CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Healthy Tomorrows Quarterly Meeting

February 24, 2025

Care Transformation Collaborative of RI

AGENDA

Topic	Presenter	Time
Welcome and Review of Agenda	Susanne Campbell, Senior Program Administrator, CTC-RI	12:00pm - 12:05pm
Team Updates	CCAP Health Center and CCAP Aquidneck Pediatrics and EBCAP Blackstone Valley CHC and Children's Friend	12:05pm - 12:35pm
RI FV Data and Post program Survey Results	Sara Remington, RIDOH Carolyn Karner, Program Coordinator, CTC-RI	12:35pm - 12:50pm
Parent Lead - Learning Collaborative Reflections	Tiffaine Cataldo, Parent Lead	12:50pm – 12:55pm
Meeting Close and Next Steps	Susanne Campbell, Senior Program Administrator, CTC-RI	12:55pm - 1:00pm

CCAP Health Center and CCAP HFA

Referrals

- Number of shared families? - FHS and FV currently have 11 shared families, 9 in HFA and 2 in PAT.
- How are referrals are determined? Providers, nurse care managers and SW have all made referrals to FV. This is usually based on family need or concerns that are noted by the staff.

Successes and Challenges

- The CCAP medical record now identifies HFA and PAT families
- Arthur has continued education to FV to providers – yielding more referrals and knowledge of the program
- Enhanced communication and flexible case conferences, as needed
- CCAP Health is utilizing KIDSNET reports to see overlap
- HFA has outreached CCAP prenatal patients

How can we continue this?

Continue education with staff – important to schedule this regularly; education at ALL of the CCAP health center sites

Women's Care – resume partnership for prenatal referrals, HFA to co-ordinate with new OB provider

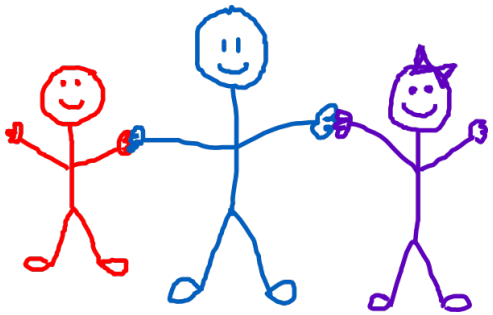
HFA/PAT to outreach to prenatal patients and newborns

Data analytics – FHS to run report of new patients under 3 months and/or prenatal

FHS will start utilizing a newborn packet – vaccinations, medication chart, safe sleep, resources, add HFA and PAT flyers in packet (use Intern to help)

Patient/Family Story

- Arthur and Beatriz have been coordinating about a 1yr old patient diagnosed with a blood disorder (Hemolytic anemia). They have been able to assist mom to navigate the hospital for urgent care and the provider for routine care and have communicated test results and recommendations. Arthur was able to space out the 6m and 12m vaccinations to minimize the impact on the child
- FHS has been coordinating with Beatriz and Wendy for a 3yr old with high lead levels (23 now 9). The team has been working on getting the toddler to take the iron supplement and for mom to give regularly. This has been successful, except now the toddler spits out the generic supplement. HFA will pay for non-generic supplement (that child will take) to try to continue to reduce the lead level to acceptable limits. HFA worked hard to convince mom to allow EI to work with the child due to delays. HFA and FHS also coordinated to get toddler to repeat the lead test after a bad blood draw.



Aquidneck Pediatrics and EBCAP HFA

Referrals

- **10 shared families**

- **The KIDSNET Characteristic Report** helps identify newborns and high-risk pediatric patients who may benefit from Family Visiting and early intervention services. It provides data on factors like low birth weight, prematurity, and maternal health risks, allowing providers to refer families for in-home support and education. The report also aids in tracking immunizations and preventative care, ensuring high-risk infants receive timely interventions. By supporting care coordination and addressing social determinants of health, it helps improve long-term outcomes for vulnerable children and families.

- **Referrals for Family Visiting are determined** based on newborn and maternal risk factors identified in the KIDSNET Characteristic Report and upon assessment of the patient and the family in the office. Factors like low birth weight, prematurity, NICU admission, maternal substance use, and limited prenatal care help providers identify high-risk infants who may benefit from additional support.

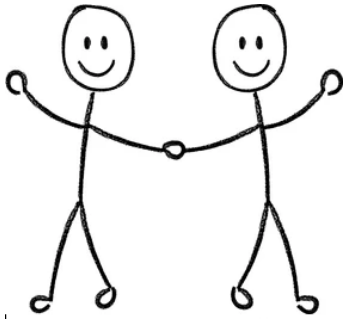
Successes and Challenges

- Increased Referral Rates: Achieved a measurable rise in FV referrals through streamlined processes and staff education.
- Efficient Tracking System: Implemented an electronic system for referrals, enabling quicker submissions and improved follow-up tracking.
- Enhanced Family Engagement: Positive feedback from families who appreciated the proactive support and resource sharing during appointments.
- Improved Collaboration: Strengthened partnerships with community organizations like EBCAP, leading to shared outreach efforts and better continuity of care.

