
CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

# Welcome
# Healthy Tomorrows Kick Off Meeting
## First Learning Collaborative of 5 year program

HEALTHY TOMORROWS KICK OFF MEETING 03-29-2021

# Agenda

| Topic<br>*Presenter(s)* | Duration |
|---|---|
| Welcome & Overview of Healthy Tomorrows Program<br>*Blythe Berger, RI Department of Health* | 10 minutes |
| Overview of Family Visiting Programs<br>*Sara Remington, Family Visiting RIDOH* | 5 minutes |
| Getting to Know Meeting Street and Blackstone Valley Community Action Program (BVCAP)<br>*Cris Massey, Meeting Street and Shana DeFelice , BVCAP* | 10 minutes |
| Getting to Know our Family Consultants<br>*Joanne Theroux and Katya Nanson* | 10 minutes |
| Getting to Know Hasbro Pediatric Primary Care<br>*Carol Lewis, MD* | 5 minutes |
| Getting to Know Providence Community Health Center – Central<br>*Ursulina Bencosme, MD* | 5 minutes |
| Meet CTC & Next Meeting Deliverables and Timing<br>*Susanne Campbell, CTC-RI Senior Program Director* | 10 minutes |

# Getting to Know
## Rhode Island Department of Health (RIDOH)Team

Blythe Berger,
Healthy Tomorrows
Project Director

Kristin Lehoullier,
Healthy Tomorrows
Project Coordinator

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

# Our Goal

Build and strengthen relationships between pediatricians & family visitors to improve service coordination and help families access

- Health care services, including well child care
- Family visiting services
- Other supports and services they might need (basic needs, jobs, education, etc.)

Increase referrals

- From Pediatricians to Family Visiting
- From Family Visiting to Pediatricians

HEALTHY TOMORROWS
Partnership for Children

# How Will We Do This?

By meeting as a "learning community" to get to know each other and explore ideas and ways to

- Improve information sharing between pediatricians & family visitors
- Improve and coordinate communication with families
- Develop shared understanding of family visiting programs and what they offer families and well-child care
- Find ways for pediatricians & family visitors to share information about resources that could help families with their needs for support

# What Will We Work On Together?

Building relationships with each other

Improving our knowledge of family visiting and well child care

Create tools for collaboration

# How Do We Build The Tools?

- Decide on the processes pediatricians and family visitors will use to communicate with each other
- Decide what kind of reports and/or information pediatricians and family visitors need to improve referrals
- Decide what kind of reports and/or information pediatricians and family visitors need to improve coordination with each other
- Decide what information and communication that families need to feel comfortable engaging in family visiting and/or well child care

# Who Is Participating?

| What Organizations or Community Members are Participating? | Who are we? |
|---|---|
| RI Department of Health | Blythe Berger, RIDOH Project Director<br>Kristin Lehoullier, RIDOH Project Coordinator<br>Sara Remington, RIDOH Program Manager |
| Family Visiting Providers<br>• Meeting Street<br>• Blackstone Valley Community Action Program (BVCAP) | Cris Massey, Family Visitor, Meeting Street<br>Iesha Rocha, Family Visitor, Meeting Street<br>Shannon Lemus, Family Visitor, BVCAP<br>Shana DeFelice, Family Visitor, BVCAP |
| Parent Consultants | Joanne Theroux<br>Katya Nanson |
| Pediatric Practices<br>• Hasbro Pediatric Primary Care<br>• Providence Community Health Center - Central | **Hasbro Pediatric Primary Care**<br>Pat Flanagan, MD, FAAP, PCMH Kids co-chair<br>Carol Lewis, MD, Provider Champion<br>Gail Davis, RN<br>Katherine Gregory, NCM<br>**Providence Community Health Center – Central**<br>Ursulina Bencosme, MD, Provider Champion<br>Nadine Hewamudalige, MD, Medical Director<br>Chelsea De Paula , MPH |
| PCMH Kids | Pat Flanagan, MD, FAAP, PCMH Kids co-chair<br>Susanne Campbell, Senior Project Director<br>Carolyn Karner, Program Coordinator<br>Suzanne Herzberg, Practice Facilitator |

