ADVANCING INTEGRATED HEALTHCARE

Welcome
Healthy Tomorrows
Workflows for screening children and families for FV program and referrals with parent engagement

HEALTHY TOMORROWS 05-24-2021

Agenda

Topic *Presenter(s)*	Duration
Welcome, Review of Agenda & update on TA meeting *Blythe Berger and Kristin Lehoullier, RIDOH*	5 minutes
Parent Engagement Discussion *Jo Theroux and Katya Nanson*	10 minutes
PCHC - Workflows for identifying children and families in need of Family Visiting support.	10 minutes
Meeting Street – Identification of children/families who might benefit from care coordination with pediatric practices	10 minutes
Hasbro - Workflows for identifying children and families in need of Family Visiting support.	10 minutes
BVCAP – Identification of children/families who might benefit from care coordination with pediatric practices	10 minutes
Next Meeting Deliverables *Susanne Campbell & Team Discussion*	5 minutes

Family Consultants: What is helpful for families?

Some reasons the family would possibly be interested in FV might be

- **Developmental Concerns**
- The opportunity for at **home weight checks for newborns or failure to thrive kids**
- **Breastfeeding support**
- **Sleep issues** or help with a baby to toddler that is having trouble sleeping through the night
- **Family support** for fun activities or for things like mental health and even community engagement opportunities (play groups run by FVP. They could be a good place and time to make that first contact if they are open to all families, not just the one they already signed.)
- **Nutritional support**

Family Consultants: Indicators for clinical team to think about offering FV Programs

- **New to the area**
- **Lack of transportation or car seats**
- **No family support** in the area
- Ratings on the **maternal mental health screening**
- **General hunch** that a parent or caregiver is in a tough spot
- **Lack of proper housing or nutrition**
- Parent brings up **developmental concerns**

Family Consultants: Timeframe for speaking to families about FVP

We discussed that this as **different for each family**. Everyone has a unique situation and the "need" for this service may vary form each caregiver and their circumstance and each age or developmental stage.

We agreed that **too much too soon will be overwhelming** for most. Starting at the very first visit, might be too much for someone who just gave birth a few days ago.

We think that based on some of the Anticipatory Guidance and "Social determinants of health" outlined in each visit in the **Bright Futures guideline book would be a good place for clinical team to start**, realizing it might be a good time to ask a family if they may be interested.

If a baseline is absolutely necessary. We would say 2M, 4M, 6M, 1YR, 18M, 2YR, 2.5YR and 3YR visits.

Family Consultants:
The referral process to Family Visiting

From the parents standpoint, this needs to be the **least amount of steps as possible** (less phone calls, things to fill out, etc.) the better.

The **fewer contacts with the people, the better**, too. This makes it **more personal** and makes it feel like whomever is helping with this process might know the family of the situation on a more personal level.

Susanne suggested that the **“Care Coordinator”** could possibly play a part in this.

Family Consultants: How information might be best received?

- Small, easy to read **brochure of FV information**
- **Poster on the wall** of the Pediatric office (I tend to read them)
- **Scanable QR code** on back of Pediatric Appointment Card (scan it and a quick easy questionnaire or "quiz" for what FV program is right for you and your baby)
- Less random handouts the better. A folder with the information might work for some parents and caregivers.
- An actual **human stopping in before vaccines** or while waiting for someone on the clinical team to see the patient and sharing some info might be helpful.
- Maybe some sort of **"picture book"** showing off the benefits of FV programs for parents to read with kids?? (Just a thought)
- There are 4 or 5 FV programs. If they could be outlined clearly and quickly (the **visual that Sara shared is nice**). It would hook more families.

Family Consultants:
Training sessions for residents

Taping an information session for residents to view as part of a class might be beneficial.

This could have a quick overview of FV and its goal in helping kids and families

Each program can have a rep share a quick snippet about what they are and who they are geared to help.

Maybe include a **quick video of an actual FV session??**

Name of organization: **PCHC - Central**

Identification of point people within practice	Yes	No	In Progress	Comments
IT contact person has been identified and is available to assist with EMR integration	X			Felicia Silva, Tara Lautieri
Analytics person has been identified for report assistance	X			Dan McGuire/team
Practice has identified a practice representative to be point person for referrals to FHV and to receive information from FHV			X	Immediate term: Amy Perry. Long term: Senior NCM role
Practice has identified person to discuss FHV referral with family (FHV point person, provider, care manager). This person has sufficient training to feel comfortable discussing FHV.			X	Could be provider, CHA, NCM. Ideally provider, but anyone who works with pt. **Amy emailed Sara Remington to ask for a training to be done with staff. She'd like to have training recorded so that anyone can watch it. The video could then be part of clinicians' onboarding.** Staff are knowledgeable about the programs but have had no formal training as of yet.