Determine ways to scale this up/spread:

- Offering to family in the hospital (newborn)
- Offer referral at first in person visit and subsequent after
- Provide flyers about what it is

Patient/Family Story



- A case that demonstrates collaboration between the Rhode Island Family Visiting Program, Headstart, and a pediatric doctor's office involved a Spanish-speaking mother concerned about her child's vision after a Headstart screener flagged astigmatism. Headstart contacted the pediatric office, and the concern was discussed with the PCP, who recommended addressing it during the child's upcoming well visit, with a referral to an eye doctor if necessary. The family visiting representative communicated this plan to the mother, providing reassurance and support. This collaboration highlights the importance of proactive communication, cultural competence, and a family-centered approach in connecting community resources with primary care for seamless care coordination.
- Another success: prenatal mom hadn't known she had to pick a pediatrician, Kristen connected her with Aquidneck for care, baby in now a patient

Blackstone Valley Community Health Center and Children's Friend HFA

Referrals

- 48 shared families
- KIDSNET Characteristic Report?
  - BVCHC refers universally to FV, so report isn't helpful (risks are vague)
- How are referrals are determined?
  - BVCHC referring patients universally
  - Enrolling all prenatal patients
  - Consider patients daily to determine if there are patients who may benefit from FV, then refer

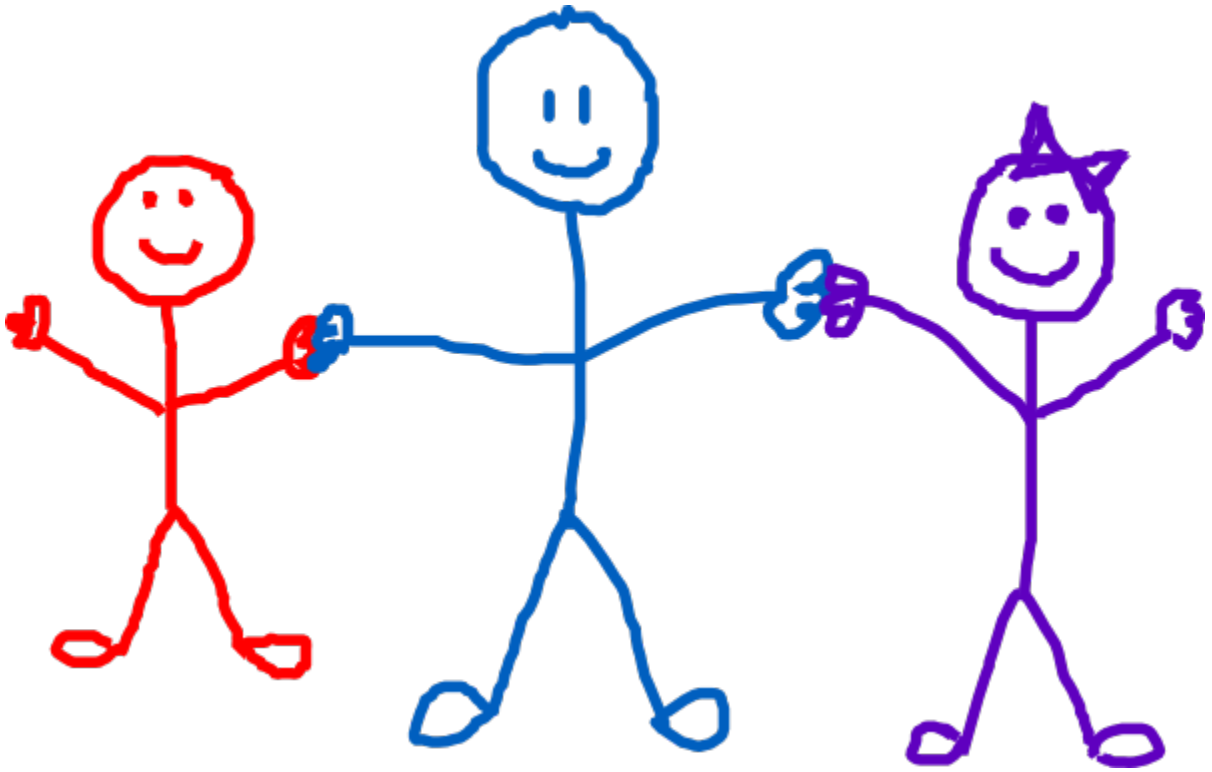
Successes and Challenges

- Built direct line of communication with Children's Friend, communicate ad hoc
- Children's Friend relationship with BVCHC – attendance at monthly inter-disciplinary mtg.
- Better understanding of mechanics of all FV/eligibility, etc. based on meetings and conversations with Michelle
- Still hard to encourage families to join despite benefits communicated

Sustainability Plans (given staff changes, etc)

- Continue with relationship with Children's Friend
- Continue with universal referrals to Family Visiting

Patient/Family Story



RI Family Visiting Data

Children's Friend HFA

- 100% of primary caregivers were screened for depression at time of intake, using the PHQ-9
- 94% of birthing parents that enrolled prenatally had their postpartum care visit within 56 days after delivery
- 87% of index children have had their most recent well child visit
- 100% of primary caregivers were screened for substance and alcohol use disorders at time of intake using the AUDIT and DAST-10

