Health Resources and Services Administration
Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

Spring Meeting
Bend, Oregon
April 26th-28th

Meeting Summary

The 92nd meeting of the National Advisory Committee on Rural Health and Human Services (NACRHHS) was held April 26-28 in Bend, Oregon. The meeting topic was the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Rural Considerations.

The committee members in attendance: Jeff Colyer, Committee Chair; April Anzaldua; Kari Bruffett; Isabel Garcia-Vargas; Meggan Grant-Nierman, DO, MBA; Clifford Hunter; George Mark Holmes, PhD; Cara V. James, PhD; Michelle A. Mills; Brian Myers; Kellie Phillips-Asay, MSN, RN; Patricia Schou; James Werth, Jr., PhD, ABPP; and Loretta Wilson.

Present from the Department of Health and Human Services: Tom Morris, Executive Secretary; Office of Rural Health Policy; Sahira Rafiullah, Senior Advisor, Office of Rural Health Policy; Jocelyn Richgels, Director National Policy Programs, Rural Policy Research Institute.

Ex-Officio Members: Humberto Carvalho, Public Health Advisor – Project Officer, Substance Abuse and Mental Health Services Administration; Percy Devine III, MSW, Region 8, Regional Administrator, Administration for Community Living; Darci Graves, MPP, MA, Special Assistant to the Director, Office of Minority Health, Centers for Medicare & Medicaid Services; Diane Hall, PhD, MSED, Senior Scientist for Policy and Strategy, Office of the Associate Director for Policy, Centers for Disease Control and Prevention; Kellie Kubena, USDA Rural Health Liaison, Innovation Center, Rural Development; Aleta Meyer, Senior Social Science Research Analyst; Office of Research and Evaluation, Administration for Children and Families.

Wednesday, April 26, 2023

Governor Jeff Colyer, Chair of the Committee, convened the meeting.

WELCOME AND INTRODUCTIONS

Jeff Colyer, MD
Committee Chair

Jeff Colyer opened the meeting by thanking the National Advisory Committee for their service and the Federal Office of Rural Health Policy staff for their hard work. He stated that the focus of the meeting was the Maternal, Infant, and Early Childhood Home Visiting (MIECHV)

Program and delivery of home visiting services. He noted that following the meeting, staff will collaborate with the committee members on a policy brief to present to the Secretary of Health and Human Services.

WELCOME TO OREGON

Robert Duehmig
Director, Oregon Office of Rural Health

Robert Duehmig thanked the committee for visiting Bend, Oregon. On February 14, 1859, Oregon officially became the 33rd State in the Union. The name Oregon came from the French-Canadian word "ouragan," which means windstorm or hurricane, associated with the Chinook winds that form in the area where the Columbia River meets the ocean.

Mr. Duehmig shared that Oregon's diverse landscape includes the Malheur Wildlife Refuge is home to the largest freshwater marsh in the United States. The John Day Fossil Beds National Monument in Wheeler and Grant counties. The rock formation preserves over 40 million years of plant and animal evolution. Oregon also has one of the largest concentrations of bald eagles located in the Klamath Basin. Hells Canyon in Northeastern Oregon is 7,913 feet deep and the deepest river gorge in the United States. The pear is the Oregon state fruit, and the hazelnut is the official nut. Oregon produces ninety-nine percent of the hazelnuts grown in the United States.

Oregon is the ninth largest State in the Union covering 98,380 square miles. The federal government owns fifty-three percent of Oregon, so that limits local communities' ability to make decisions related to economic development and it affects services in those areas.

Mr. Duehmig shared that the Oregon Office of Rural Health (ORH) is one of the 13 university based rural health systems in the United States. The office is based in Portland but there are staff located throughout the state. The Oregon ORHs 40th Annual Health Conference is in the fall and there will also be a forum on aging for rural stakeholders to discuss best practices and ways to support elderly people in rural communities.

The Oregon ORH grant programs include Elder Service Innovation Grant, population health grants, and the Helping EMS in Rural Oregon (HERO)Training Grants that assist rural and frontier EMS volunteers pay for training. The Community Health Worker (CHW) Pilot Program incorporates training with both a public health focus and clinical focus so the CHWs are cross trained. There is technical assistance available to Critical Access Hospitals (CAHs) and Rural Health Clinics (RHCs) as well as telehealth through ORH and the Oregon Broadband Advisory Committee (OBAC). ORH also has a full-time recruiter supporting rural facilities, practicing providers, and student provider incentive programs.

Oregon's definition of rural is any geographic area ten or more miles from the centroid of a population center of 40,000 people or more. This definition helps manage the varied sizes of the communities throughout the State of Oregon.

More than half of rural hospitals in Oregon are healthcare system-owned hospitals versus independently owned. There are approximately 114 rural health clinics in the state and CAH own around 50% of the clinics. There are 11 tribal clinics throughout the state.

Oregon Coordinated Care Organizations (CCOs) are a network health care providers that includes physical health care, addiction and mental health care, and dental care, who work together in their local communities to serve people who receive healthcare coverage under the Medicaid Oregon Health Plan. CCOs focus on prevention and helping people manage chronic conditions, like diabetes. This helps reduce unnecessary emergency room visits and supports preventative care. One CCO has purchased three hotels and turned them into housing for the homeless. CCOs focus on social determinants of health which increases the overall health and wellbeing of the community.

The Oregon Health Authority (OHA) focuses on the overall health of Oregonians. The mission of the ORH is to improve the quality, availability, and accessibility of health care for rural Oregonians. The Oregon ORHs vision statement is to serve as a state leader in providing resources, developing innovative strategies, and cultivating collaborative partnerships to support Oregon rural communities in achieving optimal health and well-being.