# Rhode Island Department of Health

## Family Visiting Overview

# Family Visiting 101

**Family Visiting Program**

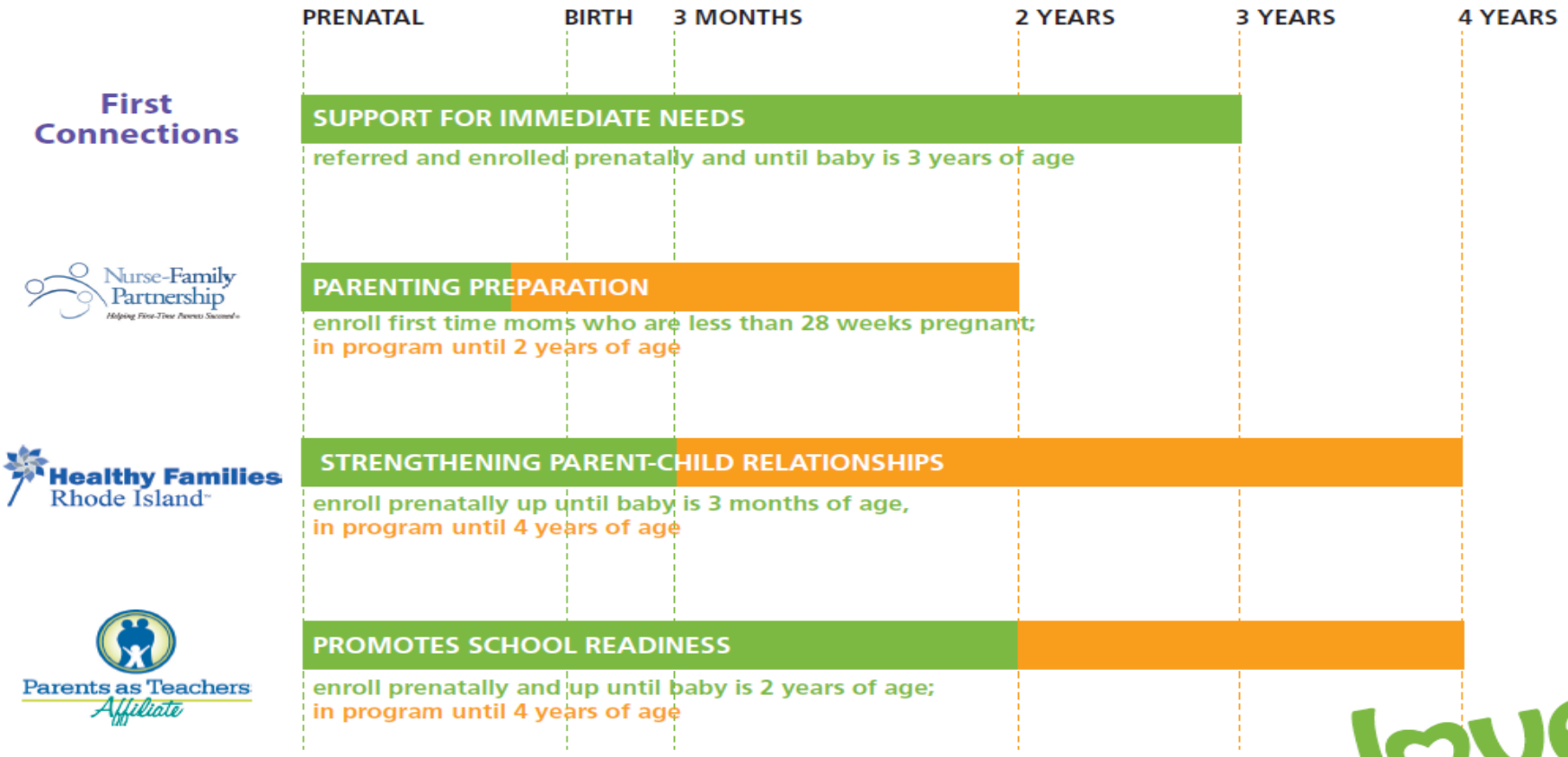
- Foundational program is First Connections. First Connections is RI developed, child-find short term linkage and referral program
- MIECHV and PDG federal funds to implement evidence-based programs (HFA, NFP, PAT)
- Voluntary, home-based service provided during pregnancy and through the early years of a child's life
- Services are administered by the Rhode Island Department of Health (RIDOH) with 15 contracted local implementing agencies that have 23 teams with statewide coverage