Comprehensive Community Action Program HFA

- 87% of index children have had their most recent well child visit
- 82% of infants under 1 are sleeping safely/following safe sleep guidelines
- 100 % of primary caregivers were screened for interpersonal violence at time of intake
- 100% of primary caregivers were screened for substance and alcohol use disorders at time of intake using the AUDIT and DAST-10

East Bay Community Action Program HFA

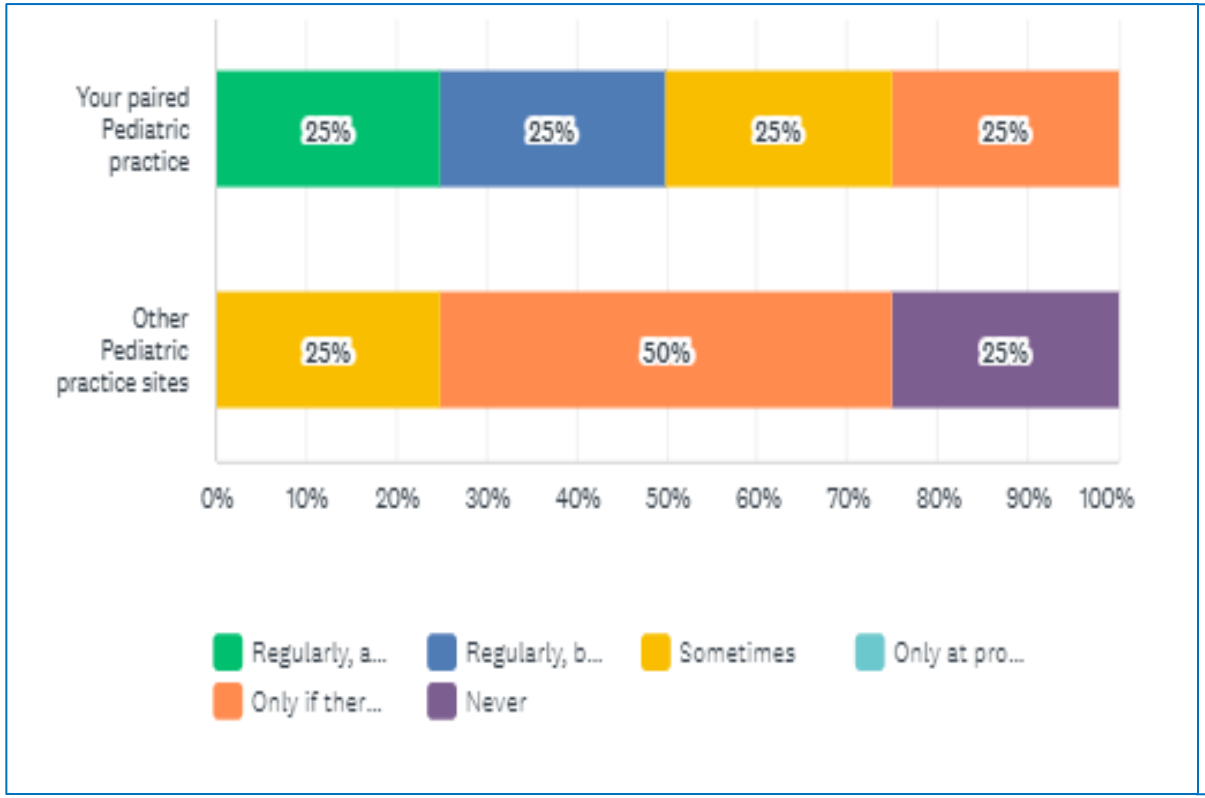
- 100% of primary caregivers were screened for depression at time of intake, using the PHQ-9
- 92% of index children have had their most recent well child visit
- 83% of infants under 1 are sleeping safely/following safe sleep guidelines
- 100% of children had a developmental screening at 9, 18 or 30 months