FEDERAL PERSPECTIVES ON MIECHV

Michael Warren, MD
Associate Administrator, Maternal and Child Health Bureau
Health Resources and Services Administration

Michael Warren thanked the committee for the invitation to speak and for advising the work performed at Heath Resources and Services Administration (HRSA). He also thanked his colleagues from the Maternal and Child Health Bureau (MCHB) for speaking to the committee. The MIECHV program is administered by the MCHB in partnership with agencies across the Departments of Health and Human Services (DHHS).

Dr. Warren shared that the committee's work is especially meaningful to him because he grew up in rural Eastern North Carolina. He is reminded about the challenges in his hometown when he returns to visit his family and there is no broadband and his parents just recently connected to the county water system. Dr. Warren is a pediatrician by training and worked in public health in Tennessee during the initial years of the MIECHV program when community agencies were struggling to get resources because there were a limited number of models. It was challenging to measure the program work and coordinate services at the state level.

MIECHV was established in 2010 as part of the Affordable Care Act. ACF administers the tribal portion of MIECHV. The goals of MIECHV are to improve maternal and child health, prevent child abuse and neglect, and improve child development and school readiness. The MIECHV program outcomes are improved when families with children relate to a social worker, nurse, or community health worker. MIECHV serves 140,000 parents and children annually through 840,000 individual home visits. Of the counties served, about 60% are rural. There is flexibility in how states direct the MIECHV programs.

When Dr. Warren worked in Tennessee, there were already home visiting programs run by community-based organizations and the child welfare agency. States decided how to cover as many counties as possible with a limited number of resources. Medicaid did not fund home visiting but case management, so states found ways to leverage that through Temporary Assistance for Needy Families (TANF) funds, MCH Block Grant Funds, state funding, and funds related to the Families First program. How children's brains develop during early childhood and early exposures is vital to their success throughout life so early home visiting is important for healthy outcomes.

The MCHB is the only entity of the federal government that focused on the health and wellbeing of all of Americas mothers, children, and families when established in 1912 as the Children's Bureau. Child labor was not regulated and there was no child welfare system at that time. Social workers were the first Chiefs of the United States Children's Bureau which demonstrates the early recognition of the importance of social determinants of health. The first Chief of the Children's Bureau drafted a report on maternal mortality in 1916 that stated maternal mortality was on the rise in the United States and the United States fared worse than most other countries and most cases were preventable. This is still the case today so there must be changes so there is not the same conversation 107 years from now.

Dr. Warren shared that his first exposure to home visits was in eastern North Carolina as a third-year medical student. He conducted home visits with a PHN for part of his rotation and they visited a family who had returned home with their newborn. The family lived in a trailer that was very cold because there was a hole in the wall. The public health nurse (PHN) connected the family with a resource to fix the damaged trailer. Dr. Warren learned from that experience that clinical care is important, but it is vital for families to have other supportive services when they return home with a new baby. Population health outcome studies show that clinical care accounts for only 20% of overall health and wellbeing. A family's human service challenges are not resolved by a doctor in a fifteen-minute office visit, so community support is key to success.

Nurse home visits provide breastfeeding support, assess the child's development, and evaluate the new mother for post pardon depression. Prior to the birth of the baby, home visits include educating mothers about what is normal or what is a concern when returning home with their newborn. Medical assessments are important but also assessments for other types of needs, for example, connecting families with community assistance for heating their home and meeting other human service needs.

The MCHBs new strategic plan outlines goals around access, equity, capacity, and impact, which are all addressed by the MIECHV program. The Maternal and Child Block Grant Program goes to all 50 states and nine territories and is the most flexible funding, allowing states to design their own programs based on the needs of the mothers, children, and families.

MCHB uses the Accelerating Upstream Together framework to hasten the pace of change, continue to be innovative, and build evidence. Moving upstream refers to promoting prevention and a life course approach. Additionally, it is essential to work together in collaboration with partners and families receiving services.

Existing MIECHV awardees can apply for FY2023 funding which includes 435 million dollars in total available funding for base grants to support home visiting services. The applications are due June 28th. There are other upcoming funding opportunities through The Institute for Home Visiting Workforce Development and the Jackie Walorski Center for Evidence-Based Case Management to improve the recruitment and retention of a diverse and qualified maternal and child health home visiting workforce.

Nationally, 15 million people stand to lose Medicaid or Children's Health Insurance Program (CHIP) coverage. About half of those are still eligible but will need to reenroll so states will restart eligibility reviews to assist people with the reenrollment process. People who are not eligible for Medicare or CHIP can access HealthCare.gov to learn about other options.

Cynthia Phillips
Director – Division of Home Visiting and Early Childhood Systems
Maternal and Child Health Bureau
Health Resources and Services Administration

Cynthia Phillips said that MIECHV reauthorization was a yearlong process and originated on December 22, 2022, through the Jackie Walorski Home Visiting Reauthorization Act. It is a significant expansion to continue to deliver coordinated, comprehensive, high-quality, and voluntary early childhood home visiting services to eligible families. The funding for FY2023 is $500 million and up to $800 million in FY2027. Six percent of the funding is for tribal grants, and 2% for workforce support, retention, and case management.

The Institute for Home Visiting Workforce Development and the Jackie Walorski Center for Evidence-Based Case Management assesses the needs of the home visiting workforce. The MCHB will prepare supply and demand projections and work with states on workplace responsibilities and compensation. The MIECHV Technical Assistance Resource Center provides technical assistance to build capacity in the states and territories. The funding through The Home Visiting Innovation Awards will support the awardees with development and implementation focusing on workforce development. Iowa was able to use the innovation funding to establish an institute for support professionals who assisted with professional training.