Evidence-based programs: Nurse-Family Partnership (NFP), Healthy Families America (HFA) and Parents as Teachers (PAT)

# Family Visiting 101

## What can family visiting support?

- Accessing basic needs
- Connections to community resources, such as WIC, behavioral health
- Assistance with benefit applications
- Breastfeeding support
- Parenting support
- Social/emotional support
- Screenings, including maternal depression, developmental screenings

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# Getting to know First Connections

***Success Story (example of family that benefitted from program):***

Family included a Mom with a 16 month old and 2-week old premature infant. Family currently residing at a hotel due to DV with FOB. Family referred to FC for SW support and RN services for infant care teaching. DCYF referred family for a developmental screening on both children. Upon admission MOB discussed with SW her concerns re: newborn baby. MOB discussed concerns with possible jaundice, feeding, lethargy and baby not waking to feed. MOB called pediatrician but was told baby has appt. the next day and baby could be evaluated at that time. SW consulted with FC RN and Supervisor re: concerns. SW assisted with call to the pediatrician, with MOB on the line, and discussed concerns/need for baby to be seen ASAP. Family was given appt. for that day for baby to be evaluated. MOB took baby in and baby was evaluated. Family given lab slip for bloodwork to be done that day for bilirubin check.

***Reason for Referral:***

High Risk infant born premature at 34 weeks gestation. Family residing in a hotel. MOB victim of DV and with significant mental health history.

***Intervention:***

Family was referred as a high risk level 1 as well as a DCYF CAPTA referral.

***How were they referred?***

# Getting to Know
## Meeting Street

Cris Massey
Program Manager
Healthy Families America

Iesha Rocha
Supervisor
Healthy Families America

# 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

# Getting to Know
## Blackstone Valley Community Action Program (BVCAP)

Shana DeFelice
Program Manager
Healthy Families America
& Parents as Teachers

Shannon Lemus
Supervisor
Healthy Families America
& Parents as Teachers?

# Getting to know
# BVCAP / Healthy Families America

***Success Story (example of family that benefitted from program):*** When we began working with Mom she had recently moved here from Columbia and was having difficulty finding employment. We were able to match her with a Family Visitor who met her language needs. Mom was eager to learn about the program and enjoyed the activities. When we provided her with the information regarding safe sleep, she was agreed to make small changes to the baby's sleeping arrangements and setting goals to make additional changes. Mom also had many goals that she wanted to accomplish for herself. She wanted to apply for and receive her citizenship and open her own daycare. As the baby grew older he was doing well in terms of motor skills, however his communication screening showed a need for an intervention. The Family Visitor spoke to Mom about the options and she stated that she wasn't concerned because he heard that babies who are learning two languages can have delays. She did agree to a referral to Early Intervention and the child is still enrolled in the program. He has made improvements in his communication and is working towards the developmentally appropriate number of words for his age. Mom eventually gave the baby his own space to sleep in that was free of blankets and pillows. We provided the family with a sleep sack because Mom's concern was that he would be too cold without a blanket. Mom also earned her citizenship this month and has a fully licensed daycare.

***Risk Factors:*** cannot name a lifeline: little to no support, basic needs, knowledge of milestones, safe sleep

***Intervention:*** relationship building and developing a working, trusting relationship. Use of Growing Great Kids child development modules and activities, praising Mom's accomplishments, and collaborating with Mom around goals. ASQ screenings and referral to EI

***How were they referred?*** Children's Friend First Connections

# Getting to know Family Consultant – Joanne Theroux

***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.

# Getting to know Family Consultant – Katya Nanson

***Family (short description of family):*** I live in Bristol with my husband and two boys (Ivan - 9 and Yuri-4). Ivan is in 3rd grade. He has been on Distance Learning since last March. Yuri is with Home based Head Start program (EBCAP).

