CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Healthy Tomorrows Virtual Resource Binder

2021 Healthy Tomorrow Learning Collaborative

Well Child Care: Improving Care Coordination and Communication Between Pediatric Practices and Family Visiting Programs

Virtual Resource Binder

This is a resource for pediatric practices, family visiting staff, and family consultants participating in the CTC-RI / PCMH Kids IBH Learning Collaborative: With a focus on improving well child care through improved coordination and communication

Contents

Project Background

This project is funded through Healthy Tomorrow Partnership for Children Program(HTPCP) which is a cooperative agreement between the federal Maternal and Child Health Bureau (MCHB) and the American Academy of Pediatrics (AAP) which supports community-based health projects that improve the health status of mothers, infants and children and families by increasing access to health services.

Objectives

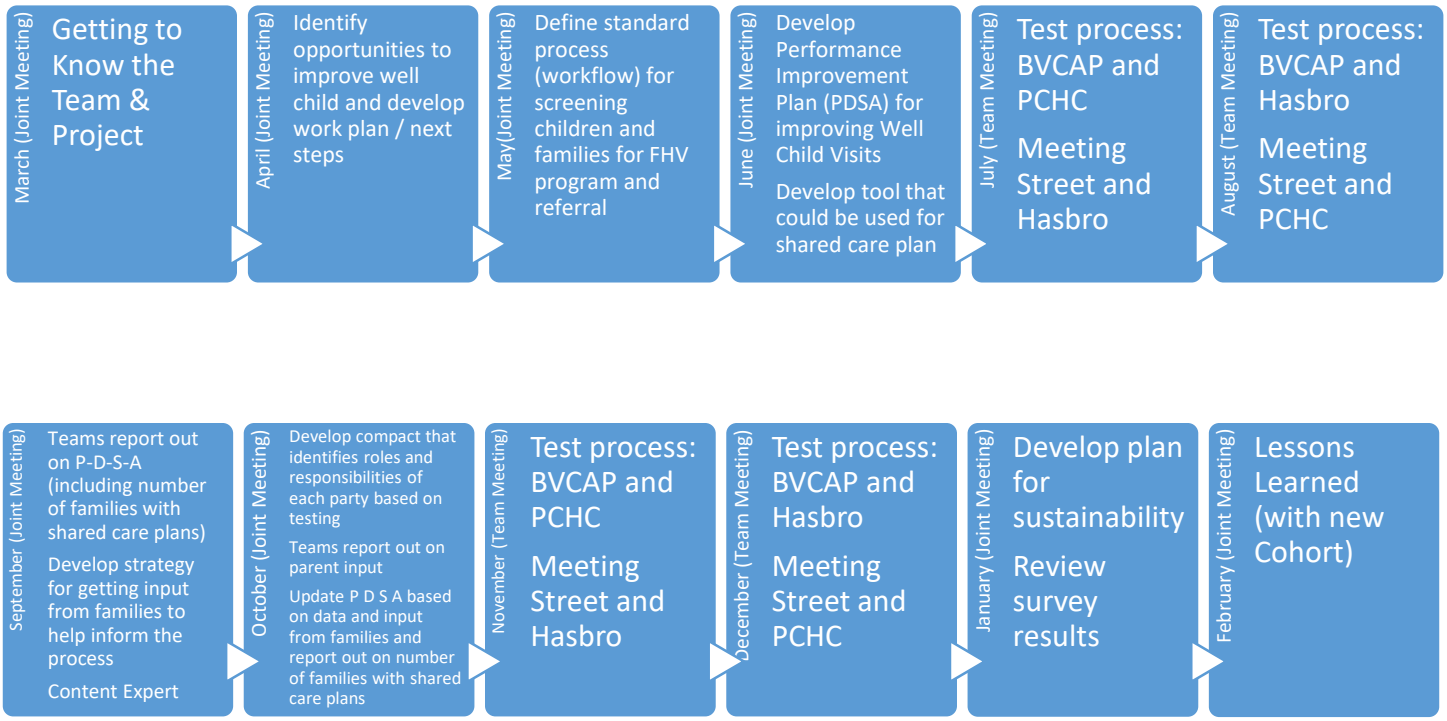
Goals/Objectives for family home visiting and pediatric practice partners is to participate in a twelve month learning collaborative that will help develop relationships and awareness that result in:

1) A method to identify patients and families who may benefit from a family home visiting referral;
2) Current information about the patients jointly seen by FHV and Pediatric practices;
3) A document (compact/MOU) that identifies coordination and communication expectations for the FHV and Pediatric practice;
4) A standardized process for making referrals to FHV practices;
5) A standardized care planning process;
6) Evaluation through pre and post survey information of increased knowledge and awareness;
7) Improved well child outcomes as a result of improved communication and coordination that is additionally informed by person(s) with lived experience.

This effort will be supported by:

1) Monthly planning meetings that help to plan and prepare for learning collaborative meetings including identification of tools and resources that will assist the effort;
2) Consultants, including pediatrician who will serve as a content expert and Family Consultants, who will serve as content experts for what children and families need from family home visiting programs and pediatric practices.

Learning Collaborative meeting Schedule



Joint Meetings: ***Develop the Process*** - Practices and Family Home Visiting Partners build processes for improving communication and care coordination with a focus on improving Well Child Care; work is informed by the Family Consultant voice and recommendations.

- Kick off meeting - 3/29/21 (12-1pm);
- April Joint meeting – 4/26/21 (12-1pm);
- May Joint meeting – 5/24/21 (12-1pm);
- June Joint meeting – 6/28/21 (12-1pm);
- September Joint meeting – 9/27/21 (12-1pm)
- October Joint meeting – 10/25/21 (12-1pm)
- January Joint meeting – 1/24/22 (12-1pm)
- February Joint meeting – 2/28/22 (12-1pm)

Team Meetings: ***Test the Process*** - Partners will "test the care coordination and communication processes", report back at joint meetings and improve process based on experience and as informed by the patient voice. Team partners will identify standard dates and times for the Team Meetings.

Content expert(s) will be asked to present with topics selected by the learning collaborative partners

Meeting Locations:

- Joint Meetings: https://ctc-ri.zoom.us/j/864670581?pwd=UUhDOVdlNy84TmtxUjBTaXgySXowdz09
  Meeting ID: 864 670 581; Passcode: 646876
- Team meetings: to be determined

Participative Agreement

Healthy Tomorrow Learning Initiative
Consisting of 4 pages
Practice/Family Home Visiting Program Organization and Model: _____
Pediatric Practice: _____

Introduction/Purpose

The Rhode Island Department of Health, in partnership with CTC-RI/PCMH Kids, successfully applied for a five (5) year "Healthy Tomorrow" grant whose goal is to improve care coordination between the Family Home Visiting Program (FHV) and Pediatric Primary Care Practices (PCMH Kids) with a specific focus on improving well child care

The Rhode Island Department of Health (RIDOH) and the Care Transformation Collaborative of Rhode Island PCMH Kids (CTC-RI/PCMH Kids) have selected your practice/organization to participate in the twelve (12) month Healthy Tomorrow Learning Initiative. The Healthy Tomorrow Participative Agreement outlines the practice/organization responsibilities as outlined in the Healthy Tomorrow Milestone Document (Attachment A).

Healthy Tomorrow Strategic Goals:

The goals of the Healthy Tomorrow project include:

1) PCMH Kids practices and FHV programs have the tools, data and work flows needed to integrate care coordination;
2) PCMH Kids practices and FHV programs acquire the knowledge, skills and relationships for integrating care coordination through participation in a year-long learning collaborative;
3) PCMH Kids practices and FHV programs develop and implement strategies to support family engagement in primary care and FHV programs;
4) Integrated Care Coordination activities will continue after federal funds end.

