expensive and difficult to treat.

We are proposing to the Blueprint to embrace the VFBA

- We appreciate the attention H.572 is drawing to health promotion and prevention with a child family focus.
- We have designed and developed an intervention, The Vermont Family Based Approach (VFBA) that takes a health promotion, ACES and illness prevention, integrated intervention approach. We have discussed this with Blueprint and CHT leadership.
- The VFBA (discussed later) employs an evidenced based integrated health care team of Family Wellness Coaches and Focused Family Coaches to build health, prevent and treat illness behaviors.
- Each of these can easily fit into the Blueprint models.

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H.762

Introduced by Dr. Till et al.

- § 1901g. ADVERSE CHILDHOOD EXPERIENCE QUESTIONNAIRE

Reimbursement for primary care provided to a Medicaid patient shall be

contingent upon the provider's use of the Adverse Childhood Experience

Questionnaire for the purpose of assessing the patient's health risks. As used in this section, "primary care" means health services provided by health care professionals to identify and treat asymptomatic individuals who have risk factors or preclinical disease, but in whom the disease is not clinically apparent, including immunizations and screening, counseling, treatment, and medication determined by scientific evidence to be effective in preventing or detecting a condition.

ACES and the Primary Care Community

THE EFFECTS OF CHILDHOOD STRESS ON HEALTH ACROSS THE LIFESPAN

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science Into Lifelong Health

Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics, Andrew S. Garner, Jack P. Shonkoff, Benjamin S. Siegel, Mary I. Dobbins, Marian F. Earls, Andrew S. Garner, Laura McGuinn, John Pascoe and David L. Wood

Pediatrics 2012;129;e224, originally published online December 26, 2011;
DOI: 10.1542/peds.2011-2662

Comments on Timing and Execution of H.762

- We applaud the authors of this bill for bringing attention to the importance of family based health promotion and ACES prevention.
- The ACES was a survey and many key questions were not asked (abuse and neglect).
- Special training and significant time is needed to carefully assess for ACES in children and families.
- Patient Centered Medical Home Care Coordinators (such as the Family Wellness Coaches described below) who work with the entire family may be better placed to do assessment for ACES in the context of health promotion and prevention.
- Although I agree that the primary care setting is the ideal place to achieve these goals, perhaps a period of study of the proper implementation of ACES assessment and prevention should precede implementation of H.762.
- Primary care teams will need training on the assessment and implementation of intervention strategies (there are other complicating factors).

Outline:

1. The ACES Study in Vermont
2. How Adversity affects health care outcomes
3. How the Blueprint, VT can use this information to improve the health of all Vermonters and change the economic landscape of Health Care.
4. The Bill
5. **The Vermont Family Based Approach as 'one' rationale model of health promotion and ACES prevention.**
6. Proposal

The Vermont Family Based Approach

Definition:

A paradigm for promoting health and wellness, prevention and treatment of health related problems that applies evidence-based strategies from the family perspective.