***How did you get involved with Family Visiting?*** The first Family Visiting program that I was involved with was Visiting Nurses right after Ivan was born 9 years ago. Since then I had experience with Family visiting Early Head Start, Head Start, HFA, Parents as Teaches, Mom-to-Mom.

***How did your family benefit from Family Visiting?*** They helped in so many different ways. It was a great support for the first time mom reassuring that everything was going fine and developing in the right direction. They gave access to various resources that I would never find otherwise. I think Ivan's first significant adult outside the immediate family was his family visitor at the time. He remembered her name and was excited to see her every week.

# Family Consultants "What I'd love to see come out of this project"

**Jo Theroux:** I would like to see a more streamlined way for families to connect to a representative from the various FV programs that the state offers. This could be at the pediatrician's office or a possible workshop set up quarterly, for example at local libraries or WIC clinics. If there was a phone hotline that could be used that would also be helpful. I think having a child development screener for speech, OT, PT, etc., it would be greatly utilized at pediatrician's office. This point of contact could screen the "at-risk" kids, then provide a knowledgeable "next-step" for the family. This contact or the pediatrician would follow up. The challenge is engaging families. If this can be done at the pedi visits in an easy and friendly way I think more participants would benefit from the great FV programs RI has to offer.

**Katya Nanson:** I hope there will be open line communication between pediatric practices and family visiting programs that will help to identify the needs of the families and provide support to them in the most efficient way. Possibly some basic communications could be formalized down to protocols to make interactions easier.

# Getting to know Hasbro Pediatric Primary Care

Patricia Flanagan, MD

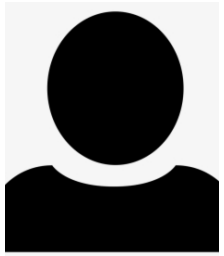
Professor and Vice Chair Department of Pediatrics Warren Alpert Medical School Brown University; Associate Pediatrician-in-Chief Hasbro Children's Hospital

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

# Getting to know Hasbro Pediatric Primary Care

**Information about practice (structure):** Hasbro Children's Hospital Primary Care is a pediatric primary care practice affiliated with the Warren Alpert Medical School of Brown University. Located in Providence, RI, it is an urban practice with the majority of patients stemming from resource poor communities. Approximately, 40% of patients have an attending pediatrician as their PCP and the remaining 60% have resident physicians. The practice is divided into 10 micro practices that are each staffed with 6-12 pediatric residents, 2 supervising attendings and 1-2 nurses. The resident PCPs see patients one half day a week. Historically, we have had integrated behavioral health. We are recognized as a Patient Centered Medical Home and have a designated care coordinator. We have children with complex care needs who are managed by a specific complex care provider and care coordinator. We also have a refugee health program and a fostering health program. We have a LICSW integrated within our practice as well as a staff from CEDAR.

***# of providers & patient demographics:***

10 Attendings; 2 NPs; 15 Nurses (14 RNs and 1 LPN); 1 Program Administrator; 1 LCSW
CEDAR
Connect for Health
4 Outpatient Service Representative/Administrators; 6 MAs
10,000 patients
>90% Medicaid
Providence, Pawtucket, Central Falls and Woonsocket areas

***How office works:*** Patients can schedule well care appointments through the portal or lifespan call center which they can reach by calling our clinic number. Urgent care visits are scheduled through the nurse or administrative staff. Care coordination is a team effort with care provided by physicians, micro practice nurses, and the care coordinator all working together.

# 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.

# Primary Care Practices "What I'd love to see come out of this project"

**Hasbro Pediatric Primary Care:**

1. Learn more about family visiting programs.
2. Streamline communication to promote more team-based care and avoid gaps in care while also avoiding overlapping services.
3. Establish relationships between outside community providers and pediatric community providers.

**Providence Community Health Center – Central:**

1. Develop a best practice for submitting and tracking family visiting referrals for our practice.
2. Build a stronger relationship with Meeting Street and designate a liaison at Meeting Street and Central to improve care coordination and communicate.
3. Learn more about the family visiting programs and resources available for our patients.