The MIECHV program was in 1,017 counties in FY2023, and 60% of all counties served were rural. MIECHV awarded grants to fifty-six states, territories, and nonprofit organizations for voluntary, evidence-based home visiting services. Evidence-based home visiting models are based on continuous learning and performed across six statutory benchmark areas.

MIECHV Priority Populations Include:

- Low-income families, families with a history of child abuse or neglect
- Families with children with low student achievement
- Families in priority communities
- Families with a history of substance misuse
- Families with children who have developmental delays or disabilities.
- Pregnant women under the age of twenty-one

- Families with tobacco users in the home
- Families with individuals who are serving or have served in the armed forces.

Most state and jurisdiction MIECHV awardees can subcontract with Local Implementing Agencies (LIAs). The awardees must monitor LIAs to assure they are providing high-quality services, meeting the needs of eligible families, and are demonstrating performance improvement.

Kyle Peplinski
Branch Chief, Policy, Data, and Technical Assistance Coordination
Maternal and Child Health Bureau
Health Resources and Services Administration

Kyle Peplinski indicated that states are mandated to use MIECHV funds on evidence-based models or up to 25% of the funds on non-evidence-based models that qualify as a Promising Approach; a tiered evidenced-based standard of MIECHV that it is based on evidence but also building evidence through the program. ACF oversees the Home Visiting Evidence of Effectiveness Review that conducts an annual assessment of home visiting literature to determine new models that would meet the HHS criteria for evidence of effectiveness.

Currently, there are twenty-three evidence-based models that states and jurisdictions can choose from to implement as part of their MIECHV program. There are requirements for states who are implementing promising approaches to also conduct an evaluation of the approach with the goal of it becoming evidence-based in the future. States can choose a model and tailor it to fit the needs of their communities. MIECHV is based on evidence-based models through the learning agenda, a continuous program of research and evaluation to identify what is effective for home visiting.

Improving outcomes for families and young children through continuous quality improvement includes:

- Improving family recruitment and retention
- Understanding what works for whom and why
- Addressing specific family outcomes
- Improving measurements of processes and outcomes
- Understanding community context and systems
- Understanding program costs and cost benefit return on investment
- Understanding program implementation
- Improving home visiting staff recruitment, retention, and wellbeing

ACF published a brief on MIECHV and ways of continuous learning in rural communities. Key findings of the brief include:

- Home visiting programs address deeply personal topics and experiences with families, so MIECHV program staff need to build mutual trust within rural communities.
- Service providers should be aware and respectful of cultural differences and tailor services and programs more broadly to the cultural context of the community.

- MIECHV programs in rural areas may be critical for addressing social isolation of new mothers.
- Significant pandemic-related needs among families, particularly in the areas of mental health issues, substance use, job loss, and trauma
- Stronger connections to other early childhood programs may help address needs outside of home visiting.

The six benchmark areas identified in the MIECHV statute are:

- Improvement in maternal and child health
- Prevention of childhood injuries and child abuse and maltreatment, and reduction of emergency department visits
- Improvement in school readiness and achievement
- Reduction in crime and domestic violence
- Improvement in family economic self-sufficiency
- Improvement in the coordination of, and referrals to, other community resources and supports.

In FY2022, 79% of children enrolled in MIECHV had a family member who read to them, told stories and/or sang to them daily. Reading to a child is important for early language, literacy, and school readiness. Seventy percent of children received the most recent recommended well-child visit based on the American Academy of Pediatrics schedule, and 81% of caregivers had screening for depression.

Katherine Bark
Project Officer, MIECHV Program, Regions VII and VIII
Maternal and Child Health Bureau
Health Resources and Research Administration

Katherine Bark shared that prior to working for HRSA, she was the Program Manager for the Utah Office of Home Visiting and the Project Director for MIECHV in Utah, so she is familiar with challenges when implementing services in rural communities.

A primary challenge for rural communities is a lack of primary care providers, maternal child health providers, and human service providers. Home visitors have a problematic time connecting families with providers and services due to a long waiting list, transportation barriers, and lack of insurance coverage. Transportation is an issue for home health providers in rural areas because they must travel long distances, especially where home visiting programs cover multiple counties or large regions. There is a lack of technology and there are broadband issues in rural communities so many families do not have access to Wi-Fi, which is a barrier for virtual or hybrid services. Early childhood programs and rural home visiting programs are facing staffing shortages so vacancies can be difficult to fill and that has a significant impact. Families in rural communities are facing unemployment challenges that can lead to lack of funds for cell phone services and lack of ability to engage in home visiting services.

The home visiting workforce can have a positive effect on the community if the home visitor is local and understands the community they are serving. In the State of Minnesota, home visiting

programs are incentivizing pay ranges, competitive compensation, and professional development opportunities. States are also supporting increased home visitor pay and bonuses.

There are challenges with home visiting models, for example, the Nurse Family Partnership Model requires a nurse home visitor, whereas other models may only require a GED or high school diploma which broadens the workforce opportunities. A rural community in Nevada is experiencing family participants graduating from the Nurse Family Partnership Program are then going to college to become nurses. The new Institute for Home Visiting Workforce Development design is to support and increase the home visiting workforce.

Virtual home visits were crucial during the COVID-19 pandemic. The Jackie Walorski Maternal and Child Home Visiting Reauthorization has included an opportunity for states and jurisdictions to identify when virtual visits are relevant and appropriate due to public health emergencies or local issues. Funding flexibility during the COVID-19 pandemic allowed agencies to immediately address a variety of family needs that included providing gas cards, grocery cards, mobile hotspots, and laptop computers. The ability to provide 5G and broadband internet services in certain instances would allow for virtual and hybrid home visiting services to continue. There will be services expiring at the end of the COVID-19 Public Health Emergency, but there will be services that expand through the Maternal and Child Home Visiting Reauthorization.