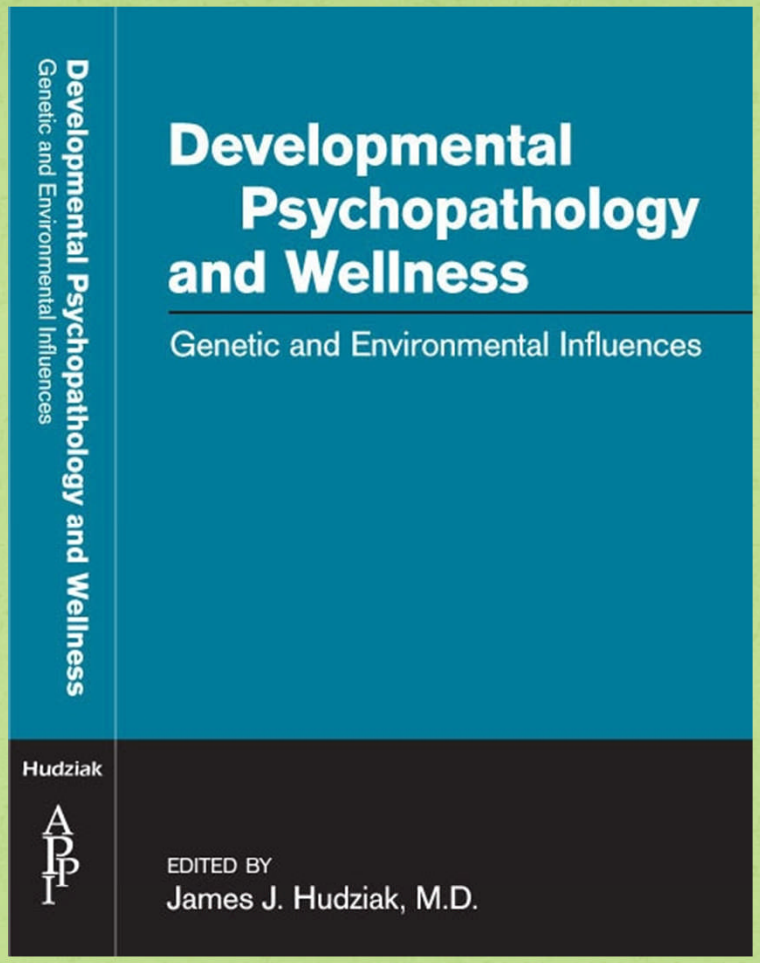
Goal:

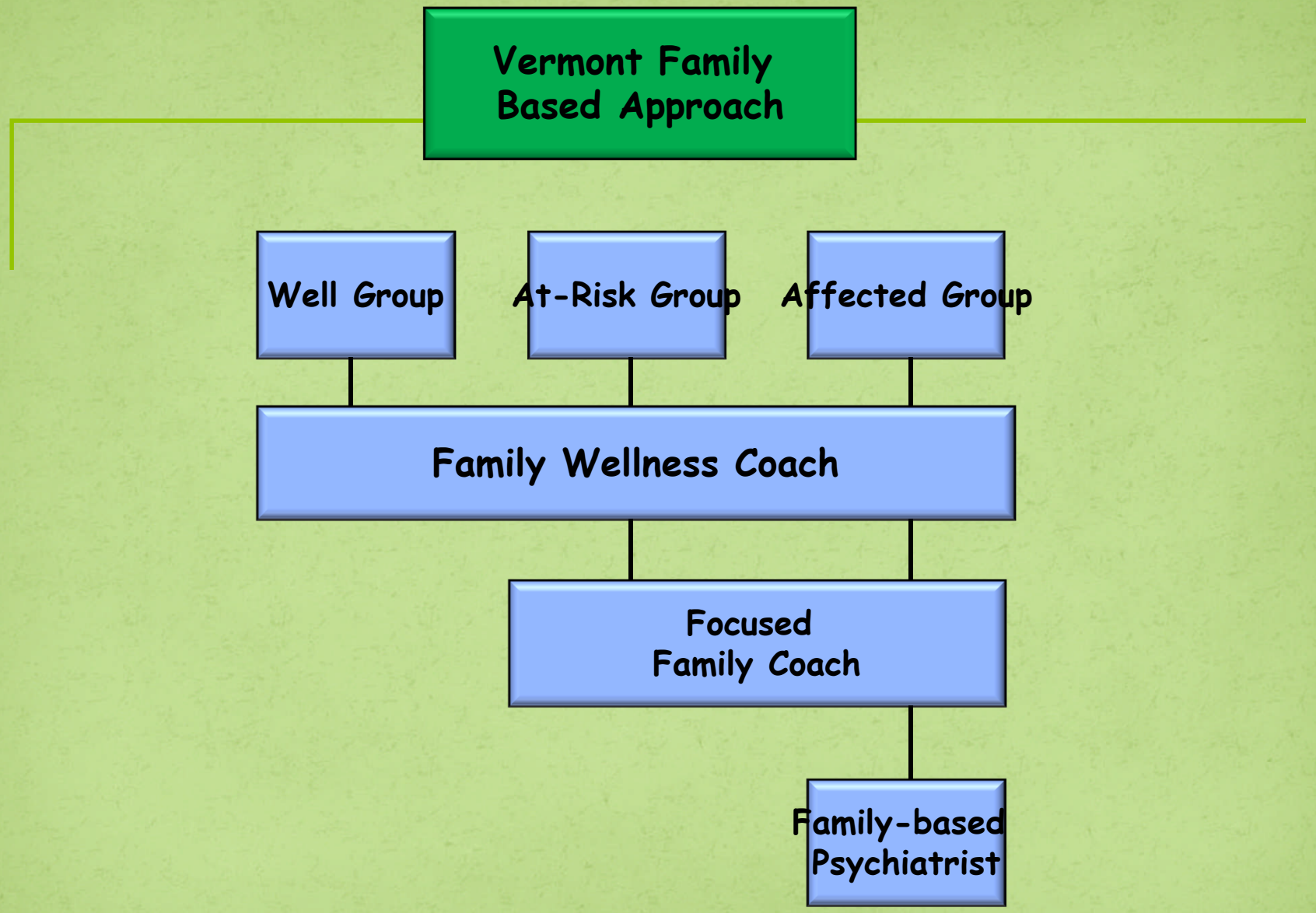
To keep the well well, protect those at risk from developing medical problems, and effectively treat those who are suffering from such problems.