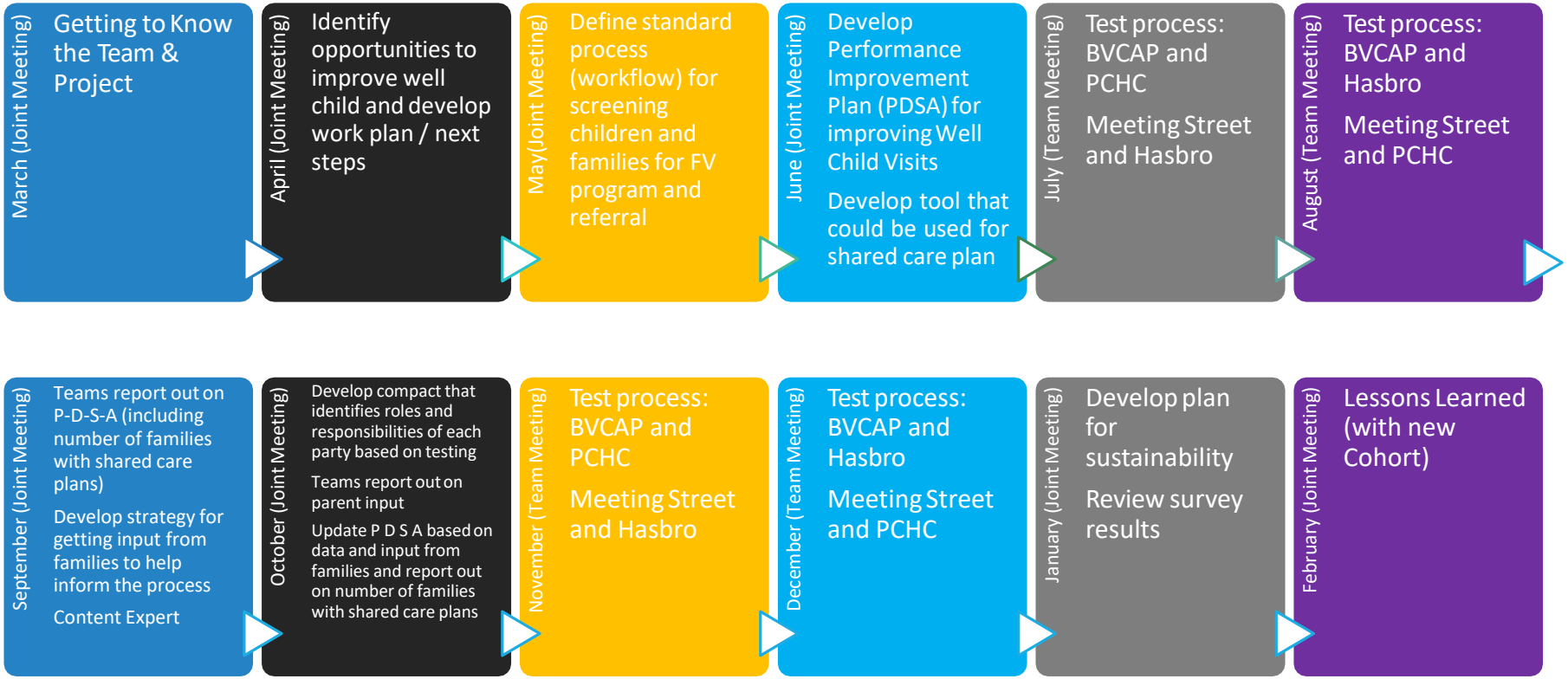
# Getting to Know the CTC Team

- **Susanne Campbell**, RN, MS, PCMH CCE
  - Senior Project Director

- **Carolyn Karner**, MBA
  - Program Coordinator and Data Analyst

- **Suzanne Herzberg**, PhD, MS, OTR/L
  - Practice Facilitator

# Process Overview



# Next Meeting

Meeting 2 (Joint meeting): Identify opportunities to improve well child and develop work plan / next steps

Objective: Mutual understanding of present state of collaboration and identification of future state

Meeting prep:

***Family Visiting:***

Comes to the meeting with data of all children enrolled in HFA at BVCAP and Meeting Street that report one of our practice partners as their medical home.

