CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Healthy Tomorrows Quarterly Meeting

April 24, 2023

Care Transformation Collaborative of RI

Agenda

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Topic	Presenter	Time
Welcome and Review of Agenda	Susanne Campbell, CTC-RI Pat Flanagan, CTC-RI, PCMH Kids	12:00pm - 12:05pm
RIDOH Family Visiting Overview and Data	Sara Remington, RIDOH	12:05pm - 12:20pm
Pre-Program Survey Results	Kim Nguyen-Leite, CTC-RI	12:20pm - 12:30pm
Team Introductions & Discussion	Care New England Family Care Center & Children's Friend Thundermist West Warwick & CCAP Dr. Susan Stuart & Westerly PAT	12:30pm – 12:55pm
Meeting Close and Next Steps	Kim Nguyen-Leite, Program Coordinator, CTC-RI Susanne Campbell, Senior Program Administrator, CTC-RI	12:55pm - 1:00pm

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Rhode Island Department of Health

Family Visiting Overview

Prepared by RIDOH for CTC-RI

ADVANCING INTEGRATED HEALTHCARE

Getting to Know
Rhode Island Department of Health (RIDOH) Team
Office of Family Visiting

Kelsey Blinn,
Contract Manager/CQI Coordinator

Sara Remington,
Program Manager

Luisa DePina,
Family Engagement Specialist

Sidra Scharff,
Implementation Specialist

Carol Votta,
Professional Development and Training Coordinator

Pat Luce,
Data Analyst

Alex Busuito,
First Connections Manager

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 contracted local implementing agencies
- Services are offered statewide

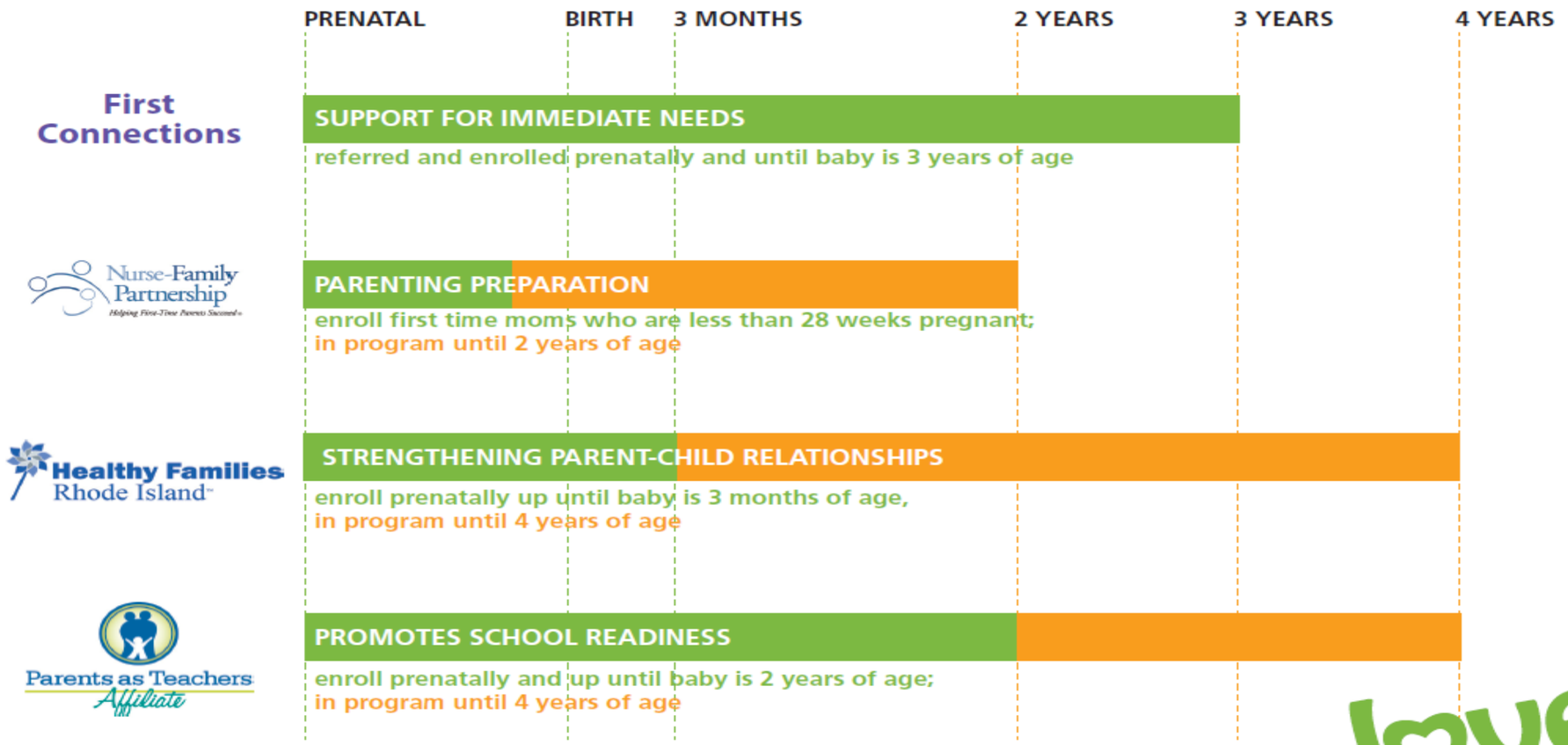
Evidence-based programs: Nurse-Family Partnership (NFP), Healthy Families America (HFA) and Parents as Teachers (PAT)