Method:

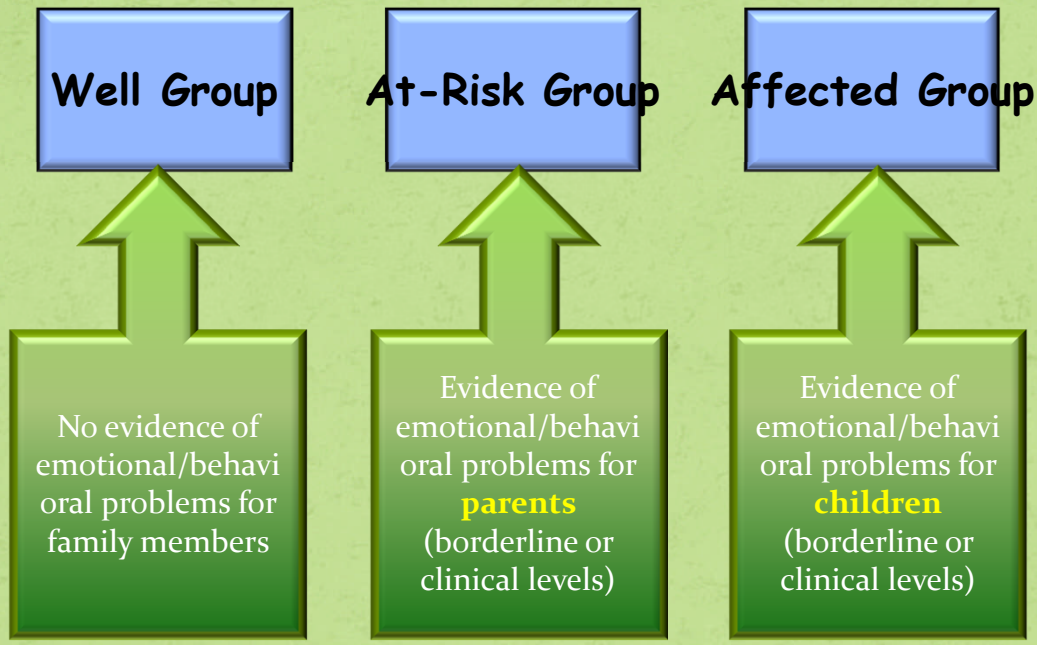
Through the deployment of an integrated health care team, emphasizing the importance of a patient centered medical home, use careful screening to tailor health promotion, prevention and intervention using the family perspective.