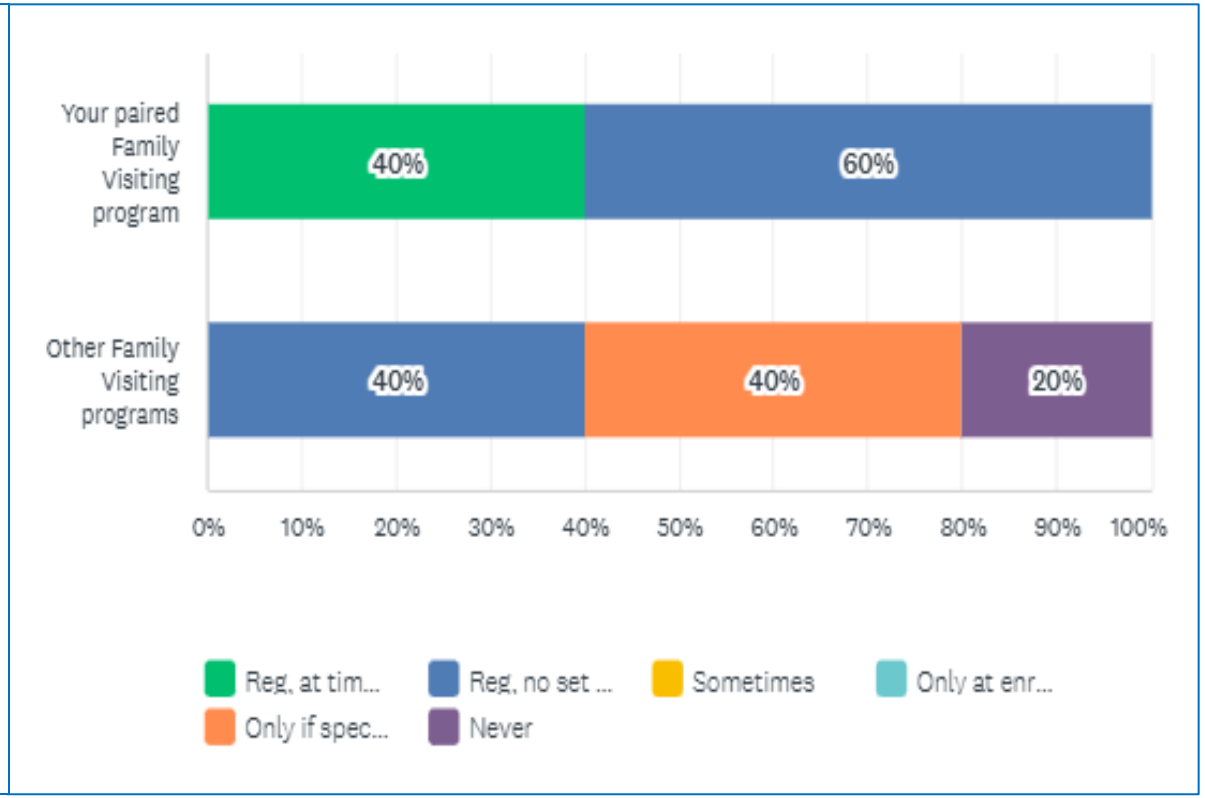
Post Program Survey Results

Four (4) survey respondents from three (2) **FV agencies**

Five (5) survey respondents from three (3) **practices**

How often do you communicate with?