Family Visiting 101

ADVANCING INTEGRATED HEALTHCARE

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
- Supporting early relational health
- Screenings, including maternal, depression, developmental screenings, substance use, IPV



This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under D89MC28279 Affordable Care Act- Maternal, Infant and Early Childhood Home Visiting Program $9,272,115.00. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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RI Data

ADVANCING INTEGRATED HEALTHCARE

Timeframe: July 1, 2022 – December 31, 2022

Healthy Families America highlights:

- 97% of primary caregivers were screened for depression during the enrollment period (PHQ-9)
- Over 82% of children enrolled had their most recent well child visit
- Over 73% of children enrolled that needed support after a developmental screening were either evaluated by Early Intervention or received a similar type of support to a child's development

Parents as Teachers highlights:

- 85% of children enrolled had their most recent well child visit
- Over 95% of caregivers enrolled reported that they sang songs, read or told stories to their children every day during a typical week
- 90% of primary caregivers were screened for interpersonal violence during the enrollment period (OAS).

Nurse-Family Partnership highlights:

- 80% of children enrolled during the time period were sleeping safely- always put to sleep on their back, without soft bedding, no bed sharing
- 83% of enrolled moms were breastfeeding their infants at six months of age
- Over 96% of enrolled mothers were screened for substance use disorder (DAST-10)

General

Approximately over 7,300 visits were done during the time period (HFA & PAT)

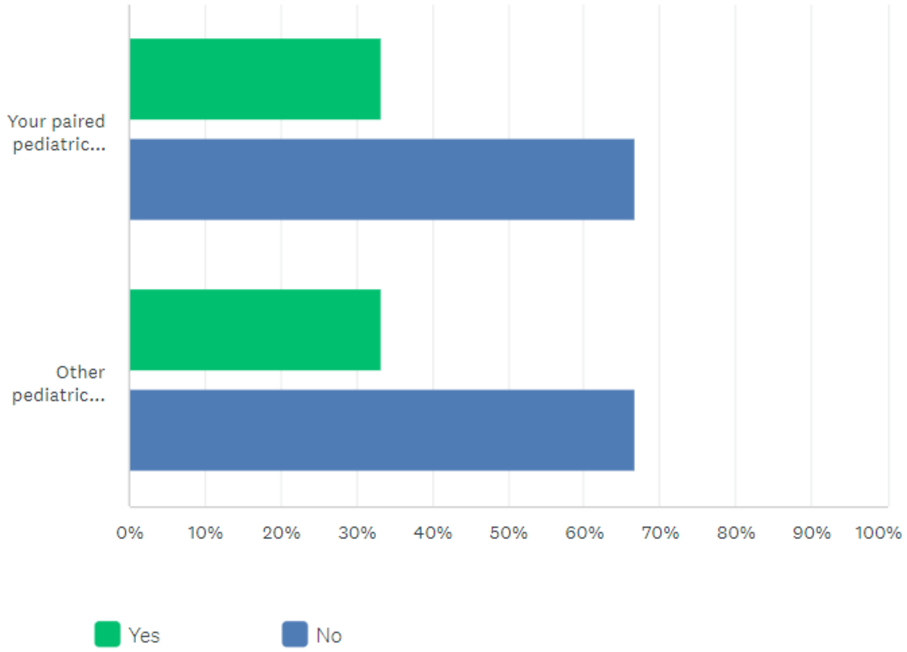
Pre Program Survey Data

Family Visiting Survey Data

ADVANCING INTEGRATED HEALTHCARE

Do you have a designated point of contact to communicate with:

Answered: 3 Skipped: 0



	YES	NO	TOTAL	WEIGHTED AVERAGE
Your paired pediatric practice	33.33% 1	66.67% 2	3	1.67
Other pediatric practices	33.33% 1	66.67% 2	3	1.67

Family Visiting Survey Data

ADVANCING INTEGRATED HEALTHCARE

How often do you communicate with:

	REGULARLY, AT TIMED INTERVALS	REGULARLY, BUT WITH NO SET SCHEDULE	SOMETIMES	ONLY AT PROGRAM ENROLLMENT AND/OR DISCHARGE	ONLY IF THERE ARE SPECIFIC CONCERNS	NEVER	TOTAL
Your paired pediatric practice	0.00% 0	0.00% 0	33.33% 1	33.33% 1	33.33% 1	0.00% 0	3
Other pediatric practices	33.33% 1	0.00% 0	33.33% 1	0.00% 0	33.33% 1	0.00% 0	3

What methods(s) of communication do you typically use to contact your paired Pediatric site? (check all that apply)

ANSWER CHOICES		RESPONSES	
Faxed/mailed letter		66.67%	2
Phone call		66.67%	2
Care Conference Meeting		0.00%	0
Telehealth co-visit		0.00%	0
None/Not applicable		0.00%	0
Other (please specify):	Responses	33.33%	1
Total Respondents: 3			

Family Visiting Survey Data

ADVANCING INTEGRATED HEALTHCARE

Please identify the typical reasons your Family Visiting program contacts your paired Primary Care provider team (check all that apply):

ANSWER CHOICES		RESPONSES	
To notify the medical provider that the child is enrolled in Family Visiting Program		33.33%	1
To review missed home visits/assist with locating the family		0.00%	0
To review missed medical visits		0.00%	0
To review immunization status		33.33%	1
To inform of specific screening results (development, hearing/vision, etc.)		66.67%	2
To discuss specific health-related concerns about the child		66.67%	2
To review medical recommendations given about the child		33.33%	1
Other (please specify):	Responses	33.33%	1
Total Respondents: 3			

Family Visiting Survey Data

ADVANCING INTEGRATED HEALTHCARE

Select all the reasons your paired Primary Care practice site contacts your program? (Check all that apply):

ANSWER CHOICES		RESPONSES	
To discuss missed home visits		0.00%	0
To discuss planned medical visits		0.00%	0
To discuss specific health-related concerns the health care provider identified		0.00%	0
To request health related information from the Family Visiting program		0.00%	0
Not applicable/Practice doesn't contact the Family Visiting agency		66.67%	2
Other (please specify)	Responses	33.33%	1
Total Respondents: 3			