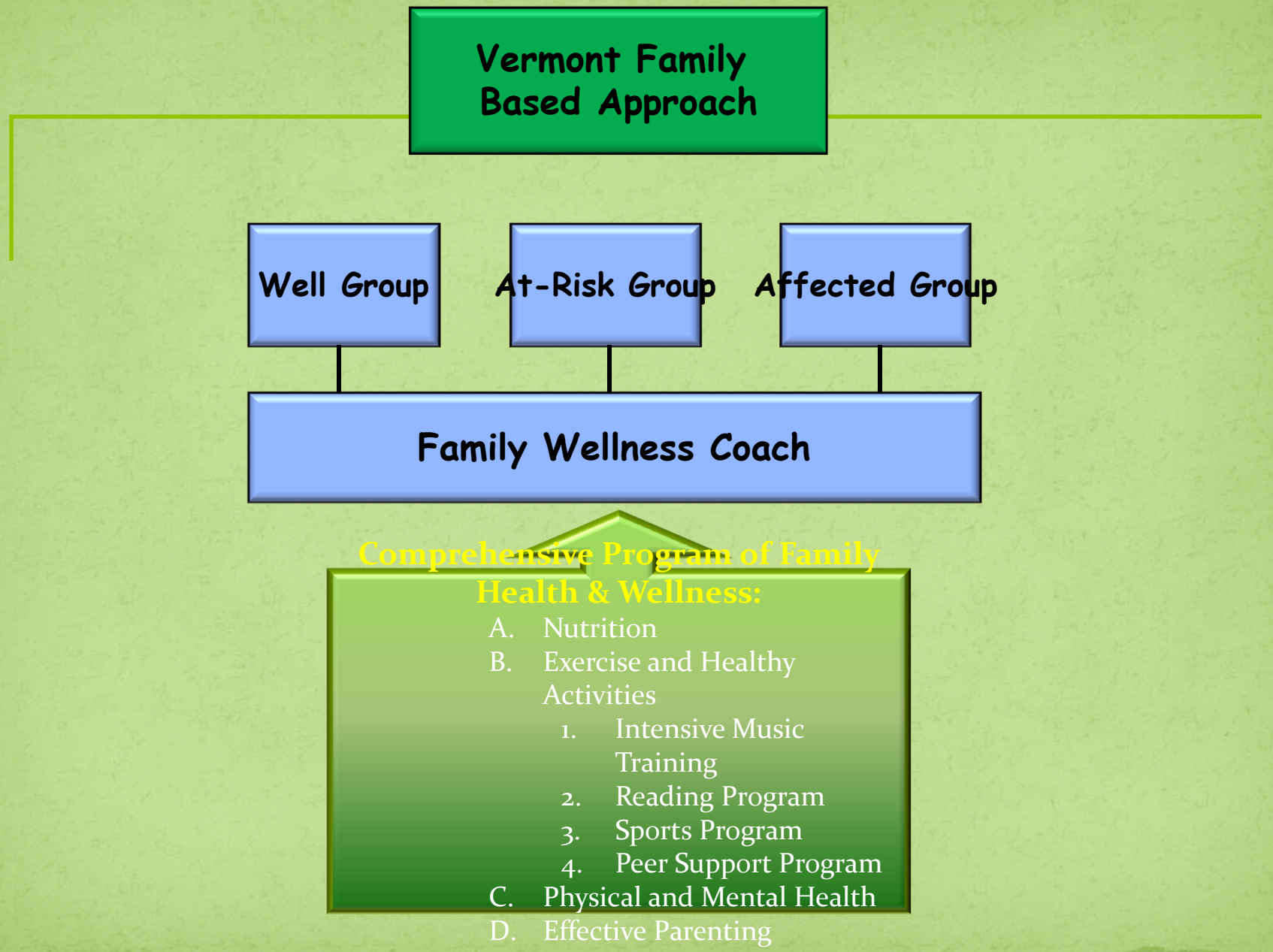
Vermont Center for Children Youth & Families
Vermont Family Based Approach