A Core Planning Team has been formed to provide oversight for the planning, implementation and evaluation of the Healthy Tomorrow project. This group has helped design a twelve month learning collaborative during which selected PCMH Kids practices and FHV programs will meet monthly to:

1) Identify data needed to identify families who may benefit from care coordination services;
2) Develop an interview guide and obtain information from families on their needs;
3) Identify relationship and knowledge gaps and strengths;
4) Identify potential communication workflows, tools, knowledge that would help improve care coordination;
5) Incorporate input from family consultants in testing a process for integrating and improving care coordination for children and families that would benefit from this support.

Benefits to Participation

As noted in the American Academy of Pediatrics Early Childhood Home Visiting Policy Statement (Sept 2017) "The home visiting program presents a valuable strategy to buffer the effects of poverty and adverse early childhood experiences that influence lifelong health". Home visiting has been shown to increase children's

readiness for school, promote child health (such as vaccine rates) and enhance parents' abilities to promote their children's overall development (Fergusson, Horwood, Ridder, 2005). Hardy and Street (1989) found that home visits conducted 2 to 3 weeks before a well-child visit resulted in fewer missed visits, fewer sick and acute care visit, decreased hospitalization and decreased abuse and neglect.
The Healthy Tomorrow Learning Collaborative is intended to assist FHV programs and PCMH Kids practices develop more intentional systems of care coordination and communication to more effectively link families with services and improve well child health outcomes.

Other benefits include:

1. **Infrastructure Payment:** Each practice/organization will be eligible to receive $4,000.00 infrastructure payment to cover the cost of staff time participating in the learning collaborative meetings and in completing the program deliverable requirements;
2. **Family Consultation:** Family consultants who have Family Home Visiting/Pediatric care lived experience will help inform the development of effective solutions by providing input on the following questions:
   a) What is needed to improve Well Child Care from the perspective of the parent and the child;
   b) What are the barriers to obtaining Well Child Care from the perspective of the parent;
   c) What solutions will best support the parent in obtaining Well Child Care
   d) Other recommendations around how to improve care coordination and communication based on the needs of families;
3. **Quality Improvement Consultation:** A practice facilitator will provide assistance with developing, testing and evaluation workflows and communication tools to improve communication and care coordination;
4. **Learning Community:** FHV programs and pediatric practices will have the opportunity to develop relationships and implement standardized communication systems which are anticipated to be applied by future state-wide cohorts of FHV and pediatric practices and reduce administrative burden.

Practice /organization Responsibilities and Requirements:

PCMH Kids Practices/FHV programs will participate via zoom format in a twelve month learning collaborative from March 2021 to February 2022.

4 Month Preparation Period QI Initiative Activities (March -June 2021):

- Identify members of the practice quality improvement (QI) team; For pediatric practice this would include a provider champion, a care coordinator and an IT staff member; For FHV program, this would include two family home visitors from your organization and model team and include the participation of the supervisor or program manager.

- Complete the Participative Agreement and pre-survey (Attachment B) to assess current level of coordination between FHV and PCMH Kids practices;

- Attend a virtual orientation kick-off learning session and present patient story that helps shows "present state" example of improving care coordination through partnership;

- Actively participate in joint meetings (April-June) and come prepared to discuss use of data that helps identify present use of partnership, and opportunities to improve well child care and development of standardized processes (workflow for screening, referral, care plan);

- In consultation with family consultant, develop and submit a Performance Improvement Plan (Plan-Do-Study-Act) including AIM statement, baseline information, measurement of success, plan to capture data

and use shared care plan;

QI Initiative Performance Period (July 2021-February 2022):

- Test the process with your rotating partner (July and August) and update performance improvement plan based on experience;
- Share updated Performance Improvement Plan at joint meetings and develop strategy for obtaining input from families to help inform the process, develop and implement MOU/Compact that outlines communication/coordination expectations (September and October);
- Test updated process with your rotation partner (November and December), implement strategy to obtain family input and submit updated Performance Improvement Plan;
- Present final Performance Improvement Plan at Joint Meeting, and complete post survey;
- Attend joint meeting with new cohort and share "lessons learned".