Identifying families who could benefit from FHV	Yes	No	In Progress	Comments
Practice has an established workflow for obtaining information on children missing MMR, well-visits and/or developmental screening. This workflow includes when report will be run, who will run it and who will have follow-up responsibilities			X	These might be areas that the care team could reach out to without referral to FHV. These reports are run regularly (2x/wk). HCAs/Nurses reach out to patients and schedule visits or talk to providers about status. **PCHC wants to think through the process of referring based on outreach to patients.** Some questions include whether a referral is still indicated if a patient shows up to a visit after being contacted. What happens if patient cannot be reached by phone? What if patient is reached but continues to miss appts?

Name of organization: **PCHC - Central**

Identifying families who could benefit from FHV	Yes	No	In Progress	Comments
Practice has an established workflow obtaining information on children missing follow-up visits for asthma, autism, down syndrome and/or obesity. This workflow includes when report will be run, who will run it and who will have follow-up responsibilities		X		These areas are not on missed opp report, except for obesity. Analytics team could support process by pulling reports
Practice has an established workflow obtaining information on children with SDOH concerns.			X	Chelsea had analytics pull an initial report to look at volume, but this would be a new report with details to be arranged. This screening is done at least annually on all patients and for any babies born at Women and Infants.
Practice is familiar with FHV tab in KidsNet and reviews this information before making referrals			X	**Care management could benefit from further instruction in this area.**

Identifying families who could benefit from FHV	Yes	No	In Progress	Comments
Practice has identified workflows to review above information and refer these families to FHV			X	First step would be prioritizing areas of focus and then looking at volume. **There would be two workflows: a formalized workflow for case management to review lists and outreach to patients and an ad hoc one for primary care teams who may identify patient/family who could benefit from services.**
Practice has identified who will discuss FHV program with families and how that will be done	X			Care management team and/or primary care team.
Practice has information to share with patients/families on FHV (brochure, referral form)			X	Amy will check with Sara Remington. There may be a pamphlet created by FHV.

Name of organization: **PCHC - Central**

Protocols

	Yes	No	In Progress	Comments
Practice has a protocol for notifying provider of FHV status before patient visit. There is a place in the EMR to indicate FHV and a designated workflow for entering that information.			X	Centralized person would be able to coordinate notifying provider. This process could be facilitated through the EMR. **Need to figure out from a provider perspective which avenue would be best.** Options include: task, sticky note and/or alert, adding different providers to care team in EMR, including an outside agency.
Clinical staff (providers, NCM/CC, MA, Social workers) have sufficient training to comfortably discuss the FHV process with patients				Discussed above
Practice has workflow for provider to contact point person within practice to arrange for referral to FHV				Discussed above

Referral Process

	Yes	No	In Progress	Comments
Practice has integrated an FHV referral form into EMR		**X**		Not started yet. Amy will check with IT team to see if is possible. May be able to create a referral opportunity. Would be easier process if provider could generate referral through EMR.
Practice is aware of the variety of ways to initiate referral and has that information accessible (fax, email, phone call)			X	Either the referral (if could be generated through EMR) or the care management team could take care of this, probably by fax. Referral team would be preferable.
Practice has standardized visits at which to offer FHV services (ie – newborn appointments)		X		Will consider a general campaign for OB patients. Newborn nurse coordinator at W&I/CHA and pediatricians could have access to information to hand out to all. May be able to upload information through patient portal. May be able to put information on TV monitors in site. Chanita will follow up

Name of organization:	PCHC - Central

Follow up

	Yes	No	In Progress	Comments
Practice has developed a workflow for communicating FHV information to provider and documenting in EMR			X	**Currently, notes get attached as an image and the medical records dep't tasks providers to alert them that there is a new attachment. This process has some breakdowns,** including the timing of the visit related to when the info came through. A centralized person would be able to collaborate with providers and provide something more visual for providers, such as list of collaborators in the care team section.
Practice has developed workflow for tracking progress with FHV team		X		**Many different ways to collaborate. Need to think through what want to accomplish with this pilot.** **Need to have some guidance from the larger group on what is considered progress – what are measurable goals of this pilot?**

Completed by (print name)	Chanita Hall, Amy Perry

Name of organization:	**Meeting Street** Family Visiting – Identification of children/families who might benefit from care coordination with pediatric practices			
Identification of point people within agency				
	Yes	**No**	**In Progress**	**Comments**
Agency has identified a point person to receive and to provide information to/from pediatric primary care practices.	X			Iesha Rocha. Practices can contact via phone or email: 401.261.8687 irocha@meetingstreet.org
Agency is aware of point person within pediatric primary care practice and best method of communication			X	
Identifying areas of collaboration with primary care				
	Yes	**No**	**In Progress**	**Comments**
Agency has a process in place to identify children who are missing well-child visits including who and when to generate report and have follow up responsibilities with primary care	X			Tracking sheet. Have been tracking for the past year – track who has gone and who hasn't gone. Offer to make appts for the families or with them. The information is based on parent report.
Agency has a process in place to identify children who are missing immunizations including who and when to generate the report and follow up responsibilities with primary care			X	Need more formalized procedures. Review KidsNet and review with families. No follow up with PCP in place.
Agency has process in place to identify children with out-of-range screen results including who and when to generate the report and follow up responsibilities with primary care		X		Currently use ASQ tracker for internal only