Family Visiting Survey Data

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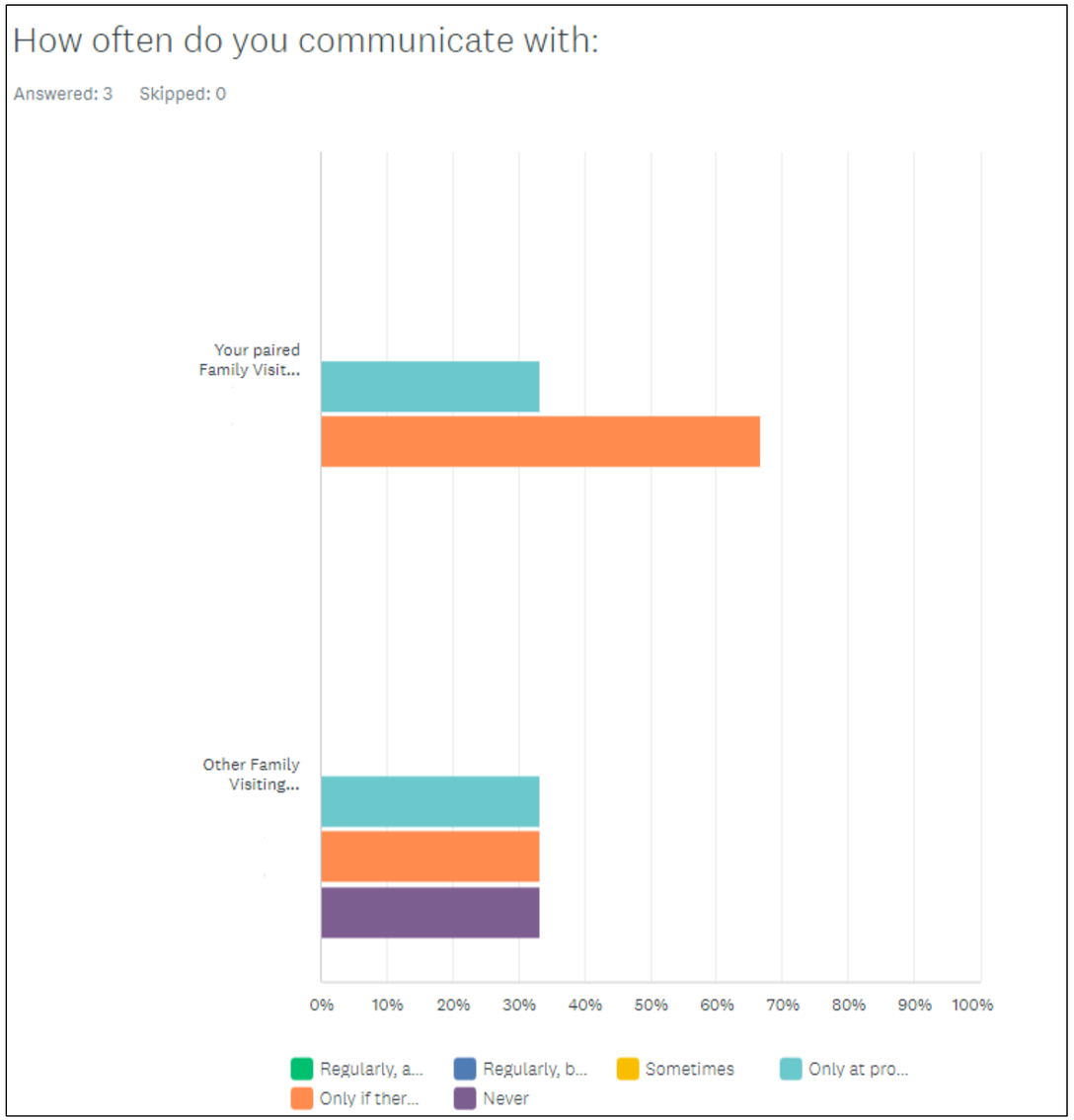
Strongly Agree or Agree with the following statements:

- I can describe the features of the Pediatric medical home
- I can communicate with the family the importance of the Pediatric medical home
- The paired Primary Care team and my Family Vising program share common goals

Strongly Disagree or Disagree with the following statements:

- I know who the designated contact from my program's paired pediatric practice is and how to contact them
- Our program has a Family Visitor/Collaborative Agreement with our paired pediatric practice that identifies care coordination and communication expectations.
- Our program has scheduled time for care conferences with our paired pediatric practice
- Our program has scheduled time for care conferences with other pediatric practices
- The paired Pediatric practice has used Family Visiting to find a family that has missed well child visits or to help meet health goals

Practice Survey Data



	REGULARLY, AT TIMED INTERVALS	REGULARLY, BUT WITH NO SET SCHEDULE	SOMETIMES	ONLY AT PROGRAM ENROLLMENT AND/OR DISCHARGE	ONLY IF THERE ARE SPECIFIC CONCERNS	NEVER	TOTAL
Your paired Family Visiting program	0.00% 0	0.00% 0	0.00% 0	33.33% 1	66.67% 2	0.00% 0	3
Other Family Visiting programs	0.00% 0	0.00% 0	0.00% 0	33.33% 1	33.33% 1	33.33% 1	3

Practice Survey Data

ADVANCING INTEGRATED HEALTHCARE

What methods(s) of communication do you typically use to contact your paired Pediatric site? (check all that apply)

ANSWER CHOICES		RESPONSES	
Faxed/mailed letter		33.33%	1
Phone call		100.00%	3
Care Conference Meeting		0.00%	0
Telehealth co-visit		0.00%	0
None/Not applicable		0.00%	0
Other (please specify):	Responses	0.00%	0
Total Respondents: 3			

Practice Survey Data

ADVANCING INTEGRATED HEALTHCARE

Please identify the typical reasons your practice contacts your paired Family Visiting program (check all that apply):