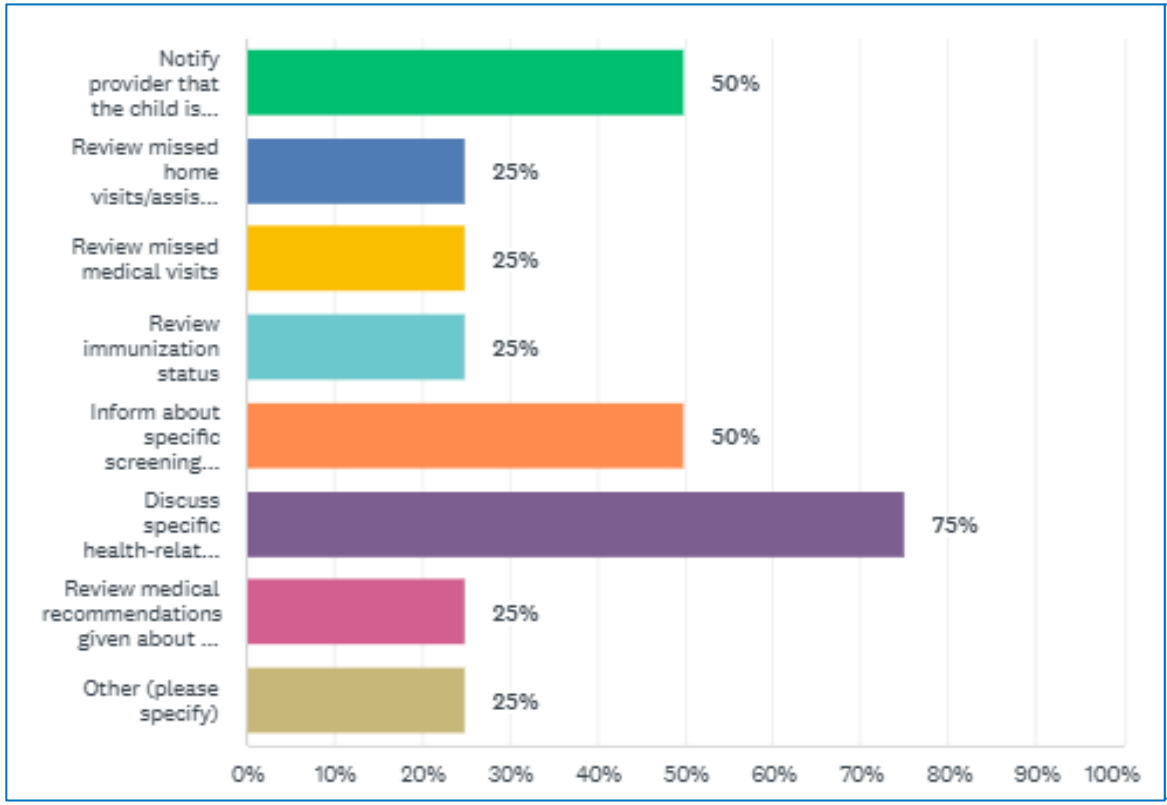




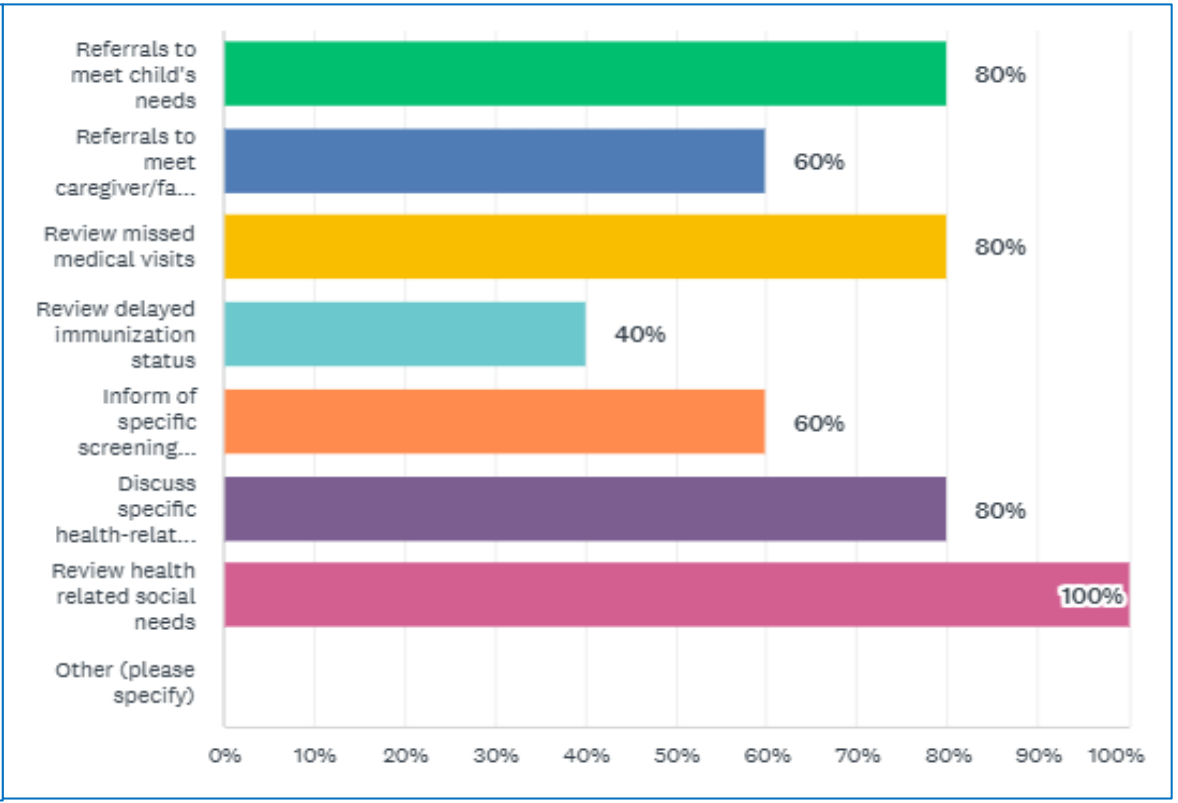
Post Program Survey Results

Please identify the typical reasons your practice contacts your paired Family Visiting program / practice:

Family Visiting



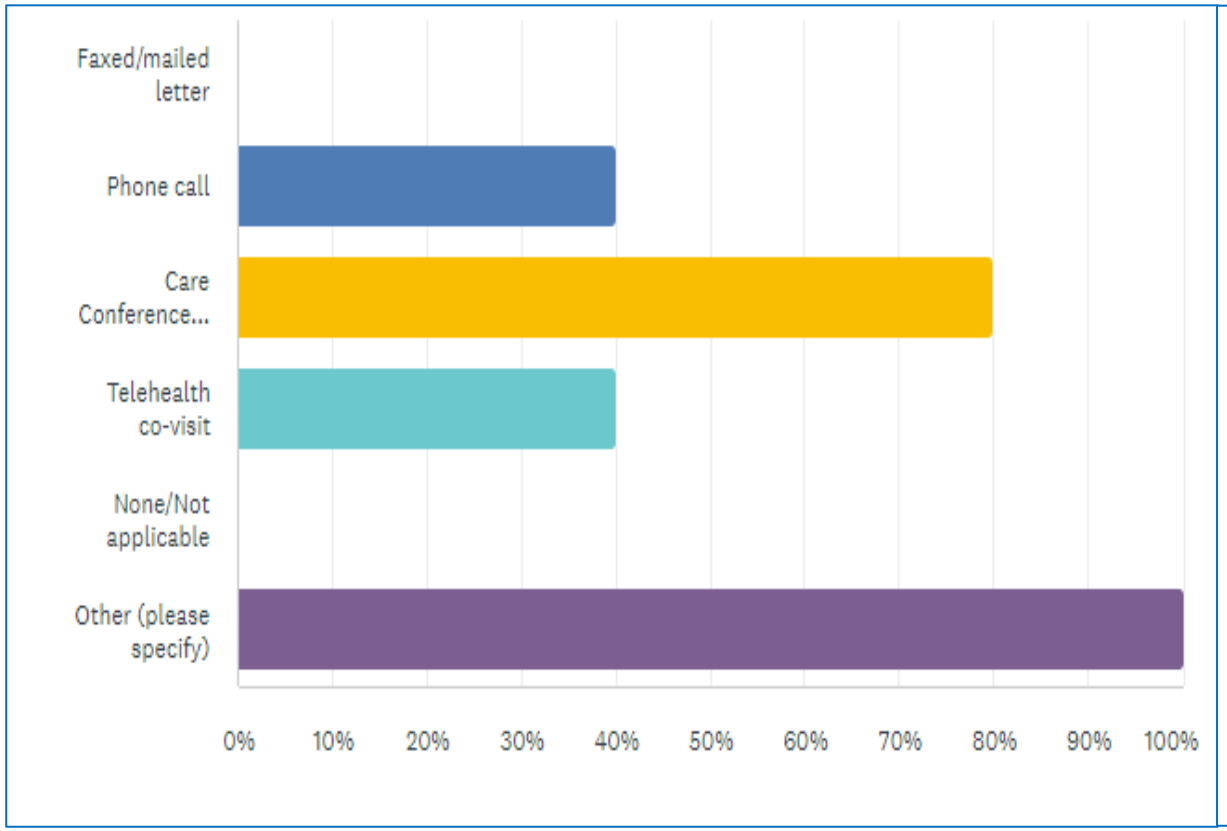
Pediatric Practice



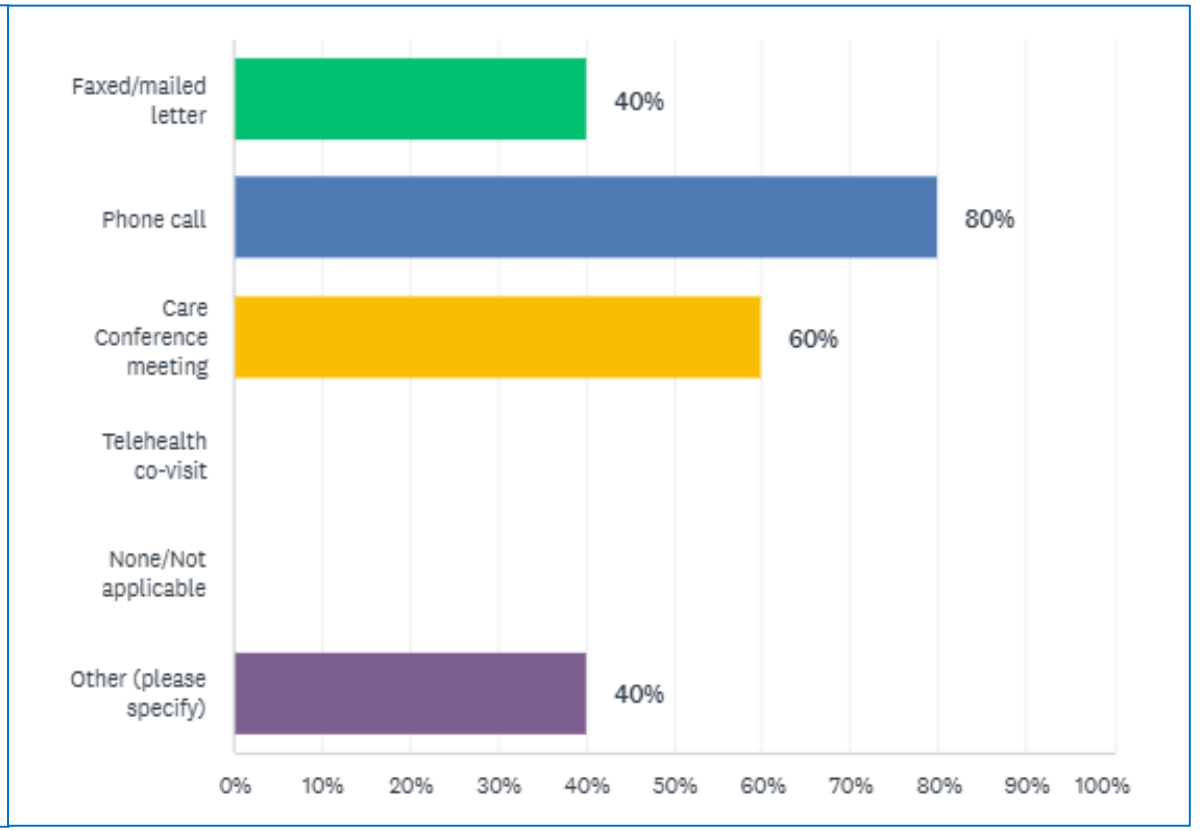
Post Program Survey Results

What methods of communication do you typically use to contact your paired partner?

