





ADVANCING INTEGRATED HEALTHCARE

Welcome Healthy Tomorrows Lessons Learned from Cohort 1

HEALTHY TOMORROWS 3-28-2022

Agenda

Topic Presenter(s)	Duration
Welcome, Review of Agenda	5 minutes
Improving Referrals to Family Visiting at PCHC	10 minutes
Increasing Knowledge about Family Visiting at Hasbro	10 minutes
What's important to know about Family Visiting from the family perspective	10 minutes
Family Visiting Measures	5 minutes
KIDSNET Family Visiting Report demo	10 minutes
New cast of characters	5 minutes
What to expect at April meeting	5 minutes

Improving Referrals to Family Visiting at PCHC

- We identified contact people at PCHC and at BVCAP
- BVCAP provides a monthly list of shared patients
- We instituted monthly care conferences
 - Process needed to be tweaked so that discussions focused on information that was useful to both groups
 - The number of referrals has increased over time, perhaps due to increased awareness of the programs.
 - We identified categories of patients who may benefit from referral. However, these reports were not run due to staffing challenges.

Improving Referrals to Family Visiting at PCHC - Central

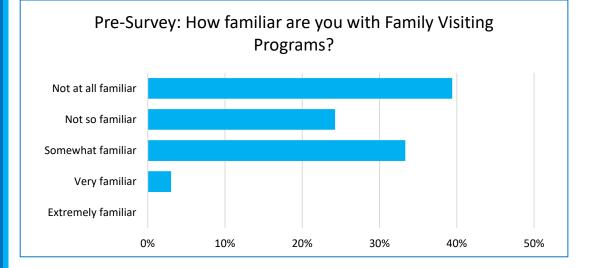
Year	Aug	Sep	Oct	Nov	Dec	Jan (2022)	Total
2021	5	6	4	4	1	7	27
2020	1		5		1		7

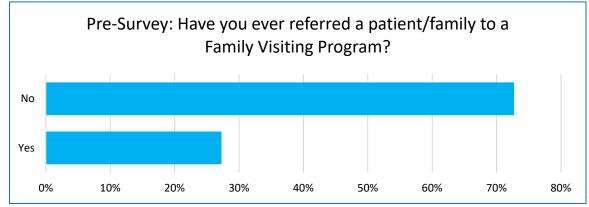
Next Steps:

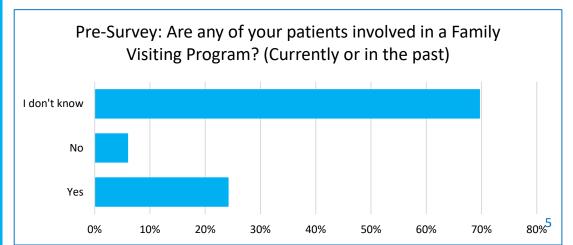
- With new EMR, may be able to integrate referral form.
- Having a centralized referral team that handles referrals to family visiting could streamline the process, including coordinating collaboration and providing more visual information in the EMR.
- Review frequency of meetings may switch to bi-monthly
- Run reports of patients who may benefit from family visiting

Increasing Knowledge about Family Visiting at Hasbro

Survey of residents and faculty: <u>Hasbro Pediatric</u> <u>Primary Care and Family Visiting Programs - Responses | SurveyMonkey</u>







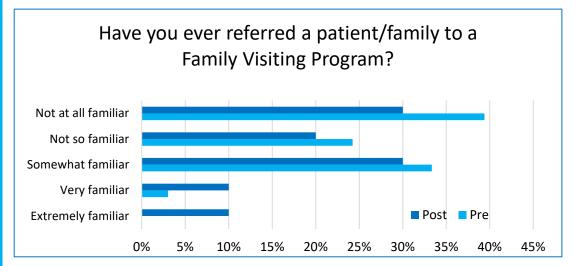
Increasing Knowledge about Family Visiting at Hasbro

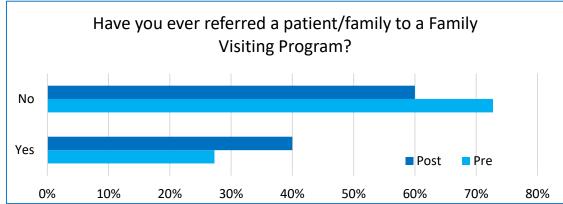
- Educational opportunities, including <u>video provided by</u>
 <u>Meeting Street</u>
- Case conferences with Meeting Street team