Name of organization: **Meeting Street** Family Visiting – Identification of children/families who might benefit from care coordination with pediatric practices

Communication with primary care

	Yes	No	In Progress	Comments
Agency has developed a workflow for communicating FHV information to practices		X		Dependent on how practice wants to receive information and what information would be helpful.
Agency has determined together with primary care practice the best mode of communication (email, fax, phone call, in-person meeting). This mode may differ depending on reason for contact (missed well child visits, review screening status, enrollment in FHV, etc.)			X	Will be meeting with primary care practice in July.
Agency has determined frequency/timing of communication with primary care practice		X		
Agency has determined the type of information to share with primary care practice		X		
Agency has developed a template for sharing information		X		
Agency has a formal MOU with pediatric practices regarding information sharing, including reasons for communication		X		

Completed by (print name) Cristina Massey & Iesha Rocha

Name of organization:	Hasbro			
Identification of point people within practice				
	Yes	**No**	**In Progress**	**Comments**
IT contact person has been identified and is available to assist with EMR integration		X		No point person is available. Not a lot of flexibility. Using Epic for Lifespan.
Analytics person has been identified for report assistance	x			Kat will be able to pull reports.
Practice has identified a practice representative to be point person for referrals to FHV and to receive information from FHV				May be difficult to have one point person given size of clinic (10,000 patients, 12 attendings). 60% of patients are seen by 65 residents who are there ½ day/week. There are 14-15 nurses. Staff are divided into practices of 12 residents, with 2 nurses assigned to each micro-practice. If there a problem/issue, Hasbro's ideal situation would be for the agency to contact attending or provider via phone – triage line. 444-4471 option nurse triage line. Hasbro would appreciate a monthly list of all patients receiving services. That list could be sent to attn of Kat. Carol would love to have agency service provider come to a well visit.
Practice has identified person to discuss FHV referral with family (FHV point person, provider, care manager). This person has sufficient training to feel comfortable discussing FHV.				Have identified a need for training to staff/nurses/providers on what programs are available.

Name of organization: **Hasbro**

Identifying families who could benefit from FHV	Yes	No	In Progress	Comments
Practice has an established workflow for obtaining information on any family that has a baby <9 months old who has had a positive Edinburgh postpartum depression screen. This workflow includes when report will be run, who will run it and who will have follow-up responsibilities				Kat is able to pull this information. Not pulled regularly, but have been looking at this information for the IBH program. Fits in nicely with initiative for family visiting program. Hasbro screens at 1,2 4, 6 months. **Families might be involved with home visiting, but not be aware of that label.** Sara is encouraging family visitors to give business card to families to photograph so they can show primary care.
Practice has an established workflow obtaining information on any patient 3 months- 3 years of age missing a PCV13 or a Hep A This workflow includes when report will be run, who will run it and who will have follow-up responsibilities				Gail Davis (?) runs immunization reports. That's how they identify many of their kids at risk. They do reach out to these families, but don't have a protocol for referring to home visiting at that point. First step would be to figure out how to get them in. May need to have a protocol to discuss with parents when come in for that visit.
Practice has an established workflow obtaining information on any family identified by the DOH in 2020 for Plan of Safe Care and/or are a substance exposed newborn.				This was recommended by Dr. Flanagan. This is not something that the practice can run, but these children are automatically referred to First Connections.
Practice is familiar with FHV tab in KidsNet and reviews this information before making referrals				Practice is familiar with the tab but not using it regularly.
Practice has identified workflows to review above information and refer these families to FHV				**Practice would like to have better understanding of when and where to refer.** **One place to refer to get triage to most appropriate service would be helpful.** Practice does review information, which triggers outreach for an appt.

Name of organization:	Hasbro

Identifying families who could benefit from FHV (continued)

	Yes	No	In Progress	Comments
Practice has identified who will discuss FHV program with families and how that will be done				Providers will discuss FHV during visit, following outreach to family.
Practice has information to share with patients/families on FHV (brochure, referral form)				Practice has some First Connection brochures.