ANSWER CHOICES		RESPONSES	
To make a referral for home visiting to meet the needs of the child		100.00%	3
To make a referral to meet the needs of the caregiver/family		33.33%	1
To review missed medical visits		33.33%	1
To review delayed immunization status		0.00%	0
To inform of specific screening results (development, hearing/vision, etc.)		33.33%	1
To discuss specific health-related concerns about the child		100.00%	3
To review health related social needs		66.67%	2
Other (please specify):	Responses	0.00%	0
Total Respondents: 3			

Practice Survey Data

ADVANCING INTEGRATED HEALTHCARE

Select all the reasons your paired Family Visiting practice contacts you? (Check all that apply):

ANSWER CHOICES		RESPONSES	
To discuss missed home visits		0.00%	0
To discuss planned medical visits		0.00%	0
To discuss health related social needs		33.33%	1
To discuss specific health-related concerns the Family Visitor identified		100.00%	3
To request health related information from the Pediatric practice		66.67%	2
Not applicable/paired Family Visiting program doesn't contact the practice		0.00%	0
Other (please specify)	Responses	0.00%	0
Total Respondents: 3			

Practice Survey Data

ADVANCING INTEGRATED HEALTHCARE

Strongly Agree or Agree with the following statements:

- I can communicate with the family the importance of the Family Visiting program to my patients
- The paired Family Visiting staff welcomes my communication about health-related concerns
- The paired Family Visiting staff understands the purpose and services offered by our Pediatric practice.
- The paired Family Visiting program and my Pediatric practice staff share common goals.

Strongly Disagree or Disagree with the following statements:

- Our practice has a Family Visitor/Collaborative Agreement with our paired Family Visiting program that identifies care coordination and communication expectations
- Our practice has scheduled time for care conferences with our paired Family Visiting program.
- Our practice has scheduled time for care conferences with other Family Visiting programs

Team Introductions

CNEMG Family Care Center

Care New England

Pawtucket, RI

Practice serving the people of Pawtucket and Central Falls with the goal of reducing health disparities.

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

Team Members

Dr. Marybeth Sutter, MD
Debra Moorhead, Academic Social Worker
Jalyn Alzate, Referral Coordinator, Family Specialist

Getting to Know CNEMG Family Care Center

Providers and Patient Demographics

- Family and Internal Medicine (15+)
- Resident Training
- ≈ 190 Newborns a year
- Participating in DULCE Learning Collaborative

Family Story

- Newborn
- Familial structure
  - Siblings: 9-month-old and 3-year-old with Autism
  - Mom has Diabetes
- Additional Information: Family living in poverty and has barriers with transportation
- Family Visitor attends visits with family

Experience with Family Visiting

- Familiar with making referrals to Family Visiting
- Family Visitor has contacted provider about newborns and provided information about the home

Why join the learning collaborative?

- Strengthen relationship with Family Visiting
- Create a process for regular communication

Getting to Know
Children's Friend Healthy Families America Program

Maggy Jeremie
Bilingual Family Support Specialist

Alba Pinales
Bilingual Family Support Specialist

Michelle Hirst
Supervisor

Getting to know Family Visiting

Children's FRIEND

Our Mission: *Children's Friend is the innovative leader in improving the well-being and healthy development of Rhode Island's most vulnerable young children.*
We were founded in 1834 and primarily serve Rhode Island's urban core, although some services are statewide. The agency provides a wide array of services including Healthy Families America, Nurse Family Partnership, First Connections, EI, Early Head Start, Head Start, WIC, Permanency Services, Project Connect, and FCCP.

Success Story (example of family that benefitted from program): *Maggy was able to help mom transfer to Care New England's Family Care Center as it was closer to home and easier for mom to access than the practice that she'd been randomly assigned by the baby's insurance. Until becoming involved in HFA when baby was about 3 months old, mom had only been able to get baby to his first pediatric appointment. He was falling behind in his well-child visits until Maggy was able to connect mom to the new practice and attend the first few appointments with her.*

Risk Factors: *New immigrant mom fleeing significant trauma in her home country, including the murder of her husband and having to leave her 5-year-old daughter behind when she fled. She has few supports in the area and limited financial resources , as well as language and transportation barriers.*

Intervention: *By coordinating with the pediatric practice, Maggy was able to help mom get baby back on track with well-child care as well as making sure practice was able to meet her language and transportation needs. Practice is coordinating an Uber for mom when they schedule her next appointments.*

How were they referred? *First Connections*

Why join the learning collaborative? (goals and hopes for project): *Michelle was lucky to be able to shadow the work done by Healthy Tomorrows cohort 2 as part of the program's participation in a health equity CQI project and this is a great opportunity to continue to expand the work we started with that project.*