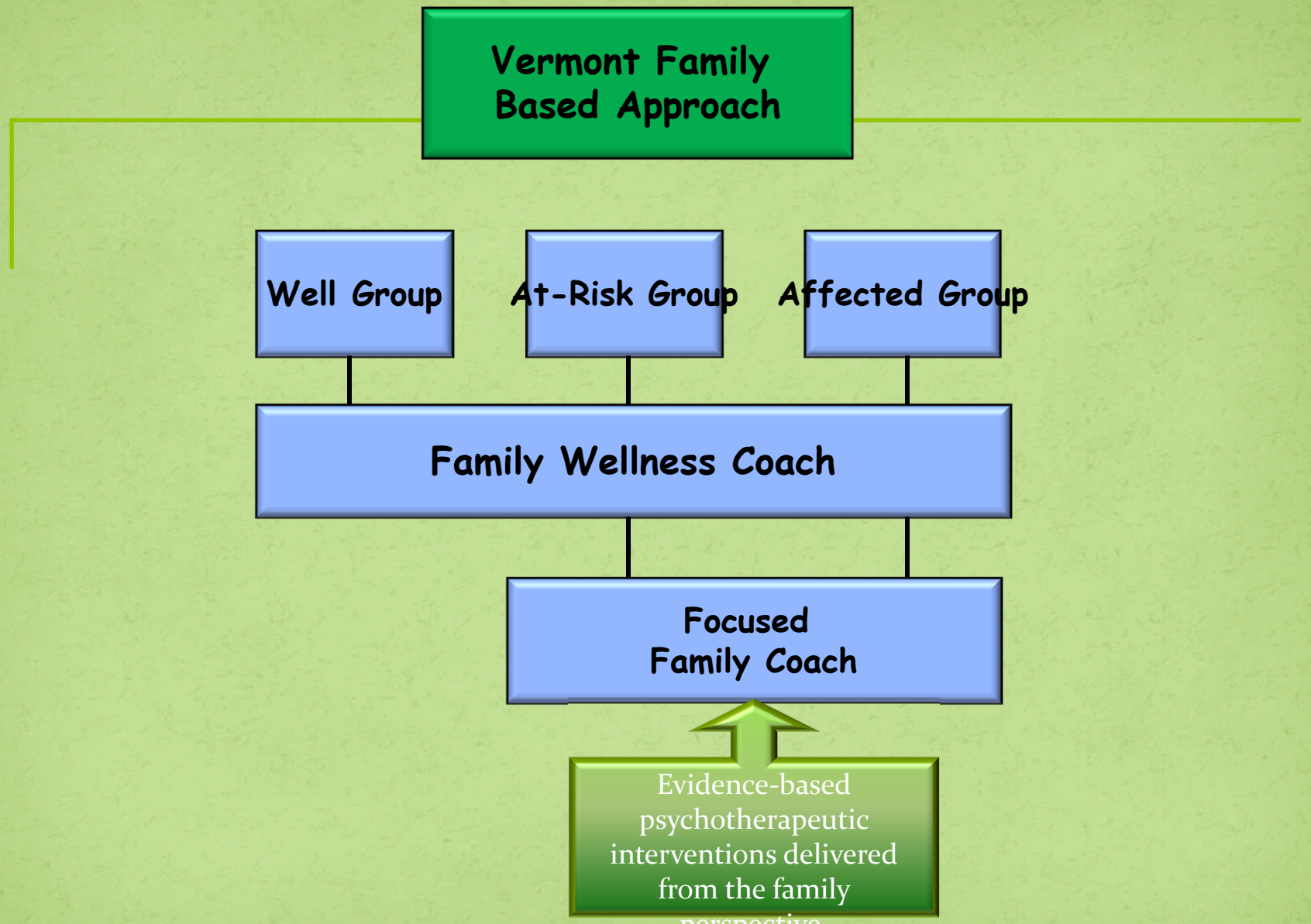


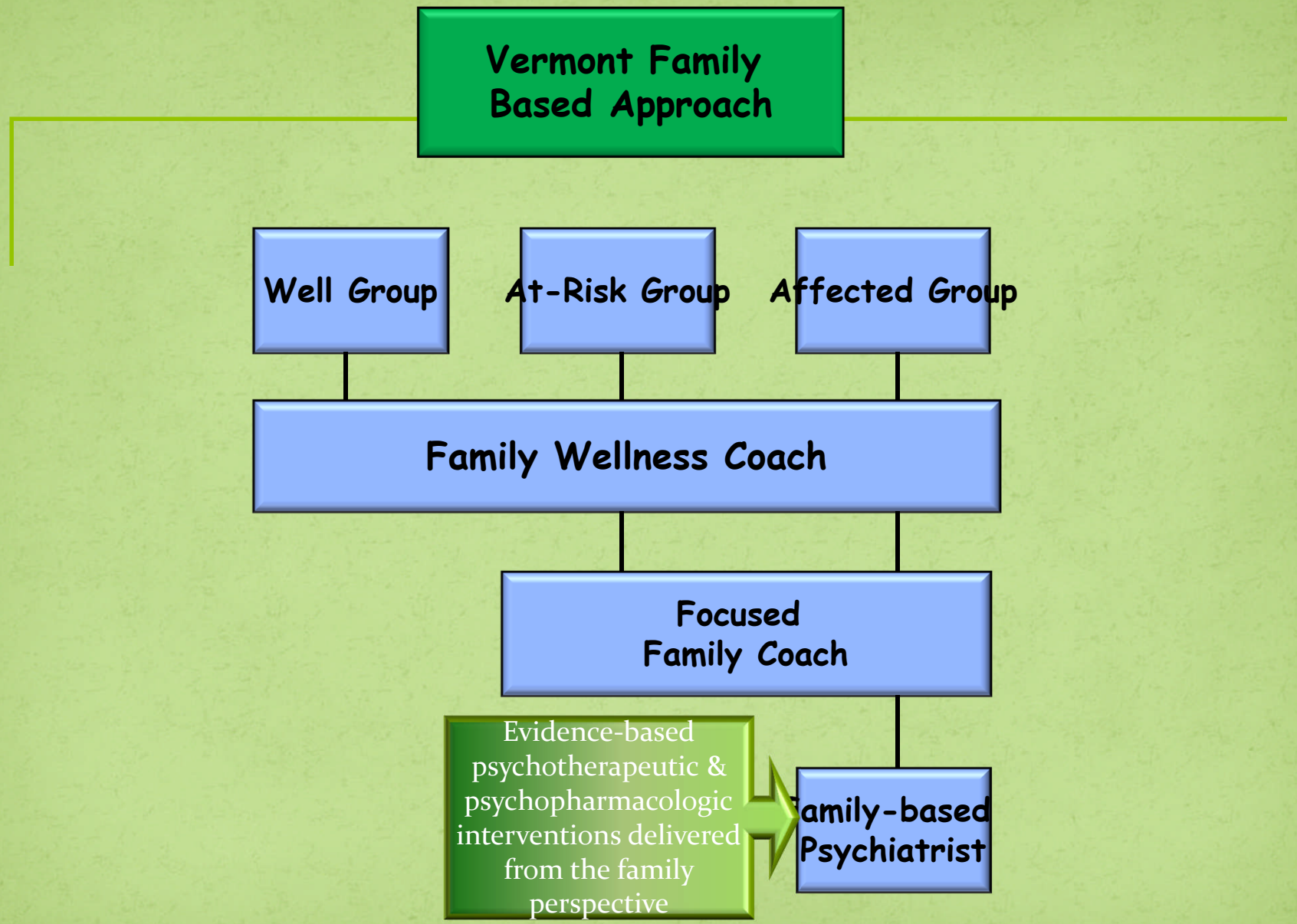

Vermont Family Based Approach
Well Group
At-Risk Group
Affected Group
Family Wellness Coach
Focused Family Coach
Family-based Psychiatrist

Vermont Family Based Approach




Vermont Family Based Approach
Well Group
At-Risk Group
Affected Group
Family Wellness Coach
Comprehensive Program of Family Health & Wellness:
A. Nutrition
B. Exercise and Healthy Activities
1. Intensive Music Training
2. Reading Program
3. Sports Program
4. Peer Support Program
C. Physical and Mental Health
D. Effective Parenting

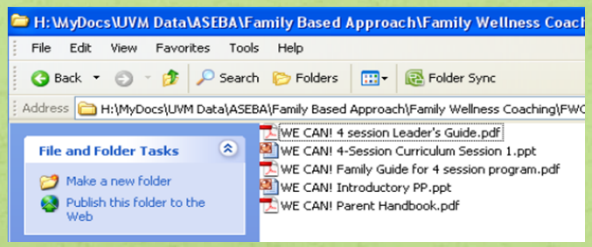

Vermont Family Based Approach
Well Group
At-Risk Group
Affected Group
Family Wellness Coach
Focused Family Coach
Evidence-based psychotherapeutic interventions delivered from the family perspective.