Q&A

Matthew Probst asked if undocumented and migrant families have access to the MIECHV services.

Mr. Probst also commented that rural communities are cross-training CHWs, Emergency Medical Technicians (EMTs), sheriffs etc. It is a way to use one individual to cover more services and get a pay increase so they will remain in the community. This is something to consider since the workforce is a major issue.

Dr. Warren responded that in Tennessee MIECHV services are based on residency. He stated that he does not think there are restrictions for undocumented and migrant families, but states and local agencies make that decision.

Kari Bruffett asked if there are limitations in MIECHV regarding distributing supplies since supplies since the COVID-19 Public Health Emergency is ending.

Katherine Bark responded that there are services not accessible through MIECHV funding beyond that allowed during the COVID-19 Public Health Emergency. Home visiting programs do not provide basic needs for families because the programs are short-term, so parents get support through other agencies.

Cara James asked how MIECHV is evaluating who are participants of the program in rural communities and if there is aggregate data to provide information on rural communities.

Kyle Peplinski responded that participant demographics are confidential, so the MCHB knows what communities are in the program but not who in the communities are receiving services. There are additional evaluation projects researching enrollees and systemic differences between families who are entering the system versus the families who are not entering the system.

Dr. Warren added that states must show demonstrations of improvement in four of the six benchmarks, or their funding could potentially be at risk. A topic of consideration with MIECHV is how much to focus on service delivery versus primary data collection. There is restraint around the amount of data to collect because this can cause a trust issue with families.

Cara James said that if there are only15% of families eligible for MIECHV, it is excluding people. Program data is necessary to understand how to improve, especially with the MIECHV expansion because with a 5-million-dollar budget and 25% of families included, there are still families who are not getting services.

April Anzaldua said that during the COVID-19 pandemic, there were additional resources that allowed more services in rural communities. She asked what services will be difficult to sustain moving forward.

Kyle Peplinski replied that there were virtual and hybrid adaptations during the COVID-19 pandemic that were not just about funding. There is an evaluation project that is identifying practice improvements learned during the COVID-19 pandemic and how to modify and sustain those improvements moving forward.

TRIBAL MIECHV

Moushumi Beltangady
Senior Policy Advisor, Tribal Early Childhood Development
Administration for Children and Families

Moushumi Beltangady said that she would give perspective regarding the historical trauma that tribal communities have experienced over generations. Tribes had federal recognition terminated and there was a long history of children removed from their communities and sent to federally run boarding schools and were often required to stop speaking in their native language, wear western clothes and cut their hair. In the 20th century there were children removed from their homes by the child welfare system and raised by white families. There was a loss of culture and language embedded in distressing historical events, and this is all linked to the historical trauma and the disparities observed today.

Most reservations are in rural areas where there are not enough resources or economic opportunities. Tribes had treaties with the government and gave up their land in exchange for a guarantee that their communities would receive healthcare, education, and other services. The treaties were not upheld so there is a continued lack of services in the tribal communities. Home visiting is not a new concept, it is the traditional concept of a community coming together to support a woman and her family during pregnancy and after pregnancy and as the child develops. MIECHV is an evidence-based policy initiative, meaning that it is both building on the

existing evidence and constantly generating new evidence through data, continuous quality improvement, research, and evaluation activities. The Tribal MIECHV Program is authorized by Title V, Section 511 of the Social Security Act. MIECHV began in 2010 as part of the Affordable Care Act with a set-aside for grants to Indian tribes, consortia of tribes, tribal organizations, and urban Indian organizations. The Tribal MIECHV program is administered by ACF in collaboration with HRSA.

In 2023 the MIECHV Reauthorization will double tribal set-aside from 3% to 65 and quadruple tribal funding by FY 2027.

Tribal MIECHV Program goals include:

- Support the development of healthy, happy, and successful American Indian and Alaskan Native (AI/AN) children and families.
- Implement high-quality, culturally relevant, evidence-based home visiting programs in AI/AN communities.
- Expand the evidence base around home visiting interventions for Native populations.
- Support and strengthen cooperation and coordination and promote linkages among early childhood programs and coordinated early childhood systems.

Tribal MIECHV Grant Activities Include:

- Conduct a needs and readiness assessment of at-risk communities (Year 1)
- Engage in collaborative planning and capacity building efforts to address identified needs through a home visiting program.
- Provide high-quality, culturally grounded, voluntary, evidence-based home visiting services to expectant families and families with children 0-5
- Establish, measure, and report on progress toward meeting “benchmarks” – performance measures for participating children and families.
- Participate in continuous quality improvement activities.
- Engage in activities to build the evidence base for home visiting programs with AI/AN populations.

In FY2022, Tribal MIECHV grantees served 3,489 parents and children in 1,668 families. Since 2012, grantees have provided 161,000 home visits.

The Tribal MIECHV Home Visiting program is building capacity for the implementation of evidence-based practices, data collection, and evaluation. The definition for evidence-based models is slightly different for the Tribal MIECHV program. It includes both evidence-based models and promising approaches so grantees can use up to 100% of their funding on promising approaches. There is only one evidence-based model that meets the HHS criteria for evidence of effectiveness in tribal populations, which is The Family Spirit Home Visiting Program. The other twenty-three models would qualify as promising approaches for tribal communities. The Tribal MIECHV Home Visiting program has the flexibility to incorporate tribal culture, language, and traditions and to meet the culture and context of the community and families.