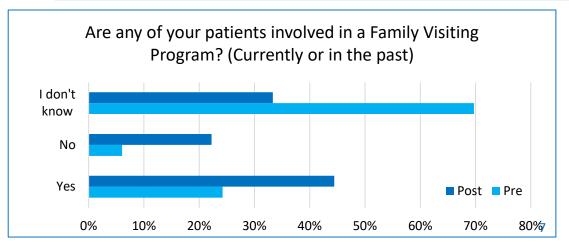


Increasing Knowledge about Family Visiting at Hasbro

Post Survey of residents and faculty: <u>Hasbro</u>
<u>Pediatric Primary Care and Family Visiting Programs - Responses</u>
SurveyMonkey







What's important to know about Family Visiting from the Family Perspective

I think home visiting programs have *access to a lot of resources*- a lot more than a common person can imagine. It does not matter what is your initial request, a good home visitor can *help you navigate* through various available programs and resources and *work with you on both your family urgent needs and long term goals*.

- My Early Head Start home visitor helped me to apply for my husband's Medicaid health insurance when he lost his job and I was completely lost in the application process.
- She also recommended me for the Head Start Policy council and eight years later I am on the National Head Start Association Board.
- She gave my son Dr. Seuss book "Oh, the places you'll go" and signed it for him. Since then I give this book to his teachers every year to sign. It became a good tradition.
- Our Family Visitor made a big impact in the life of my family. We were very fortunate to have her.

What's important to know about Family Visiting from the Family Perspective

Family visiting is a way for a skilled and knowledgeable care worker to **get a closer look on how a child/family is developing and growing**. FV is also a way to help **connect a family to community happenings and programs** available.

The Family Visiting Programs have a variety of goals (ie child development, family health needs, parental supports) these goals are almost impossible to meet with a once yearly 15 minute well visit at the pediatrician or an intake appointment for families at a local resource outreach center for example.

It's a way for the family to get one on one guidance on how their children are doing developing, help with community resources etc.

Family visiting is **NOT just for low income families or children with documented disabilities.**

These programs are for all families can benefit in some way.



What Else Did We Learn from Cohort 1?

OPEN DIALOGUE AND QUESTION & ANSWERS

Family Visiting Outcomes

Data from October 1, 2020 – September 30, 2021

- % of children enrolled in family visiting that received their most recent AAP recommended well child visit (Birth through 36 months) = 80% (个 of 6% over previous reporting period)
 - During the reporting period, Meeting Street HFA and BVCAP HFAs data were 86.6%
- % of infants enrolled in family visiting that are always placed on their back to sleep, without bed sharing and soft bedding (Birth through six months) = 56.2% (↑ of 10% over previous reporting period)

Provisional data for Q1, October 1, 2021 – December 31, 2021:

% of children enrolled in family visiting that received their most recent AAP recommended well child visit (Birth through 36 months)

- BVCAP HFA = 84%
- MS HFA = 92%



Paired Partners

Family Visiting Programs	Pediatric Practices
Parents as Teachers - Westerly	Coastal Narragansett Bay Pediatrics
Healthy Families America - EBCAP	East Bay Health Center
Healthy Families America & Parents as Teachers - BVCAP	Hasbro Pediatric Primary Care
Healthy Families America – Meeting Street	Hasbro Pediatric Primary Care
Healthy Families America* & Parents as Teachers - BVCAP	Providence Community Health Center
Healthy Families America – Meeting Street	Providence Community Health Center

Process Overview

Getting to Know March (Joint Meeting) the Team & **Project**

Identify opportunities to improve well child and develop work plan / next steps

Define standard process (workflow) for screening children and families for FV program and referral

June (Joint Meeting) **Examine Referral** Process – Current State, Lessons Learned & Recommendations

Develop July (Team Meeting) Performance Improvement Plan (PDSA) for improving communication/ relationship processes

Develop tool that could be used for shared care plan

Test process and report out on P-D-S-A

> **Develop strategy** for getting input from families to help inform the process

Content Expert

Develop compact that identifies roles and responsibilities of each party based on testing

Teams report out on parent input

Update P D S A based on data and input from families and report out on number of families with shared care plans