Practice/Organization Compensation:

Practices/Organizations will be eligible to receive:

- Total Practice infrastructure payment of $4,000.00 (two $2,000.00 payments) that can use to off-set costs associated with generating data reports, staff time, and participation in quality improvement activities;
    - Practice/organization team eligible to receive first infrastructure payment ($2,000) with execution of Participative Agreement;
    - Practice/organization team eligible to receive second infrastructure payment ($2,000) with team completion of pre-survey, team attendance at 12 month learning collaborative, deliverables and completion of post survey.

CTC reserves the right to delay/withhold payments if Practice fails to meet practice requirements as outlined in Milestone Document *(Please see Attachment A).*

Care Transformation Collaborative of RI

Debra Hurwitz

_____

Signature: Debra Hurwitz,

Executive Director, CTC-RI

Position: _____

Practice/Organization name_____

_____

Signature of authorized staff:

Name: _____

Attachment A: MILESTONE SUMMARY DOCUMENT

In the HRSA work plan, suggested shared learning with content experts are: ACES, Well Child Care, Social Determinants of Health. Content expert topics could be selected by teams.

Deliverable	Timeframe Due Dates	Goal	What is needed
Pre-work: Identify members of the practice quality improvement (QI) team; The pediatric practice team and FHV program complete and sign the Participative Agreement and identify Quality Improvement Team Members and complete pre-survey information Family consultant(s) sign letter of agreement	February 2021 Done by each team prior to Kick off Meeting as part of Team Commitment Participative Agreement	Commit to Action Family home visiting program commit to action by completing: Pre-survey Participative Agreement Members of the quality improvement team	Participative Agreement which will include section for team to complete identifying QI team members and link to pre-survey
Meeting 1: Joint Meeting FVH describes a patient story from each of the FVH programs and how FVH has been helpful improving well child care Pediatric practice comes to meeting with story of referral to FHV program and how FHV program is has been helpful in improving well child care Family Consultant describes experience of well child care: FHV and Pediatric practice	March 2021	Mutual Awareness and relationship building Pediatric practices will learn more about the family home visiting program through hearing about family examples of how each program can improve well child care through their programs; Family home visiting program will learn more about how pediatric practice used FHV to improve well child care FHV and Pediatric Practice learn from parent consultant what has been helpful, barriers to well child care and recommendations	Story form with section for Identification of mutual goals, benefits, barriers and what teams will do to prepare for Meeting # 2 (data)
Meeting 2: Joint meeting: Asset mapping and work plan FHV: comes to the meeting with data # of children presenting being visited from pediatric practice # of referrals from pediatric practice in last year Parent interview information Pediatric: # of children up through age year 4 identified to be “at risk” (missed immunizations/well child visits, positive risk score for social medical needs, developmental delay, dental needs	April 2021	Mutual understanding of present state of collaboration and identification of future state FHV and Pediatric Practices will identify opportunities to improve well child and work plan next steps	Data Reports Work plan tool Identification of what each team will do to prepare for Meeting # 3 (screening and referral)

Building Relationships: "Who's Who"

Rhode Island Department of Health

Blythe Berger, Healthy Tomorrows Project Director

Kristin Lehoullier, Healthy Tomorrows Project Coordinator

Sara Remington, Program Manager and Implementation Manager, Office of Family Visiting

Blackstone Valley Community Action Program Profile

Shana DeFelice, Program Manager Healthy Families America & Parents as Teachers

Shannon Lemus, Supervisor Healthy Families America

Meeting Street Program Profile

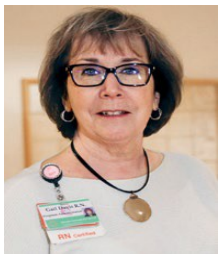
Cris Massey, Program Manager, Healthy Families America

Iesha Rocha, Supervisor, Healthy Families America

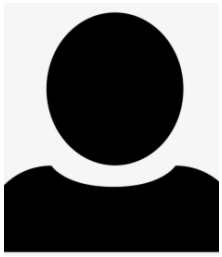
Hasbro Pediatric Profile

Patricia Flanagan, MD, Professor and Vice Chair Department of Pediatrics Warren Alpert Medical School Brown University; Associate Pediatrician- in-Chief Hasbro Children's Hospital