Kehaulani Fernandez
Program Coordinator, Tribal Home Visiting Program
Lake County Tribal Health Consortium, Inc.
Lakeport, CA

Kehaulani Fernandez shared that Lake County, California covers an area of 1,327 square miles and is about 110 miles north from San Francisco, 110 miles west of Sacramento, and about 70 miles from the Pacific Coast.

An elder from Big Valley, California names the Gouk-Gumu Xolpelema “All People Coming Together” Tribal Visiting Program. The vision is empowering native families to strengthen emotional, mental, physical, social, and spiritual wellness, and increase connections to their culture and community so that parents and children are safer, healthier, happier, and more resilient. The program follows the Parent Child Assistance Program model established in Spokane, Washington. The focus of the program is on goal setting and parent-child interactions.

The Book Read Along is a successful program activity where Elders from the Tribal Advisory Council read stories to children and discuss the importance of storytelling. There are families who had never owned a book so generated an enthusiasm for reading. During one of the reading sessions, a mother said that she did not know who the storyteller in her family could be but by the end of the event she said that she could be the storyteller.

Program goals include:

- Reducing Native children's exposure to tobacco, alcohol, and drugs
- Strengthening connections for Native families to Tribal and Non-Tribal community resources, information and services, and connections to community and Tribal activities.
- Strengthen connections for Native families to Tribal and Non-Tribal community resources, information and services, and connections to community and Tribal activities.

Gouk-Gumu Xolpelema Tribal Home Visiting team hosts and participates at community events throughout the year, including:

- Book Read Along
- Holiday Toy Giveaway
- Child Abuse Awareness Event
- Tribal Youth Olympics
- Family Dinners
- To Honor One is to Honor All Graduates Event
- Natives in Recovery Big Clean Time Event
- Honoring Motherhood
- Heroes of Health and Safety
- Tule Boat Festival
- Missing and Murdered Ingenious People Awareness Event
- Community Wellness Circle
- Cultural Teachings

Family Advocate Accomplishments for FY 2021-22 include:

- Completed 689 home visits.

- One female caregiver received inpatient SUD treatment.
- Four female caregivers attended outpatient SUD treatment.
- Served 42 female caregivers and twelve male caregivers.
- Served seventy children ages 0-5
- Family advocates made 144 referrals.
- Hosted Classes
    - Positive Indian Parenting Program
    - Circle of Security Program
    - Motherhood & Fatherhood is Sacred

Historical trauma is embedded in the Native American culture. The Pomo Indians lost their land and relocated throughout California. The tribe is attempting to purchase land and housing for their members who are homeless. The Pomo Indians have an office in Oxford, California and they come together to dance for events and to have ceremonies. The tribe inhabited the Clear Lake area over 11,800 years ago. The Pomo Tribe members fished, hunted, and crafted intricate basketry made from lakeshore tule and other native plants, feathers, and shells.

In Lake County, Native Americans make up about 4% of the general population, but account for over 22% of the homeless population, according to Department of Housing and Urban Development's 2021 Point-In-Time (PIT) Homeless count. For native people, being homeless takes on a whole different meaning considering the history of racism, colonialism, and land theft.

The lead agency for the Tribal Home Visiting Program is Lake County Tribal Health Consortium, Inc. (LCTHC). Founded in 1983, LCTHC is a federal Title I Tribally Sanctioned Organization representing a consortium of the six federally recognized Native American Tribes which are Big Valley Rancheria, Elem Indian Colony, Habematolel, Middletown Rancheria, Robinson Rancheria, and Scotts Valley Band of Pomo Indians.

Lake County Tribal Health Consortium Board of Directors is comprised of representatives from all six tribal governments in the consortium. The Board of Directors appoint tribal governments and terms are staggered so that new members can learn from those with experience. The Board convenes monthly but meets more frequently when needed. The board members are local, and several are also on the Tribal Advisory Council.

Lake County Tribal Health Consortium offers medical, dental, pediatrics, obstetrics, and comprehensive healing and pain management programs. Other services include public health and outreach, pharmacy services, purchase referred care, transportation, diabetes treatment and prevention, tobacco cessation programs, substance use disorder (SUD) assistance, and medication-assisted treatment (MAT). The LCTHC clinic will pay for people who are members of one of the six tribes to attend treatment programs.

Christopher Jarvis, MD
Director, Office of Clinical and Preventative Services
Indian Health Service

Christopher Jarvis shared that Indian Health Service supports tribes on a national level through area offices and through the public PHN program. PHNs provide an extension of care in the community to mitigate the risk of disease and illness and decrease healthcare costs. PHNs collect evidence-based data to determine a family's needs. Families live in very rural, remote areas that are long distances from clinics and a number of residents do not have transportation. Staff shortages are making it difficult for home visiting programs to meet the needs of the community. There is constant turnover of staff, especially in the last 3 years due to fatigue. PHNs are not only making home visits but also taking on other responsibilities, for example, working in behavioral health clinics.

New mothers with substance use disorders (SUDs) can have difficulties with breastfeeding so it is necessary for PHNs to visit them in their homes and give them support. There are substance abuse treatments that a PHN can perform in the home if new mothers are not able to get to a clinic or refuse help. Screening and assessments of parental SUDs are performed by a PHN in the homes of those at risk. PHNs will have another staff member go with them on home visits if there is a safety concern.

The Baby-Friendly Hospital Initiative is a quality improvement activity to increase breastfeeding initiation and duration which creates a healthy start for babies and prevents childhood obesity. An abundance of scientific evidence concludes that babies who are breastfed experience improved health outcomes and lower risks for certain diseases. Eight IHS federally operated obstetrical hospitals are Baby-Friendly.