Protocols

	Yes	No	In Progress	Comments
Practice has a protocol for notifying provider of FHV status before patient visit. There is a place in the EMR to indicate FHV and a designated workflow for entering that information.		x		**Practice cannot do this as they are not aware of FV status.**
Clinical staff (providers, NCM/CC, MA, Social workers) have sufficient training to comfortably discuss the FHV process with patients		x		**Not always sure of the nature of the programs and what is being offered.**

Referral Process

	Yes	No	In Progress	Comments
Practice has integrated an FHV referral form into EMR		**x**		
Practice is aware of the variety of ways to initiate referral and has that information accessible (fax, email, phone call)	x			Practice is aware of the variety of ways – W&I, self-referral, DOH line (phone, leaving message, fax). **Practice gets consistent follow-up information regarding contact with family, but no longer gets that information once child is enrolled in a program.**
Practice has standardized visits at which to offer FHV services (ie – newborn appointments)		x		May not be appropriate. Some families already involved, some may not need it. Information could be integrated into newborn packet. **Would need guidance on which programs to include – what is being offered.**

Name of organization:	Hasbro

Follow up	Yes	No	In Progress	Comments
Practice has developed a workflow for communicating FHV information to provider and documenting in EMR			x	If information comes through the nurse line, message goes to provider. Does get documented in the patient's chart.
Practice has developed workflow for tracking progress with FHV team		x		Again – **practice doesn't know who is enrolled so that can track this information. Would benefit from monthly list of who is receiving family visiting services.**

Completed by (print name)	Carol Lewis, Gail Davis, Kat Gregory

Name of organization:	**BVCAP** Family Visiting – Identification of children/families who might benefit from care coordination with pediatric practices			
Identification of point people within agency				
	Yes	**No**	**In Progress**	**Comments**
Agency has identified a point person to receive and to provide information to/from pediatric primary care practices.	x			Susan Ribeiro
Agency is aware of point person within pediatric primary care practice and best method of communication			x	No point person has been identified yet. Want to explore how to share information, when to share information, with whom to share information.
Identifying areas of collaboration with primary care				
	Yes	**No**	**In Progress**	**Comments**
Agency has a process in place to identify children who are missing well-child visits including who and when to generate report and have follow up responsibilities with primary care				Has report that can tell wh has missed well child visits and immunizations. Can pull report from ETO.
Agency has a process in place to identify children who are missing immunizations including who and when to generate the report and follow up responsibilities with primary care				When families are missing immunizations, have a protocol of calling practice together with families to try to schedule visits.
Agency has process in place to identify children with out-of-range screen results including who and when to generate the report and follow up responsibilities with primary care				Can check these reports monthly. Shana is pulling these reports. Protocol is to first make sure that data is entered. Next step is for family visitor to review with parent/family during visit and offer to call provider to schedule, address obstacles to attending visit.

Name of organization:	**BVCAP** Family Visiting – Identification of children/families who might benefit from care coordination with pediatric practices			
Communication with primary care				
	Yes	**No**	**In Progress**	**Comments**
Agency has developed a workflow for communicating FV information to practices			x	Currently, let practices know about involvement with families' consent. This happens with a letter, sent through mail (options: declined services, outreaching, is enrolled). Originally, sent ASQs. Now, ASQs are in KidsNet. Would like to know if practices can see ASQs, should they still send the results. Limitation of BVCAP – don't have secure email. Currently, out of office, options are more limited. If KidsNet isn't checked regularly, need another secure option for communication to make sure everyone is on same page. (This applies to all information).
Agency has determined together with primary care practice the best mode of communication (email, fax, phone call, in-person meeting). This mode may differ depending on reason for contact (missed well child visits, review screening status, enrollment in FHV, etc.)		x		
Agency has determined frequency/timing of communication with primary care practice		x		Might need to be hybrid – monthly in general, but more frequently in case of pressing issue.
Agency has determined the type of information to share with primary care practice		x		Needs to be determined with practices and in collaboration with families.
Agency has developed a template for sharing information			x	Have template for enrolled', outreaching, declined. No template for general information.

Name of organization:	**BVCAP** Family Visiting – Identification of children/families who might benefit from care coordination with pediatric practices

Communication with primary care (continued)				
	Yes	**No**	**In Progress**	**Comments**
Agency has a formal MOU with pediatric practices regarding information sharing, including reasons for communication		x		Is this recommended? Required?

Completed by (print name)	Shana DeFelice, Shannon Lemus

Process Overview

Next Steps

Scheduled for **Joint meeting** on June 28th, noon-1PM

OR

Meet in Teams (Practice/FV program)?

- Develop Performance Improvement Plan (PDSA) for improving Well Child Visits
- Develop tool that could be used for shared care plan
  - Teams develops an AIM statement for improving Well Child Visits and Plan
  - How will we measure success?
  - How will we create shared care plan for team meetings?
- Family consultant will make recommendations based on own experience

Stay Safe and Healthy

Resources

Healthy Tomorrows Virtual Resource Binder