Carol Lewis, MD, Medical Director, Hasbro Primary Care; Director, Refugee Health Program



Gail Davis, RNC, Program Administrator



Kathleen Gregory, MSN, RN, Program Manager- Care Coordination

Providence Community Health Center Practice Profile

Ursulina Bencosme, MD, MPH, Pediatrician

Nadine Hewamudalige, MD, Medical Director

Chelsea De Paula, MPH, Manager Community Integration & SDOH Strategy

Family Consultant Profile

Jo Theroux, mother of 5

Katya Nanson, mother of 2

Patricia Flanagan, MD, FAAP, PCMH Kids Co-Chair and Pediatrician Advisor to Healthy Tomorrows Program

Susanne Campbell, RN, MS, PCMH CCE, CTC-RI Senior Project Director

Carolyn Karner, MBA, CTC-RI Program Coordinator and Data Analyst

Suzanne Herzberg, PhD, MS, OTR/L, CTC-RI Practice Facilitator

Baseline Survey Results

Practice Survey Results

	Hasbro Pediatric Primary Care	*Providence Community Health Center (Central)*
Family visiting program awareness	Early Head Start Early Intervention First Connections	Early Head Start Early Intervention First Connections Health Families America Nurse Family Partnership Parents as Teachers FCCP (Family Care Community Partnership)
Do you know how to make referrals?	No	Yes
Number of referrals a month	0	BVCAP-2 Meeting Street-10
Barriers to making referrals to FV programs	Unaware of what each program provides and the suitability of for each program (differences)	- No internal standard process - No automatic referrals from medical record - Non-uniform methodology of referral - No scheduled workflow in place so it makes it difficult to track referrals
Participation of a joint visit?	No	No
Top three FV programs used by the practice	Early Head Start Early Intervention First Connection	Early Head Start Early Intervention First Connection
Screening process to identify families for FV?	No	- ASQ - Health risk assessment/SDOH screening questions
Helpful to know which families are actively involved with FV?	Yes	Yes
Helpful to be able to contact FV program for care coordination?	Yes	Yes
Resources shared with families	No	Meeting Street pamphlet and DOH referral form
Utilization of KIDSNET?	Yes	Yes
Use of FV tab?	No	No

Suggestion for coordination and communication	Notification when family is involved in a FV program/what services are provided	Liaison at FV agency for practices to contact to make referrals FV programs should standardize referral process to make tracking easier
Topics to expand knowledge	Need to know about each program and what they provide Confusion whether FV practices work collaboratively or overlap Confusion amongst families as well	How other practices make referrals and coordinate care

Family Visiting Survey Results

	Meeting Street	BVCAP
Q3. Percentage of FV services via telehealth	100	100%
Q4. Implementing agency	Community-based non-profit	Community action program
Q5. FV model(s) used at our program serving the community	Healthy Families America	Healthy Families America Parents as Teachers
Q6. Site's use of a management information system to document service delivery	- System developed by a state agency	- We use a system developed by a state agency - We use a system developed by another organization: Effort to Outcomes by Social Solutions
Q7. Languages spoken	English Spanish Swahili	English Spanish Creole
Q8. Number of families enrolled	121	210
Q9. Capacity to accept new referrals	Yes	Yes
Q10. Does the program ask whether a child has a primary source of medical care?	Yes	Yes
Q11. Does the program routinely ask where an enrolled child receives primary medical care?	Yes	Yes
Q12. How many different practices of clinics do children enrolled in your program go to for primary medical care?	5-9	< 5
Q13. Presence of a designated point of contact? (Hasbro & PCHC)	No	No
Q14. Does the program maintain formal agreements with health providers to share this information (refer to Q14)	No	Yes