Test process: **BVCAP** and **PCHC**

Meeting Street and Hasbro

Test process: ecember (Team Meeting) **BVCAP** and Hasbro

Meeting Street and PCHC

Develop plan ebruary (Joint Meeting) for sustainability Review survey results

March (Joint Meeting) Lessons Learned (with new Cohort)

We are here

Next Steps

Next Joint Meeting with Cohort 2 (ONLY) April 25, 2022

Getting to know each other

- Practices and Family Visiting Programs to provide head shots and titles for QI teams identified.
- Family Visiting programs to provide example of family that benefitted from the program (with Story, Risk Factors, Intervention and How they were referred) – see sample on next slide
- Family Consultant to provide background on their family (short description, How did they get involved with FV? How did your family benefit from FV? With pictures - see sample slide
- Practices to provide information about practice (structure, # of providers and patient demographics, How the office works) – see sample slide
- Practices to provide "What I'd love to see come out of this project"

SAMPLE: Getting to know Meeting Street / Healthy Families America

Success Story (example of family that benefitted from program): H.P was initially very difficult to engage. The first several months were touch and go as mom would often forget her appointments or the worker would have to chase her around the city to get their appointment done. This slowly began to change as they continued to meet and work through the curriculum, have successful medical appointments and meet goals. When she began the program, mom was overwhelmed with four children, a rocky relationship with dad and lots of stressors. Through her continued work with her HFA visitor, mom is now two years into the program and in a much more stable situation.

Risk Factors: Mom had a history of drug use and mental health issues. She suffered from various medical issues throughout the pregnancy. She had multiple stressors including housing issues, a difficult relationship with FOB that included some IPV and three other children.

Intervention: The family visitor was very consistent with mom. She would meet her wherever was necessary, often having to reschedule or meet in public places throughout the community. The visitor would constantly remind her of doctor's appointments and follow-up afterwards. The worker really pushed mom to create goals and this created an opportunity for her to meet them. As this became more frequent, mom gained confidence and now she is independently making and keeping appointments and reaching out to her worker to let her know about it.

How were they referred? Mom was referred by Meeting Street's WIC nutritionist

SAMPLE: Getting to know Family Consultant –





How did you get involved with Family Visiting? Our family first got involved with FV programs in the state with the birth of our first son. We had Visiting Nurses from the hospital. They came three times to help us adjust to being new parents. We have been involved with Early Intervention for three of our five kids. They received/currently receive speech services through Easter Seals Early Intervention. I am also a certified Parent Educator for the Parents As Teachers Program. I served as a PAT home visitor through the North Kingston school Dept. for 2.5 years before I had my 4th son.

Family (short description of family): My husband, Paul and I met at URI and have been married for 11 years. We have five kids together, four boys and a girl. They are 10, 9, 7, 4, and 1. We live in Warwick, RI. We do most things together as a family. We enjoy hiking, getting together with extended family, and sports.

How did your family benefit from Family Visiting? Our family benefited from FV services by gaining information from trained professionals as to what specific speech therapy needs our children would require. It was safe and easy as they came to our home. I greatly benefited from the transition services that helped us work with the school department to develop my oldest sons IEP.

SAMPLE: Getting to know Providence Community Health Center (PCHC) - Central



Ursulina Bencosme, MD, MPH, Pediatrician



Nadine Hewamudalige, MD, Medical Director



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

Information about practice (structure): Providence Community Health Centers has 11 primary care clinics in Providence, including 3 school based clinics at the MET School, Roger Williams Middle School and Mt. Pleasant High School. Our Central clinic will be participating in this learning collaborative. Each provider has one medical assistant (bilingual) and one RN. There are full time IBH services on site and a dedicated NCM and CHA that are in a centralized location, but meet with patients at the clinic and in the home as well. We also have onsite OBGYN services at all sites.

of providers & patient demographics:

- 3 Family Medicine Providers
- 1 Internal Medicine Provider
- 3 Pediatricians
- 2 OBGYN Providers

How office works: The health center is managed by an onsite Health Center Director and Assistant Health Center Director. We have open access scheduling. We have on site medical records and a lab run by East Side Labs. We have the capabilities in place to perform telehealth visits using Bluestream and Skype for Business, as well as in person visits. A majority of our patients are Spanish speaking. We accept all insurance types, including those who are uninsured.

Thank you Stay Safe and Healthy