Thundermist West Warwick

Thundermist HEALTH CENTER

West Warwick, RI

Dr. Jessica Marrero

FQHC providing full spectrum primary care to all. Thundermist was the first Rhode Island community health center to achieve patient centered medical home accreditation from NCQA. Thundermist receives Health & Human Services (HHS) and grant funding to provide patients with progressive, comprehensive health care. Our medical services include adult medicine, pediatrics, OBGYN care, geriatrics, gender care, medication assisted therapy, urgent care, behavioral health services such as therapy and medication management, and dental care. We additionally have social services, community health services, home visit services, a community garden, and weekly farmer's markets in spring/summer. All of our buildings are fully accessible to patients and staff with mobility challenges. We have an urgent care center as well as a primary care continuity practice seeing both scheduled and same day appointments. Furthermore, we have a Warren Alpert School of Medicine at Brown University Family Medicine MD residency program and Kent NP residency program.

Thundermist West Warwick

Mission:

To improve the health of our patients and communities by delivering exceptional health care, removing barriers to that care, and advancing healthy lifestyles.

Our Vision:

Every member of the Thundermist community can lead a healthy life.

Our Values:

CARING: We bring passion and commitment to serve our diverse communities, patients and each other in a safe environment.

COMMUNITY: We respect the knowledge and skills of our local partners, patients, and employees. We support, create, and lead opportunities for growth and development.

INNOVATION: We develop, adopt, and contribute to advancements for improved health. We share knowledge openly with our staff, partners, patients, and communities.

EXCELLENCE: We maintain high standards and deliver exceptional results. INTEGRITY: We are champions and advocates for our patients, communities, and each other. We stay true to our mission, vision, and values.

DIVERSITY: We are committed to building and fostering a team that is representative of the communities we serve, to ensure that all our patients, staff, and community members are seen, heard, and valued.

Getting to Know Thundermist West Warwick

# of providers/patient demographics

- Number of Providers: approximately 60 providers
- Patient demographics:
  - Race: 69% white, 20% unreported, 8% African American, 3% Asian, 2% more than 1 race, 2% Native Hawaiian/Other Pacific Islander, 1% American Indian
  - Ethnicity: 77% non-Hispanic, 19% Hispanic, 4% unreported
  - Age: 0-4 yo 5%, 5-12 yo 10%, 13-19 yo 9%, 20-24 yo 8%, 25-44 yo 33%, 45-64 yo 24%, 65+ yo 11%
  - Insurance: Uninsured 10%, Medicaid 49%, Medicare 13%, Private 28%

How the office works

Each provider has different spectrums of care but, generally, we have providers both on site and remote seeing patients any time from 8am-8pm. Our schedules consist of continuity and same day appointments as well as specialty appointments such as Obstetrics, Pediatrics, preventative care visits, and procedures. We have an urgent care center on site that will see more urgent or single-issue visits if a primary care provider is not available. Each visit can include a multidisciplinary team member such as a medication assistance nurse, community health worker, crisis therapist, pharmacist, and/or social worker.

Your experience w/ Family Visiting

I have had great but infrequent experiences with First Connections, Healthy Families, and Nurse-Family Partnership in my 6 years at Thundermist. I know that my patients have had almost universally positive experiences and learned a great deal. They have been a great support for my underserved patients who have had difficulty navigating the medical system, social services system, or their new family system. The lack of consistent, frequent experiences is likely due to the sometimes fragmented communication between the medical team and their team.

Why did you join the learning collaborative

I am so excited to strengthen the collaboration and communication between all the teams of support for our most vulnerable populations. I look forward to being a part of providing information and offering feedback to support continued quality improvement and increase services for my patients.

Getting to Know
Family Visiting - CCAP Healthy Families America

Program Manager/Supervisor – Wendy Lincoln. Wendy Has worked at CCAP for 20 years and started the HFA program at CCAP in 2014. Currently we are funded for 140 slots for families to be enrolled.

Supervisor/Home Visitor – Jerilynn DiCenzo. Jerilynn has worked as a home visitor at CCAP since 2019 and recently was promoted to a supervisor role and still has a small caseload.

Home Visitor – Heather Raji. Heather recently joined the CCAP HFA team and comes with a wealth of information and experience working with individuals with disabilities.