Q15. Frequency that information is sent to children's primary medical care practice/clinic (Hasbro & PCHC)	Sometimes (both practices)	Sometimes (both practices)
Q16. Frequency of communication with children's providers (Hasbro & PCHC)	Regularly, but no set schedule (both practices)	Only if there are specific concerns (both practices)
Q17. Mode(s) typically used to send communications to an enrolled child's medical provider	Fax/mailed letter Phone call In-person meeting	Faxed/mailed letter Phone call
Q18. Typical reasons the FV program contacts the child's primary care provider	Notify the medical provider that the child is enrolled in FV program Review missed home visit/assist with locating the family Review missed medical visits Review immunization status Inform of specific screening results (development, hearing/vision, etc) Inform of specific health related concerns about the child Discuss specific health related concerns about the child Review medical recommendations given about the child	Notify the medical provider that the child is enrolled in a FV program Review missed home visits/assist with locating the family Inform of specific screening results (development, hearing/vision, etc) Discuss specific health related concerns about the child
Q19. Does the program transport children to their medical visits?	No	No
Q20. Active participation of FV staff during primary care visit (Hasbro & PCHC)	Sometimes (both practices)	Sometimes (both practices)
Q21. Frequency of communication from child's primary care providers (Hasbro & PCHC)	Rarely (both practices)	Rarely (both practices)
Q22. Reason that children's primary care providers contact the FV program about specific enrolled children	- Request health related information from the FV program	- Request health related information from the FV program

		- Discuss health related information from the FV program
Q23. Method that children's primary care provider contacts program	Phone call/Not usually contacted	Phone call
Q24. The attendance of program staff with children for their medical visits (Hasbro & PCHC)	Sometimes (both practices)	Sometimes (both practices)
Q25. Role Policy	No (Protocol)	Yes
Q26. Training policy	Yes	No (protocol)
Q27. Supervision Policy	No	Yes

Q28 Many Family Visiting programs have explicit maternal and child health outcome performance standards. Please indicate whether your program has an explicit standard and whether staff are expected to document each family's status in achieving standard.

Neutral or disagree

- Pediatric primary care providers in my area understand the purpose and services offered by our family visiting program.

Agree / Strongly agree

- Primary care providers of children and FV programs share common goals.
- It is important to communicate with pediatric primary care providers about health-related concerns.
- It is important for a child's primary care provider to know when s/he is enrolled in our program.
- Health promotion for children is an important focus of our FV program.

Q29 How much of a challenge are each of the following reasons to coordinating FV services with primary care providers?

