

## Section 2

# Providing Family-Centered Care for Children's Social and Emotional Health



### **Part One**

Providing a  
Broad Spectrum  
of Services in the  
Medical Home

### **Part Two**

Prevention and  
Intervention:  
Creating Service  
Delivery  
Protocols for  
Family-Centered  
Care

### **Part Three**

Promotion:  
Promoting Social  
and Emotional  
Health for *All*  
Families and  
Providers

## Section 2 Overview

With an emphasis on flexibility and accessibility, this family-centered care model for early child mental health offers a spectrum of promotion, prevention, and intervention strategies that can effectively support the social and emotional health of all children and families.

For individualized services, the initial encounters with families focus on relationship building as well as exploration of strengths and needs using validated screening and assessment tools; these tools are inclusive of caregiver's mental health. As partners, the family and Core Team create an individualized Care Plan that identifies specific strategies to achieve the family's goals for their child's social, emotional and behavioral health.

Individualized care plans define stepwise action steps to implement each strategy and indicators to measure progress toward goals. Care Plan strategies may include links to

community resources, education on child development, activities for fostering nurturing caregiver-child relationships, flexible peer support for caregivers, parent-child dyadic therapy, ongoing child therapy and referrals to specialized behavioral health providers. Care plans are accessible to the family, Family Partner (FP), Mental Health Clinician (MHC), Primary Care Provider (PCP) and key community providers (with consent) as to facilitate coordinated, consistent care that is rooted in the medical home and inclusive of the community's resources.

This section focuses on how Core Teams can create and implement promotion strategies and prevention/intervention service delivery protocols to enhance children's social and emotional health in their pediatric medical home. It provides examples of service delivery tools that can be adapted for use in other medical homes piloting this model.

### Tools in this section can be used to:

- ❖ **Apply** a framework of promotion, prevention and intervention to children's social and emotional health
- ❖ **Develop** team-based prevention and intervention service protocols that define referral systems, engagement and assessment tools, Care Plan components, therapeutic service strategies, and transition plans
- ❖ **Identify** strategies for promoting children's social and emotional health among all families and providers throughout the medical home

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## Objectives

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## 1) Providing a Broad Spectrum of Services in the Medical Home

The MA Early Childhood Mental Health (ECMH) Partnership model aims to identify young children with social and emotional health needs and provide them and their families with individualized, comprehensive and coordinated services to meet their goals. For this model to work, services must be flexible and accessible to all children in the medical home.

*Flexibility* means that services both match the unique culture, strengths, and needs of each family as well as dynamically change as the family's life events evolve.

*Accessibility* means there are many doors open for families to connect and engage in care, from referrals through transitions out of Core Team services. Accessibility requires multiple referral pathways (provider referral vs. self-referral), a diversity of providers (Family Partner and Clinicians), many forums of care (group sessions and individualized sessions) and multiple care locations (home visits, community-based visits, clinic visits).

This section provides insight into the spectrum of services you can provide in the medical home based on this ECMH model, as well as a video clip that offers first-hand testimony to how this model can be used and how it was successful across demonstration sites in Massachusetts.

# PROMOTION, PREVENTION AND INTERVENTION STRATEGIES AND SERVICES EXAMPLES FROM DEMONSTRATION SITES

## The Center on Social and Emotional Foundations for Early Learning

The Center on Social and Emotional Foundations for Early Learning (CSEFEL) is focused on promoting the social emotional development and school readiness of young children birth to age 5. It is a national resource center funded by the Office of Head Start and Child Care Bureau for disseminating research and evidence-based practices to early childhood programs across the country.

\*\*Many resources for the medical home team and parents can be found on the [CSEFEL website](#)\*\*

The CSEFEL Pyramid represents the types of interventions to consider:

### Promotion, Prevention and Intervention across a Spectrum



## STAGE ONE: PROMOTION EFFORTS

The CSEFEL offers these promotion efforts to support early childhood mental health. Below, find out more about each measure and see examples of these activities and resources in action.

- 1) Mental Health Awareness Day
- 2) Clinic Room Materials
- 3) Family Activities Nights
- 4) Parent Walking Group
- 5) Community Outings

### 1) Mental Health Awareness Day

- Children’s Mental Health Awareness is recognized across the country in May each year. Some recognize the entire month, a week or a day.
- Pilot site activities included activities and interactive informational tables to engage children and their parents.
- Collaborative activities included weekend trips to the Boston Children’s Museum with special early childhood mental health awareness activities for all museum visitors.