***Pediatric:***

Comes to meeting with high risk framework & categories selected by practices

Date / Time?

# Stay Safe and Healthy

# Milestone Document

| Rhode Island Healthy Tomorrow Milestone Summary | | | |
|---|---|---|---|
| **Deliverable** | Timeframe Due Dates | Goal | What is needed |
| **Pre-work: Identify members of the practice quality improvement (QI) team;**<br><br>**The pediatric practice team and FV program complete and sign the Participative Agreement and identify Quality Improvement Team Members and complete pre-survey information**<br>**Family consultant(s) sign letter of agreement** | February 2021<br><br>Done by each team prior to Kick off Meeting as part of Team Commitment Participative Agreement | <u>Commit to Action</u><br>Family visiting program and practice team commit to action by completing:<br>Pre-survey<br>Participative Agreement<br>Members of the quality improvement team | Participative Agreement, including section to identify QI team members, and link to pre-survey<br>FV story form template<br>Practice and FV information form template<br>Pre-survey<br><br>Materials to be sent out 2 weeks before kickoff meeting |
| **Meeting 1: Joint Meeting**<br>**FVH describes a patient story from each of the FVH programs and how FVH has been helpful improving well child care**<br>**Pediatric practice comes to meeting with story of referral to FV program and how FV program is has been helpful in improving well child care**<br>**Family Consultant describes experience of well child care: FV and Pediatric practice** | March 2021 | <u>Mutual Awareness and relationship building</u><br>Pediatric practices will learn more about the family visiting program through hearing about family examples of how each program can improve well child care through their programs;<br>Family visiting program will learn more about how pediatric practice used FV to improve well child care<br>FV and Pediatric Practice learn from parent consultant what has been helpful, barriers to well child care and recommendations | FV will present story form information at meeting.<br><br>FV and practices will present information form at meeting<br><br>Will discuss data needed and format for presentation for Joint Meeting #2 and work plan tool |
| **Meeting 2: Joint meeting: Asset mapping and work plan**<br><br>**<u>FV:</u> comes to the meeting with data**<br>**# of children presenting being visited from pediatric practice**<br>**# of referrals from pediatric practice in last year**<br>**Parent interview information**<br>**<u>Pediatric:</u>**<br>**# 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 | <u>Mutual understanding of present state of collaboration and identification of future state</u><br><br>FV and Pediatric Practices will identify opportunities to improve well child and work plan next steps | Data Reports<br>Work plan tool<br>Identification of what each team will do to prepare for Meeting # 3 (i.e. referral template; work flow template) |

| Deliverable | Timeframe | Goal | What's Needed |
|---|---|---|---|
| **Meeting 3 Joint Meeting Tools and Work flow for screening and referral**<br>**Pediatric practice will come to the meeting with information on current work flow for identifying children and families in need of support for well child care and current referral process**<br>**FV will come to the meeting with current process for identifying children and families who are behind on well child care**<br>**Teams will identify improved work flow for screening and referring**<br>**Family consultant will make recommendations based on own experience** | May 2021 | Relationship building and Identification of standardized process (workflow) for screening children and families for FV program and referral | Work flow tool<br>Referral template<br><br>Needed for Meeting # 4:<br>P D S A template<br>Shared care plan template<br><br>Identification of what is needed for Meeting # 7<br>Parent information template if needed |
| **Meeting 4: Joint meeting Performance Improvement and shared care plan**<br>**Teams develops an AIM statement for improving Well Child Visits and Plan**<br>**How will we measure success?**<br>**How will we create shared care plan for team meetings?**<br>**Family consultant will make recommendations based on own experience** | June 2021 | Relationship building and Identification of Performance Improvement Plan and tool that could be used for shared care plan | Performance improvement plan<br>Template for a shared care plan<br>Teams will identify plan for meeting in July and August (date/time/place)<br>Identify suggestion for content expert for meeting # 7 |
| **Meeting 5: Team meeting**<br>**Test process: BVCAP and PCHC**<br>**Meeting Street and Hasbro** | July 2021 | Relationship building and Test team meeting process | Update PDSA at team meeting |
| **Meeting 6: Team meeting**<br>**Test process: BVCAP and Hasbro**<br>**Meeting Street and PCHC** | August 2021 | Relationship building and Test team meeting | Update PDSA at team meeting and submit to CTC |
| **Meeting 7 Joint meeting**<br>**Content Learning speaker**<br>**Teams will report out on P-D-S-A (including number of families with shared care plans)**<br>**Develop strategy for getting input from families to help inform the process** | September 2021 | Relationship building, learning from each other and learning from content expert; improving collaboration experience based on tests for change | Parent input process<br>Recommendations for content expert for next meeting based on present learning needs<br>Provide sample compact template that could be used for next meeting |