Towards the end of FY2020, the PHNs prepared for a new phase against the pandemic that included PHNs administering the COVID-19 vaccine, administering testing, and coordinating care. People were hesitant about going to clinics during the COVID-19 pandemic so in about a three-year period the Indian Health Service PHNs made about half a million home visits. During the pandemic, best practices followed by a home visitor such as collaborating with a team that included an established PHN patient referral system, working with tribal programs for assistance in monitoring patients, and hosting weekly calls with tribes to provide information about vaccination efforts.

The IHS Emergency Medical Services for Children (EMSC) Program is an interagency agreement between HRSA and IHS. The goal of the program is to expand and improved pediatric emergency care for American Indian and Alaska Native (AI/AN) children and youth. In FY2021, IHS awarded Children's Hospital of Philadelphia (CHOP) to work with 7 IHS/Tribal emergency departments to set-up training programs. There are now thirteen emergency departments with increased pediatric emergency care.

The Maternal Child Health Initiatives develop strategies to assist pregnant women so their children will have positive health outcomes.

The Maternal Child Health Initiatives are:

- The Rural Obstetric Readiness (ObRED) Initiative. It focuses on the 3T's: Training-Tools-Tracking with a focus on morbidities and causes of mortality.
- The Maternity Care Coordination Initiative (VA Model) is a program with maternity care coordinators who visit pregnant women in the community to assure they are receiving necessary services.

- The Alliance for Innovation on Maternal Health (AIM) Safety Bundles assist in preventing morbidity and mortality associated with risks that occur during pregnancy.
- The Government Performance & Results Act (GPRA) monitors and shares best practices.

Q&A

Brian Myers said with the additional MIECHV program funding there will be more opportunities to apply for grants. The process can be time consuming since the grants require approval by the board of directors and tribal council before applying. He asked if there is ample time to apply for a grant from the release date of the notice to the due date.

Kehaulani Fernandez said The Notice of Funding Opportunity ACF standard is sixty days and the Tribal MIECHV Notice of Funding Opportunity is up for 90 days.

Kellie Phillips-Asay asked if there are any Office of Research & Evaluation (OREs) grants that are awarded to rural areas.

Moushumi Beltangady responded that a grantee in Riverside and San Bernardino Counties, in California, serves a mix of urban and rural, also there is a grantee in Anchorage, Alaska that primarily serves Anchorage but also outlying communities. Albuquerque serves outlying rural areas as well.

April Anzaldua asked about the 5-year grant process and if there is a concern whether they can serve the tribe and community if a grant completes.

Kehaulani Fernandez responded that the Gouk-Gumu Xolpelema Tribal Visiting Program began in 2011 and has continued receiving funding but it ends September 30th. They are fortunate because the clinic they partner with will keep the program even if they are not able to get another round of funding.

Patricia Schou asked about the coordination of the home visiting programs with primary care and how do you get referrals.

Kehaulani Fernandez responded that referrals come from the clinics or from other programs within the clinic and the outreach and events in the community are a way for people to learn about the tribal visiting program.

Dr. Jarvis added that CHWs make referrals and there are hospital referrals for home visiting when new mothers return home.

STATE PERSPECTIVE ON MIECHV

Benjamin Hazelton
Director of Government & Community Engagement
Parents as Teachers National Center

Benjamin Hazelton shared that he worked on MIECHV from the beginning as a MIECHV Advisory Committee Member and then the MIECHV State Project Director and would provide an overview of how MIECHV works in Oregon. The Maternal Child Health Section of the Public Health Division is responsible for administering three home visiting programs and they are Family Connects Oregon, MIECHV, and PHN Home Visiting.

In Oregon, the three evidence-based home visiting models that receive MIECHV funding are Early Head Start Home Based, Healthy Families America, and Nurse-Family Partnership. Early Head Start and Health Families America started in Malheur, Multnomah, and Tillamook Counties. A development grant expanded to new communities through the Nurse-Family Partnership model and an expansion grant extended all three models reaching an enrollment capacity of around nine hundred families.

Last year Oregon MIECHV provided access to evidence-based home visiting for 1,079 households and 950 children. Many families who access home visiting services through MIECHV have lived experiences that can disadvantage their opportunities to achieve optimal health and well-being.

The MIECHV grant provided a Home Visiting Core Competency Framework that includes:

- Regional Training by partnering with Early Learning Hubs
- Scholarships for formal education for the Oregon Infant Mental Health Scholarships
- Online learning opportunities such as MIECHV orientation and self-paced learning
- Partners with other conferences such as Oregon Early Educators Parenting Education Hub

This year, Oregon provided scholarship for 45 participants for the National Home Visiting Summit, and 40 scholarships to the Anti-Racism in Perinatal Health Web Series.

The Oregon MIECHV Program Continuous Quality Improvement (CQI) highlights include:

- Joy at Work Collaborative to increase home visiting staff wellbeing.
- Cultivating Joy in Parenting
- Practicum on Safe Sleep on reducing rates of sudden unexpected infant death (SUID)
- A current CQI Project – ASQ-3 developmental screening practices for children ages 2-66 months to evaluate a child's communication skills, critical thinking skills, physical abilities, and social skills.

Brenda Comini
Central Oregon Regional Early Learning Hub Director

Brenda Comini said that there are sixteen early learning hubs that work with the Early Learning Division. The hub's early childhood systems are partnering with the Oregon Health Authority to promote implementation of Raise Up Oregon which is the first early learning system for the state. The Early Learning Hub is working with CCOs on investments in early childhood work as well as funding across housing, social services, child welfare and the Oregon Department of Human Services.