Family Visiting

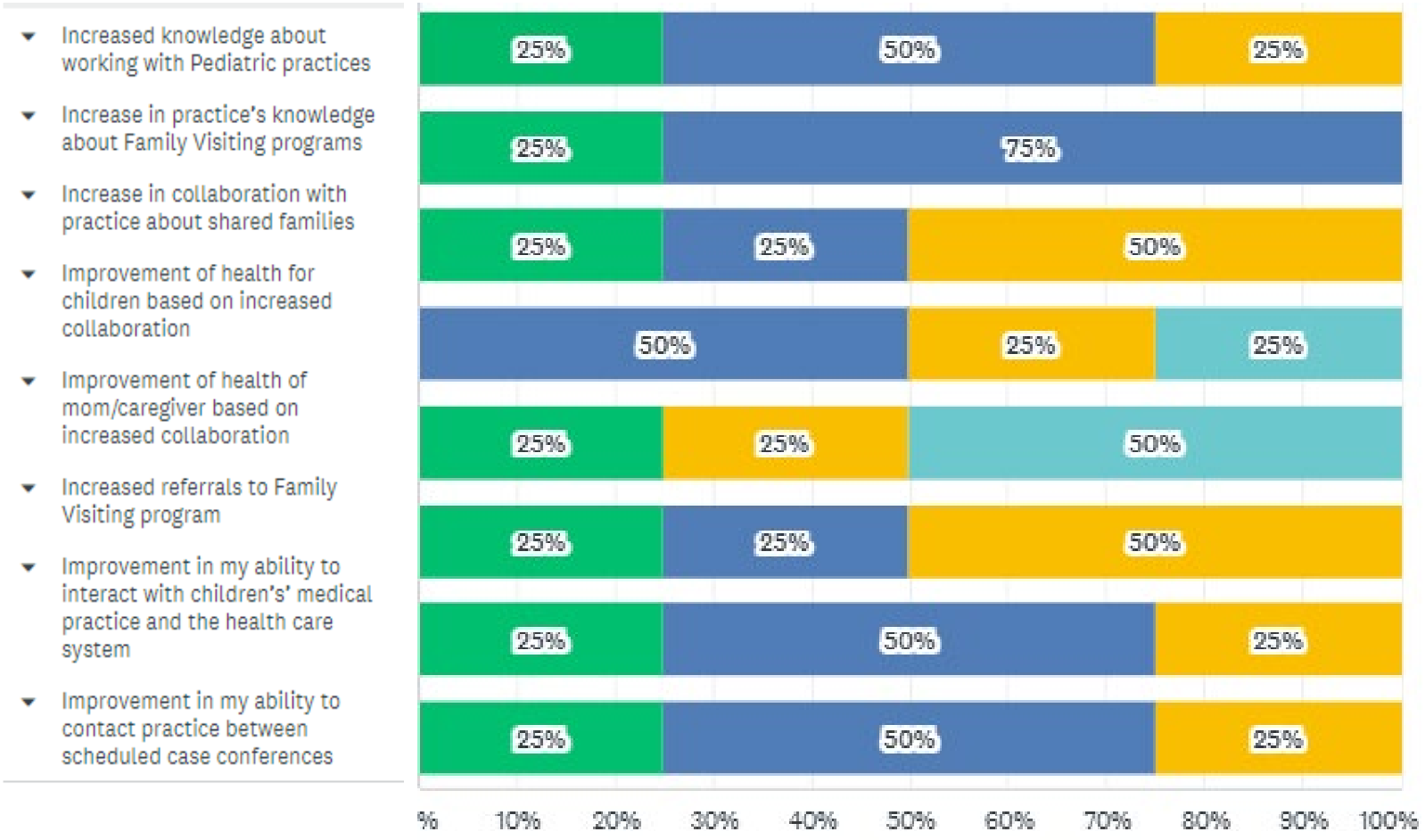


Pediatric Practice



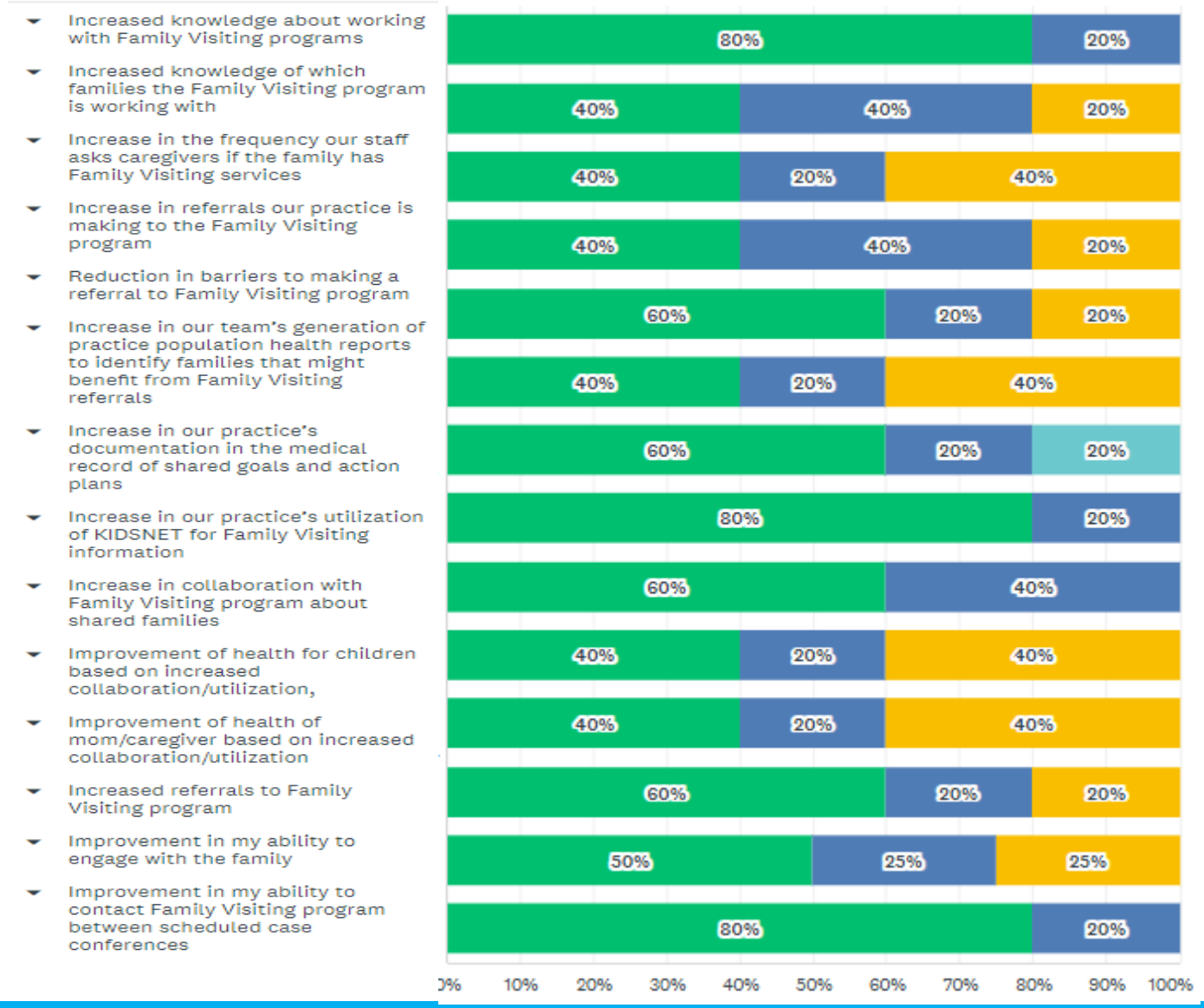
FV Post Program Survey Results

To what degree has working with a paired Primary Care Team resulted in:



Practice Post Program Survey Results

To what degree has working with a paired Family Visiting Team resulted in:



Are there any other topics for shared learning that you think would be helpful?

- How to communicate about early intervention
- I think that this was a wonderful thing to be apart of and our high-risk patients certainly reaped the rewards

Post Program Survey Results

Pediatric Practice

https://www.surveymonkey.com/stories/SM-gZ_2F3ir_2B_2Fmd7JUM_2BFM5h9Rw_3D_3D/

Family Visiting

https://www.surveymonkey.com/stories/SM-q2gs7rEyhyghFC17udG0TQ_3D_3D/

Family Voice – Tiffaine Cataldo

For me family visiting started with my youngest when she was about 2 years old. Unfortunately, I missed out on prenatal and postpartum visits.

Family visiting really helped me to

- learn how to advocate for myself and my children
- gave me the confidence to ask questions about things I might not be too sure about during drs appointments.

I really wish that there was more information made available at the time when I was pregnant about the program and that I had signed up much sooner.

I feel like the program is not explained enough to expecting parents and that a lot of parents unfortunately miss out on such an amazing program that they can really benefit from.