Getting to know Family Visiting – CCAP HFA

Organization Background *CCAP is a nonprofit agency that provides many services designed to help the community and the fight against poverty. Services include Health, Dental, Head Start, Early Head Start and childcare, Learn to Earn (GED and job training), Behavioral health and substance abuse services, Case-management services, Social services, RIW, Residential services, home visiting and WIC.*
Success Story (example of family that benefitted from program): *Next Slide*
Risk Factors: *Delays in communication and fine motor at 22 months, concerns about hearing.*
Intervention: *Referral to EI and co-ordination of care, co-ordination with the Pediatric practice to request a referral to the CNDC and concerns about development, support for the family to schedule and attend the CNDC appointment. Referral to Social Security after Dx.*
How were they referred? *By South County Home Health First Connections, RN on 4.9.19, due to baby being 10 weeks premature.*
Why join the learning collaborative? (goals and hopes for project) *To improve our relationship with Thundermist and to better collaborate with families we share.*

Getting to know Family Visiting – CCAP HFA

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

Mom (18 years old) opened to HFA in 2019 with 3-month-old born 10 weeks premature. Mom had history of being strangled by FOB during her pregnancy and DCYF involvement. When DCYF closed MOB closed to all providers including EI, but decided to keep HFA due to it being voluntary. The Family was on and off of CO for the entirety of their time at HFA, but always reengaged due to needing support with toddler and his behavior. During services Mom presented with some SI and rescue was called which resulted in mom not wanting to continue but HFA was able to make a plan for MOB to sign a release in order for her mother to participate in HFA on her behalf for the toddler . The last year and a half of their time in HFA, was spent navigating the Early Intervention re-referral due to HFA seeing delays on the ASQ assessments. During this time EI had a very long waitlist due to staff shortage, and the pandemic. Family had a barrier to visits in the EI clinic due to transportation barriers, and zoom meetings were often missed by the family due to technology issues. EI opened in time to get the toddler an IEP and connected to school system. EI referred toddler to the CNDC to get a neurological evaluation. HFA supported the family with this referral to the CNDC due to the families pediatrician "retiring" and not being responsive to any of the families calls, concerns, or following through with sending over the CNDC referral. HFA was able to get releases for all providers, and coordinate communication in order to get the toddler referral successfully over to the CNDC before the toddler turns 4. Toddler was able to get evaluated before his 4th birthday, and was diagnosed with Autism. HFA was then able to support the family in applying for social Security benefits. Family is now closed to HFA successfully, and toddler is getting the support he needs due to receiving his diagnosis and social security.

Getting to Know Dr. Susan Stuart

# of providers/patient demographics

- Solo practice in Westerly RI.
- In the past 4 years our town has lost 2of 3 pediatricians
- ≈ 2,000 Patients

Your experience w/ Family Visiting & Why did you join the learning collaborative

Introduced to this learning collaborative through CTC for weight management. I thought it would be a great opportunity to more closely connect with community providers. I have found over the years putting faces to names helps me make more meaningful referrals. Being in Westerly is quite isolating from the rest of the state, families are hesitant to leave for any reason.

I have already met with Leanne at PAT, which has increased my knowledge of so many other services. Connection is key. I welcome the opportunity to learn more about helping my patients and their families.

Getting to Know

Westerly Public Schools Parents as Teachers

Maria Camarena, IMH-E, ECMH-E

Supervisor/Parent Educator

Leanne Foley

Lead Parent Educator

Danielle King

Parent Educator

Morgan Page, IMH-E

Parent Educator

Getting to know

Westerly Public Schools Parents as Teachers

Westerly Parents as Teachers builds strong communities, thriving families and children that are ready to learn, healthy and safe.
We match parents and caregivers with trained professionals who make regular personal home visits during a child's earliest years in life, from prenatal through kindergarten.

OUR VISION

All children will develop, learn and grow to realize their full potential.

OUR MISSION

Parents as Teachers promotes the optimal early development, learning and health of children by supporting and engaging their parents and caregivers.

OUR APPROACH

The Parents as Teachers approach is to **partner, facilitate and reflect**.

Why join the learning collaborative? (goals and hopes for project)

We are thrilled to be able to be part of the learning collaborative for the second time. Our families have benefitted tremendously from our joint efforts. Working more closely with pediatric practices has been a dream for us and we look forward to working with Dr. Stuart.

I began working with a family in May 2020, after receiving a referral from WIC. At the time of enrollment, Mom was about 6 months pregnant. Mom and Dad were hesitant to begin working with WPS PAT, as they have not had positive interactions with any outside person or agency previously. The family had many risk factors including, unstable housing, low income, low educational achievement, physical disabilities and mental health concerns among others. In addition, they were going to become first time parents in about 3 months. At that time, this family was being evicted from their apartment and also did not have needed items such as a crib and clothing for the baby. Being low-income, unfortunately, their ability to overcome these challenges was significantly limited.