Vermont Family Based Approach
Well Group
At-Risk Group
Affected Group
Family Wellness Coach
Focused Family Coach
Evidence-based psychotherapeutic & psychopharmacologic interventions delivered from the family perspective
Family-based Psychiatrist

Family Wellness Coaching Training

1. The VFBA model
2. Family Based Assessment
   - The Achenbach System of Empirically Based Assessment (ASEBA)
   - Vermont Health and Behavior Questionnaire
   - Personal Wellness Profile
3. Motivational Aspects of Behavior Change
   - Motivational Interviewing
   - Health and Wellness Coaching
4. Healthy Family Nutrition and Activities
   - NIMH *WE CAN!* Program
   - Community Resources
5. Supporting Healthy Parenting (across the developmental spectrum)


You and Your Adolescent
Steinberg
Levine
PARENTS and ADOLESCENTS Living Together PART 1
PARENTS and ADOLESCENTS Living Together PART 2
PARENTING the strong-willed child
SOS HELP FOR PARENTS
LYNN CLARK, Ph.D.
Rosengren
BUILDING MOTIVATIONAL INTERVIEWING SKILLS
MAYO CLINIC COMPLETE BOOK OF PREGNANCY & BABY'S FIRST YEAR
MORROW
Vermont Center for
Children Youth & Families
Vermont Family Based Approach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Back Search Folders Folder Sync
Address H:\MyDocs\UVM Data\ASEBA\Family Based Approach\Family Wellness Coaching\FWC
File and Folder Tasks
Make a new folder
Publish this folder to the Web
WE CAN! 4 session Leader's Guide.pdf
WE CAN! 4-Session Curriculum Session 1.ppt
WE CAN! Family Guide for 4 session program.pdf
WE CAN! Introductory PP.ppt
WE CAN! Parent Handbook.pdf

Family Wellness Coaching Toolkit

(Draft date: 03-16-2010)

Domain	Tools
I. Family-based assessment	**I.** Information about the *Achenbach System of Empirically Based Assessment* (ASEBA) can be found at: www.aseba.org **II.** A copy of the *Vermont Health Behavior Questionnaire* (VHBQ) can be obtained at: http://www.med.uvm.edu/vccyf/
II. Motivational aspects of behavior change	**I. Motivational Interviewing (MI)** **MI** - a psychotherapeutic method for enhancing motivation for change by exploring and resolving ambivalence. Based on the Prochaska and DiClimente's *Stages of Change* theory.
	The official MI website: http://motivationalinterview.org/index.shtml

We Can! Is…

A national education program designed to help youth aged 8–13 stay at a healthy weight by providing strategies and tools to parents and caregivers at home and in community settings.

- Overweight & obesity prevention program
- Turn-key, science-based program for the entire community
- Improve food choices, increase physical activity, reduce screen time

We Can! Program Elements

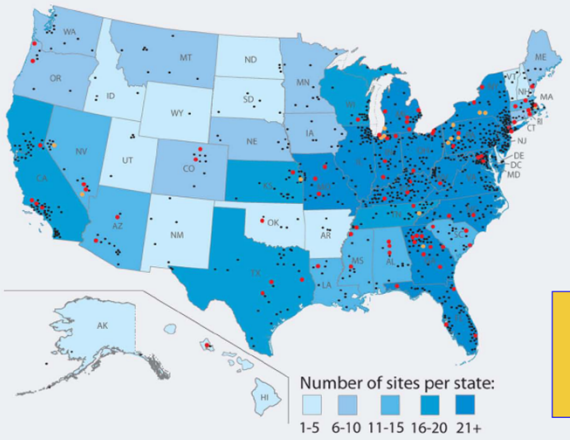
NIH Science

NIH science-based knowledge:
NHLBI
NICHD
NIDDK
NCI

- Community-based Programming
- Partner Outreach
- Media Messages

…to help children and families maintain a healthy weight.