| Deliverable | Timeframe | Goal | What's Needed |
|---|---|---|---|
| **Meeting 8 Joint meeting**<br>**Develop compact that identifies roles and responsibilities of each party based on testing**<br>**Teams report out on parent input**<br>**Update P D S A based on data and input from families and report out on number of families with shared care plans** | October 2021 | Relationship building and Teams will formulate compact/Memorandum of Understanding for communication expectations | Compact<br>Plan for reaching 75% of families with shared care plans if goal has not already been achieved |
| **Meeting 9: Team Meeting**<br>**Test process**<br>**BVCAP and PCHC**<br>**Meeting Street and Hasbro** | November 2021 | Relationship building and Test improved process | Update P D S A |
| **Meeting 10: Team meeting**<br>**Test process**<br>**BVCAP and Hasbro**<br>**Meeting Street and PCHC** | December 2021 | Relationship building and Test improved process | Update P D S A and submit<br>Distribute post survey |
| **Meeting 11: Final PDSA Joint meeting**<br>**Develop plan for sustainability**<br>**Post survey results** | January 2022 | Plan is developed to sustain communication and care coordination with standardized screening/referral process and utilization of shared care plan; | Post survey |
| **Meeting 12: Joint meeting with new cohort**<br>**Lessons learned** | February 2022 | Prepare for spread with new cohort and building of a learning community between pediatric and FV programs | |

# Who is Participating?

| What Organizations or Community Members are Participating? | What is their Role? | Who are they? |
|---|---|---|
| PCMH Kids | Project Management<br>Planning and Facilitation of the Learning Community | Pat Flanagan, PCMH Kids co-chair<br>Susanne Campbell, Senior Project Director<br>Carolyn Karner, Program Coordinator<br>Suzanne Herzberg, Practice Facilitator |
| Pediatric Practices<br>• Providence Community Health Center<br>• Hasbro Pediatric Primary Care | Participate in Learning Community<br>Develop ideas to achieve project goals<br>Try things out and see what works | **Hasbro Pediatric Primary Care**<br>Pat Flanagan, PCMH Kids co-chair<br>Carol Lewis, MD, Provider Champion<br>Gail Davis, RN<br>Katherine Gregory, NCM<br>**Providence Community Health Center – Central**<br>Ursulina Bencosme, MD, Provider Champion<br>Chelsea De Paula , MPH |
| Family Visiting Providers<br>• Blackstone Valley Community Action Program (BVCAP)<br>• Meeting Street | Participate in Learning Community<br>Develop ideas to achieve project goals<br>Try things out and see what works | Shannon Lemus, Family Visitor, BVCAP<br>Shana DeFelice, Family Visitor, BVCAP<br>Chris Massey, Family Visitor, Meeting Street<br>Danita Roberts, Family Visitor, Meeting Street |
| Department of Health | Project Oversight<br>Liaison to Federal Grant Officer<br>Reporting | Blythe Berger, RIDOH Project Director<br>Sara Remington, RIDOH Program Manager<br>Kristin Lehoullier, RIDOH Project Coordinator |
| Parent Consultants | Participate in Learning Community<br>Share lived experience as a parent<br>Contribute to ideas to achieve project goals | Joanne Theroux<br>Katya Nanson |