We looked at the family's needs together and put them in order of level of importance and together we determined that stable housing was their primary need at that time. Within the next few weeks, we were able to work closely with the WARM Center and Westerly Housing Authority to help this family. Less than two months later, we were able to successfully secure stable housing for this family. I was able to help her to obtain needed items for the baby through various community resources during this time as well.

This past September, the family welcomed a new addition to their family with the birth of their second child. However, shortly following the birth, DCYF made the decision to remove both children from the parent's custody due to a domestic violence incident that had occurred shortly before mom gave birth. As a child that grew up in the foster system, mom was devastated by the removal of her children and the surge of pregnancy-related hormones she was experiencing only added to her despair. During this time, mom and I would meet on a bi-weekly basis and I would support her with her goal of reunification with her children. We would refer to the specifics of her DCYF Service Plan and I would support her to follow through with what DCYF was asking her to do. As a result, I was able to help mom obtain various resources including those relating to mental health and domestic violence supports. While mom was unhappy about the removal of her children, she understood the importance of receiving such supports for her mental health and for the safety of herself and her children. In addition, during this time, I was able to help mom begin the process of obtaining her GED, a long-time goal of hers that she believed would never happen for her.

I am happy to report that mom and the children have recently been reunified and the transition back together has been a smooth one for all. Mom now consistently receives and follows through with mental health services as scheduled and continues to work with her DV advocate. As an added bonus, mom is also one test away from officially obtaining her GED! Walking in her graduation is an event that she and I both are very much looking forward to.
While the removal of her children was a traumatic event in mom's life and one that compounded her previous traumas related to growing up in the foster system, we were able to work together to help her obtain and follow through with needed services. Such services would help keep her and her family safe and would ultimately help her grow as a human being in the process.

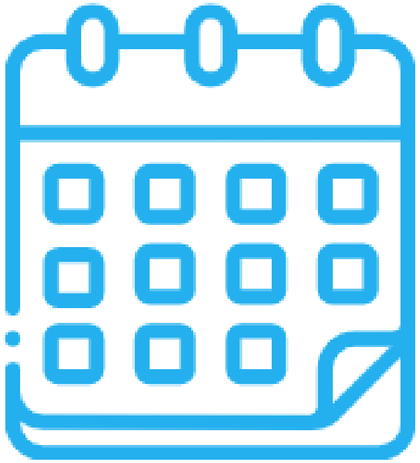
Mom frequently expresses how grateful she is for my support during this difficult time and that my support has helped to make her a healthier person and better parent. Mom states that the fact that someone had been there to help her and had consistently "shown up" for her was monumental, as that is something she had never experienced before. During our work together, we have built a working relationship based on mutual trust and respect-two things that I believe are fundamental to the services we provide to families.

WPS PAT Success Story

Closing and Next Steps

Use Data to understand current collaborations and identify future goals **Identify opportunities to improve well-child care, meet family needs, and plan next steps**	May 2023: Virtual meeting with FV and practice with PF	Teams discuss baseline survey data and RIDOH data presented at quarterly meeting. Pediatric teams discuss their selection of high-risk categories for referral, including newborns affected by substance exposure. Group discussion on managing case conferencing for multiple FV programs. Teams identify plan for meetings between FV and pediatric practice to plan for case conference. Teams report on action plan to improve knowledge of FV program at the practice site	
Relationship building and identification of present state/future state workflows for data reporting through electronic health record and other supporting documents	June 2023: Virtual meeting with FV and practice with PF	Practice and FV will select 5 shared families from FV KIDSNET list, which will be generated by pediatric practice. Review or establish workflows for the following: a) how FV will notify practice of their involvement b) how practice will identify children for referrals to FV program, including newborns affected by substance-exposure c) how practice will document FV involvement in medical record Teams will use this information to improve the communication process. Decide on a) how you will share information between team meetings b) how pediatric practice will improve knowledge of FV program among relevant staff and providers	Story Board template: Present workflow Future workflow for making referrals and documenting FV involvement in medical record Start discussing PDSA for improving care coordination

Closing and Next Steps



Monday August 28, 2023 – Cohort 3 Quarterly Learning Collaborative Meeting

Thank you
Stay Safe and Healthy

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

www.ctc-ri.org

CTC-RI