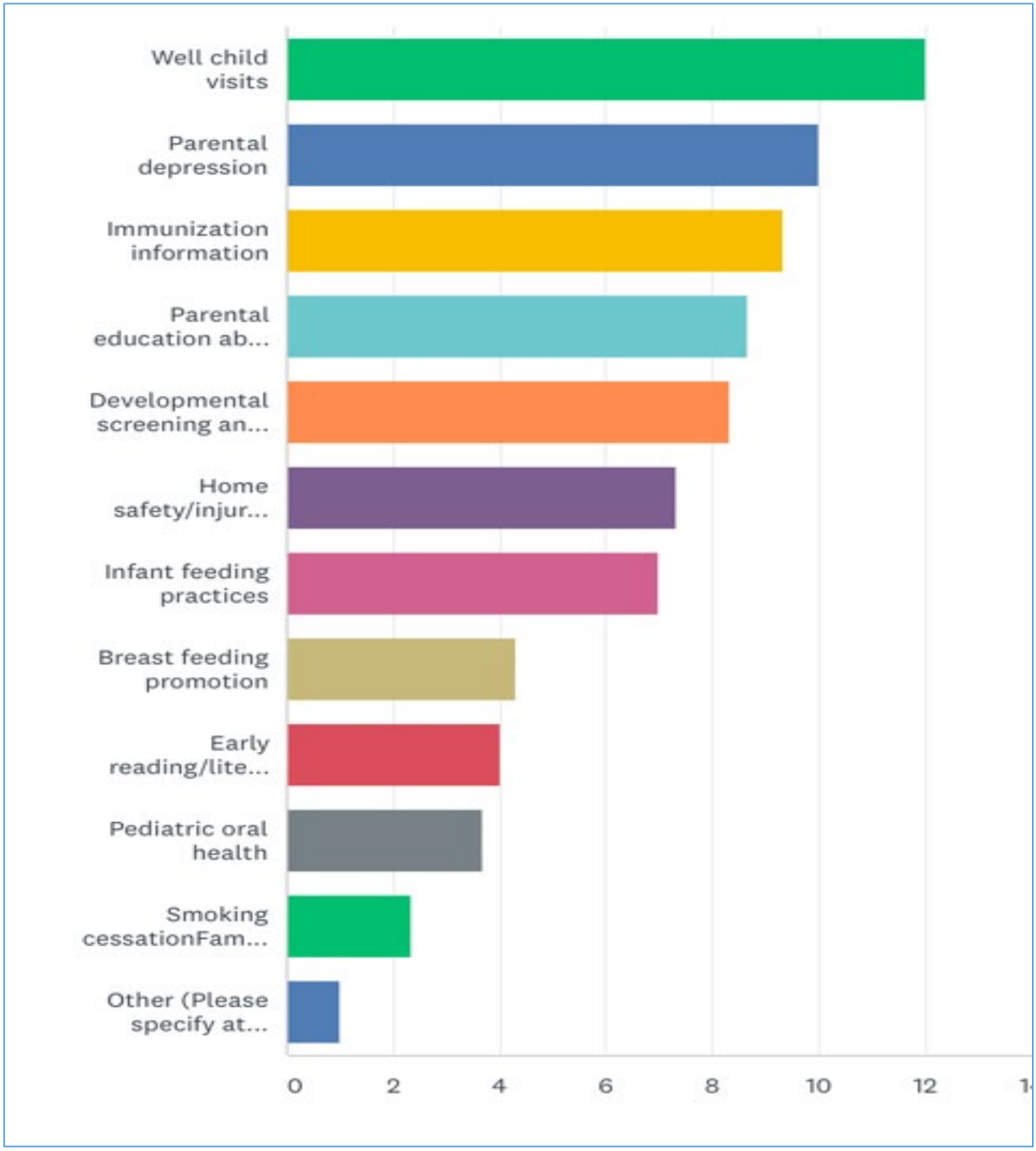
Moderate/Big Challenge:

- *Children's primary care providers not receptive.*
- *Difficult interacting with children's medical practices and the health care system.*

Small/Not a Challenge:

- *Too many pediatric medical practices.*
- *Children do not have primary care providers*
- *Children do not use their primary care provider.*
- *Not a priority of our FV program.*
- *Lack of time.*
- *Lack of training of FV staff to communicate with medical providers.*

Q30 Topics where collaboration would be most beneficial to the clients who you serve? In rank order.



Resources

Healthy Tomorrow Plan-Do-Study-Act Planning Form

Team	**Change idea:**
Cycle # (use a ramp planning form for multiple cycles):	**Start Date:** **End Date:**
What are we trying to accomplish?	
How will we know that a change is an improvement?	
What changes can we make that will result in an improvement?	
Prediction	**If we…** **It will result in…**
Plan	**Plan for this Test** 1. What 2. Who 3. With whom 4. Start Date/End Date 5. Where 6. Task or tools required to setup **Plan for Collection of Data:** 1. What 2. Who 3. With whom 4. Start date/End date 5. Where
Do	Was the test carried out as planned? What did you observe that wasn't part of the plan?
Study	What did the data tell you? *(include here the data that answers the question or prediction you sought to answer with this PDSA)* What surprised you?
Act ☐ **Adapt** ☐ **Adopt** ☐ **Abandon**	What changes are to be made to the process (decisions made/action to take)?

PDSA Tip Sheet

Guidance on completing a PDSA form

Coordinating Comprehensive Healthcare for new families

Coordination between Family Visiting and Medical Homes

Strengthening Service Coordination Between Home Visitors and Pediatric Primary Care Providers

Coordination of early childhood home visiting and health care providers

A Resource for Enhancing Referrals and Care Coordination among Primary Care Medical Homes, Early Intervention Service Providers and Community Service Providers

Well Child Visit adapted for Welcome BabY

Family Visiting Well Child Checkup Map

HV CoIIN Information Resource

Adverse Childhood Experiences: The Case for Funding Primary Prevention