A Growing Movement



- ***We Can!*** community sites are in all 50 states
- Organizations in several other countries also implement ***We Can!***

JOIN THE MOVEMENT TODAY!
http://wecan.nhlbi.nih.gov
1-866-35-WECAN
nhlbiinfo@nhlbi.nih.gov

Goals of the Parent Program

5 Behavioral Goals:

- Increase the availability of healthy foods in the home
- Limit the availability of sweetened beverages and high-fat, high-density/low-nutrient foods in the home
- Eat small portions at home and in restaurants
- Support and enable family physical activity
- Support and enable reduced screen time

Applying the VFBA in VT

- Evidence-based treatment and family-based intervention are underway in the Mary Hogan school in Addison County, VT.

- Vermont Program for Evidenced in Practice (VPEP)
  - Training rural mental health professionals in evidence-based parent training
  - Currently, implementing with 40 therapists in Washington County and Rutland County

Outline:

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5. The VFBA as 'one' rationale model of health promotion and ACES prevention.
6. **Proposal**

Conclusions:

- Perhaps H.572 can be seen as a starting point to build a truly integrated health care reform model for Vermont by drawing attention to the importance of focusing on the child and family.
- Blueprint needs to be more children and family focused and needs to work more closely with IFS (intensive family services).
- Medical Homes need mid level providers (such as the Family Wellness Coaches of the VFBA) to help families promote health and prevent illness, address ACES prevention and improve outcomes.
- Propose that blueprint could test and use the Vermont Family-Based Approach (VFBA) as a model to screen for and reduce the sequellae of ACES by building in Intervention teams in the Medical Home.
- Partner closely with Philanthropic Organizations in VT (Permanent Fund, Turrell Fund, Vermont Children's Trust, etc).
- Partner closely with all the Vermont Stakeholders who support children and families.

Conclusions (final):

- Help families facing adversity early by screening (ACES), treating, educating, and supporting all members of the family (IFS).
- Use wellness approaches, sports, music training, nutrition, job skill training, medication, tai chi
- Invest in early child education and health promotion at all stages of development.
- The Vermont Family Based Approach offers one way to achieve these goals.


Thank you.

Taking the VFBA to the REAL World:

- Careful (family based) Screening.
- Tailored Health Promotion
- Tailored Prevention
- Tailored Intervention (that incorporates Promotion and Prevention).

South Dakota School Based Application of the VFBA

- Avera Health VFBA Application in association with the Sioux Falls School District.
- We are in our 4th year of this school based program with over 470 families.
- Health Promotion
  - In school violin, tai chi, sports
  - Nutrition, Music, Parent training
- Prevention
  - Evidenced Based treatment of parents and children
- Family Based Intervention
  - Of Parents and Children

Health Services

- Keeping in mind that although Parent Training is probably the most effective treatment in all of child psychiatry, very few parents ever are trained.
- Less than 2% of children ever see a child psychiatrist.
- ***Could we, in a school based setting, engage families in parent training, treatment, and acceptance?***

Avera Family Wellness Program 2012 Update

Behavioral Health Services

AFWP	2008-2009	2009-2010	2010-2011	2011-2012
Family Wellness Coaches	469/45 10/Family	1663/118 14/Family	2266/150 15/Family	1599/159 10/Family
Individual Outpatient Therapy	61	187	243	178
Family Outpatient Therapy	18	72	95	33
Child Therapy	98	315	206	79
Psychiatry Visits	76	318	388	262

Avera Family Wellness Program 2012 Update

Behavioral Health Services, Cont.

AFWP	2008-2009	2009-2010	2010-2011	2011-2012
Nurse Practitioner Visits	13	61	83	53
Partial Hospital	3	7	11	5
Inpatient Hospital	6	6	11	7
Chemical Dep	0	0	13	14
Total Contacts	744 17/Family	2,629 22/Family	3,316 22/Family	2,225 14/Family (5 months left)

Avera Family Wellness Program 2012 Update

Community Service Referrals

AFWP	Community Service Referrals
Children's Care (Evaluation and treatment for specialty issues)	38
Fetal Alcohol Syndrome Evaluation	6
State-wide Family Support (State Program for children with disabilities/special needs)	42
Respite Care	18
Neurology Specialty Physician	8
Other Specialty Physician Referral	57
Children's Home Society (safety)	2