The hub's region is in Central Oregon and encompasses Jefferson, Crook, and Deschutes Counties with includes the Confederated Tribes of Warm Springs. This encompasses 13,000 children under the age of five with about 2,400 births annually. The MIECHV contract goes to the Regional Early Learning Hub which is the backbone organization for the funding. The Early Learning Hub subcontracts to Healthy Families of the High Desert Home Visiting which is a Healthy Families America Model that provides regional service to Jefferson, Crook, and Deschutes Counties. Healthy Families of the High Desert screens about 550 families annually and serves about 125 families annually.

MIECHV service focus was Jefferson County from 2016-2022, and with the needs assessment, the focus has shifted to Crook County since 2022. Jefferson County is still receiving services but the matching funds that come through the Early Learning Division are being reallocated due to community needs. The Healthy Family Service program will expand through a variety of funding sources to meet community needs.

The Early Learning Hub conducted a biennial workforce needs assessment to find ways to coordinate training events in central Oregon. Mothers & Babies, Maternal Depression is a best-practice program to support families. Sixty home visitors have received training through the program, and the program extended into home visits and caregiver groups. Future priorities include infant massage and increasing International Board-Certified Lactation Consultant (IBCLC) staff across the region.

Duke University founded Family Connect International, and Oregon will implement the model as the statewide home visiting program. Family Connect offers home visiting services to all families with newborns up to six months of age. The program is a community system of care including health and social support to families such as housing agencies, primary care providers, pediatricians, childcare options, and mental health services.

Q&A

Kellie Phillips-Asay asked what maternity hospitals are available for women who live in Central Oregon since there is only one healthcare system.

Brenda Comini responded that St. Charles Bend Family Birthing Center accounts for around 1,900 of the 2,400 births in Central Oregon.

Kellie Phillips-Asay asked if the health network helps fund the IBCLC staff.

Brenda Comini responded that there is some lactation support imbedded in the Federally Qualified Health Centers (FQHCs) and some in St. Charles Women's Clinic but there is only an office in Redmond which is not in proximity to the St. Charles Family Birthing Center in Bend, but they are in the process of building a lactation support staff. There are also lactation consultants in each of the two rural health departments, and there are two in the Deschutes County Health Department.

Isabel Garcia-Vargas asked how they avoid the Family Connects program providing overlapping services with other programs. Head Start Programs also perform Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and The Ages & Stages Questionnaires, Third Edition (ASQ-3) screenings.

Brenda Comini responded that the Family Connects Program is meant to be a nurse home visiting program that performs the screenings and makes referrals to the appropriate programs. The nurses receive training and work in partnership with relief nurseries, which is a home-grown model in Oregon. The Relief Nurseries work closely with families who have multiple stressors, usually in collaboration with the health department. There is an Early Head Start Program but there are only twenty-six slots in the whole region for just Redmond.

Matthew Probst said that he was interested in how universities in Oregon are designing health care related curriculums so that students may stay and work in the small, rural communities.

Brenda Comini responded that the community college is working on lived experience credits who can enter the workforce in childcare and home visiting professions. The community colleges are also building up classes that are bilingual, so the early childhood classes are all dual language. Eighty two percent of the students in scholarship award program, Partners in Practice (PIP), identified as Hispanic, Latino, or Native American so there is a workforce that reflects the population.

APPRECIATION FOR DEPARTING MEMBERS

Governor Jeff Colyer
Committee Chair

Governor Colyer shared his appreciation for the members who were completing their term on the committee. Wayne Deschambeau and Robert Blancato were not able to attend the meeting, but Governor Colyer shared that Mr. Blancato kept the committee focused on elderly issues in rural communities and thanked Mr. Deschambeau for his dedication and for sharing his knowledge about rural hospitals.

Governor Colyer congratulated Brian Myers on his new position as Director of Community Engagement at Washington State University College of Medicine and thanked him for his time on the committee and the knowledge that he shared about rural community health and capacity building.

Governor Colyer thanked Meggan Grant-Nierman, who is a physician, for sharing her primary care experience with the committee and stated the committee values her insight.

Governor Colyer recognized Patricia Schou and said that she has been instrumental with on-site visit discussions and when talking to outside groups. Her insight and participation have been invaluable.

Governor Colyer shared that James Werth's input on mental issues in rural communities has been a great benefit to the committee. Governor Colyer said that Loretta Wilson brings great energy to the committee, and she makes things happen. After the PACE meeting, Loretta returned to Alabama and started a PACE Program.

TOPIC IDEAS FOR SEPTEMBER MEETING IN COLORADO AND SPRING 2024

Governor Jeff Colyer
Committee Chair

Governor Jeff Colyer shared the NACRHHS vision statement for the new members on the committee. The vision statement is, **"**We envision rural America as diverse communities of healthy people, places and providers, who access world class care and human services by capitalizing on continued innovation and rural values – places where people have the greatest opportunity to live their American Dream."

Governor Colyer asked the committee to consider two different concepts while discussing future topics. One concept focuses on specific issues. The second concept is looking broadly, overall, at a topic that affects rural health and human services (RHHS).

Tom Morris
Associate Administrator, Federal Office of Rural Health Policy

Tom Morris informed the committee that this would be the initial discussion on upcoming topics, with another discussion on the final day of the meeting. He shared previous topics covered by the committee since 2018.

Topics Previously Covered Since 2018:

- Child Care
- Elderly Care
- Behavioral Health Integration
- Rural Emergency Hospitals
- Maternal Health
- HIV
- Older Adult Support Services
- Cancer
- COPD
- Oral Health
- Adverse Childhood Experiences
- Health Insurance Markets

Potential Broad Topic Suggestions Include:

- Encouraging new Tech and Silicon Valley to help innovate Rural Health and Human Services
- Increasing Private Capital to improve Rural Health and Human Services for both nonprofit and for-profits.