Practices Involved	Family Visiting Agencies Involved
Hasbro Pediatric Primary Care	Blackstone Valley FV – HFA and PAT
PCHC - Central	Meeting Street - HFA
Coastal Narragansett Bay Peds	Westerly PAT
EBCAP	EBCAP HFA
CNE Family Care Center	Children's Friend - HFA
Thundermist – West Warwick	CCAP HFA
Dr. Susan Stuart	
Aquidneck Pediatrics	
BVCHC	
CCAP Health Center	

Thank you for making this program such a huge success.

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Thank you HRSA and Tufts for your generous funding and support of this 5-year program.

Point32Health

HEALTHY TOMORROWS Partnership for Children

Building on the success of Healthy Tomorrows

Practice	Community Based Organization	Comments
Family Care Center	Internal CHW	
Tri-County	internal Early Head Start	
VICTA	FSRI CCBHC or Doulas or reverse CBO	
Hasbro	FSRI HFA	
Wood River	CCAP HFA	
Landmark (Full Circle Health)	Community Care Alliance	
PCHC - Central	Childrens Friends HFA	Still to be confirmed

- Combining efforts with MomsPRN
- Program starts in May
- Participative Agreements to go out in March
- Added an outcome measure of success
- Simplified pre-post readiness assessment
- Any recommendations for this new cohort?


thank you
danke
gracias
teşekkür ederim
ngiyabonga
格雷西
дзякуй
dank je
bedankt
dziękuje
hvala
obrigado
sukriya
kop khun krap
go raibh maith agat
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terima kasih
eskerrik asko
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