Potential Specific Topic Suggestions Include:

- Sustaining Opioid and Substance Use Treatment in Rural Communities
- Assessing the Rural Implications of Changing Behavioral Health Provider Types
- Assessing the Role of Community Action Agencies in Rural America
- Assessing the Rural Health and Human Service Implications of Federal Broadband Policy Efforts
- Identifying the Key Factors in Rural Hospital Financial Viability Moving Forward
- Assessing the Federal Office of Rural Health Policy's Community Based Programs

Additional Topic Ideas from the Committee Members:

- Examining Social Determinants of Health and how they can influence decision making.
- Disasters and the impact on rural areas
- Rural Health Workforce – workforce development
- Lack of healthcare human resources in rural areas – how to bring nurses and healthcare workers to rural communities.
- Disasters and the impact on rural areas
- Rural Health Workforce – workforce development
- A focus on children in rural communities – how to support them so they can thrive and become healthy adults.
- Individuals with disabilities – needs and challenges.
- Expand school-based health centers.

PUBLIC COMMENT
No Public Comment

Thursday, April 27th, 2023

Thursday morning the subcommittees departed for site visits as follows:

SITE VISIT
Crook County Health Department
Prineville, OR

Tour of Crook County Health & Human Services
Katie Plumb
Public Health Director of Crook County Health Department

Subcommittee members present at the meeting: April Anzaldua (Chair); Brian Myers; James Werth; Meggan Grant-Nierman; Michelle Mills; Pat Schou.

Present from the United States Department of Health and Human Services: Christopher Jarvis, IHS; Dhwani Kharel, Truman Fellow, ORHP; Sahi Rafiullah, Senior Advisor, ORHP.

SITE VISIT
Jefferson County Public Health

Tour of Jefferson County Health & Human Services
Michael Baker
Health Services Director of Jefferson County Public Health Department

Subcommittee members: Loretta Wilson (Subcommittee Chair); Governor Jeff Colyer (Committee Chair) Isabel Garcia-Vargas; Mark Holmes Cara James; Kellie Phillips-Asay; Matthew Probst.

Present from the United States Department of Health and Human Services: Tom Morris, Associate Administrator, ORHP; Kristen Dillon, Health Policy Consultant, HRSA; Jenna Mu, Truman Fellow, ORHP; Kyle Peplinski, Branch Chief, Policy, Data and Technical Assistance, MCHB; Cynthia Phillips, Director, Division of Home Visiting and Early Childhood Systems, MCHB.

Ex-Officio Members: Percy Devine, Region 8, Regional Administrator, Administration for Community Living. Aleta Meyer, Senior Social Science Research Analyst, ACF.

Community Panelists and Attendees

- Barbara Ibrahim, RN, IBCLC, Public Health Nurse – Jefferson County Public Health, Nurse Visiting Program, Warm Springs, Oregon
- Angie Lopez, Family Support Specialist – Healthy Families Oregon (HFO), Jefferson County Public Health. Madras, Oregon

- Janessa Wells, Central Oregon Workforce Navigator – Oregon Coalition of Local Health Officials (CLHO), Portland, Oregon

The subcommittees returned to the Waypoint Hotel in Bend, Oregon.

PUBLIC COMMENT
No public comment.

Friday, April 28th, 2023

OUTLINE THEMES FOR POLICY RECOMMENDATIONS

Jeff Colyer, MD
Committee Chair
Jeff Colyer welcomed the committee members to the final day of the meeting. He stated that there would be two sessions including policy recommendations and future committee topics. The committee will make recommendations to advise the Secretary of Health and Human Services but can also advocate for legislative changes.

Key MIECHV discussion themes:
- Workforce challenges in both recruitment and retention
- Lack of awareness of MIECHV in the broader rural health care delivery system
- Lessons learned from flexibility in the tribal program that would be beneficial to rural state programs.
- Acknowledge the difficulties of MIECHV relying on evidence-based models and the need for flexibility in rural areas.
- Acknowledge the large know of considerable number of home visiting programs funded by HHS (Medicaid, TANF, Etc.) but note the focus on MIECHV.
- Benefit of integrated service location; co-locations of services is a key in rural areas due to limited infrastructure.
- Challenges of continuity of MIECHV if a county does not receive funding each year.
- Concern about administrative burden
- How to build and learn from the flexibilities of the tribal program

Potential Recommendations to present to the Secretary of Health and Human Services:
- Develop a rural CQI process.
- Assess the impact of the matching grants on rural states with limited financial resources.
- Increase outreach to ACL for awareness among grandparents raising grandchildren.
- Require states to include State Offices of Rural Health (SORH) and local stakeholders in the Needs Assessment
- Require the states to have transition periods in how it moves funding from one area to another.
- Ensure there is a rural-urban cut in the state-by-state outcomes dashboard.
- Track entities getting matching dollars and the impact on rural.

- Maximize flexibility in the model adaptation work to identify new rural evidence-based models.

FINALIZE TOPIC IDEAS FOR SEPTEMBER MEETING IN COLORADO

The consensus was that the topic of Technology and Silicon Valley innovation in Rural Health and Human Services – may be the best option. Committee members will continue the discussion and make a final decision.

Other topic considerations include:

- Individuals with physical, intellectual, and development disabilities – 2025 is the anniversary of the American with Disabilities Act
- Child and Adolescent Health
- Disaster Preparedness
- Assessing the role of Community Action Agencies in Rural America.

PUBLIC COMMENT

No public comment.