At Boston Medical Center, both children and parents were asked to think about their feelings. Children indicated how they were feeling by marking a picture of feeling faces. Adults were asked to share, “How do you take care of yourself?”

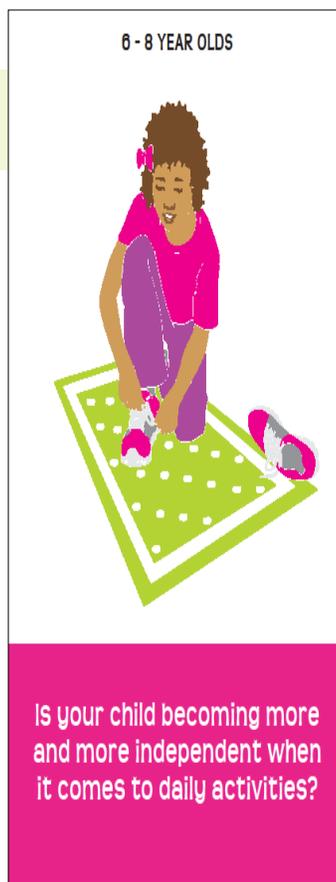


While visiting the Children’s Museum Hannah and Tayra learned that Tucker the Turtle has a good strategy to think before acting in anger or frustration.



## 2) Clinic Room Materials

- Pilot sites developed materials to inform parents and providers. These included exam room posters, resource files and electronic medical record documents.
- Collaboratively, the Boston Public Health Commission developed toolkits to support parents in asking pediatricians about their young child's social and emotional health.



## 3) Family Game Nights

- The team at Martha Eliot Health Center noticed that many children needed to learn to play games and their parents lacked comfort with this activity.
- They piloted a Family Game Night and soon found they had too many families for the space.
- Families played games together and staff aided adults and children alike in learning the rules of the game and play.

## 4) Parent Walking Group

- Caregivers at Codman Square Health Center participated in a weekly walking group.
- The group created connections between caregivers, reduced isolation, and encouraged physical health and wellness.



## 5) Community Outings

- Families from Codman Square came together for a trip to the Franklin Park Zoo.
- This outing, and others like it, support families in accessing free and low-cost community activities



## STAGE TWO: PREVENTION EFFORTS

Many interventions in early childhood are truly prevention efforts. All programs should provide those aspects at the bottom of the pyramid.

- 1) Family Nurturing Program Group
- 2) CSEFEL Play Group
- 3) Homeless Caregivers Support Group
- 4) Presentation to Staff
- 5) Newborn Behavior Observations (NBO) training



### 1) Family Nurturing Program

- The [Family Nurturing Center](#)<sup>2</sup> in Boston provided training in the Nurturing Program for Parents curriculum.
- Staff used the training and materials to work with individual families and conducted a 16-week cross site group for parents with infants, toddlers and preschoolers.
  - View a [sample infant, toddler, preschooler session](#)<sup>3</sup>.
  - View a [sample parent session](#)<sup>4</sup>.
- The group included components for parents, children, and the parents with their children.

Here we see Family Partner Rosa helping Joshua make his own Personal Power cape.

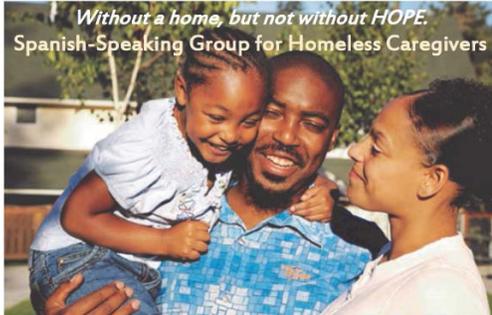


## 2) CSEFEL Playgroups

- The team at Codman Square Health Center wanted to engage more parents of children from birth to 6 months.
- They started drop-in playgroups for infants and toddlers, including a circle-time, free play, snack time and a wellness check-in for caregivers.
- The group grew to include time for parents and children to meet separately and engaged other child-serving community partners, such as Early Intervention and Women, Infants and Children.

## 3) Homeless Caregivers Support Group

- Seeing a need to support families living in homeless shelters and hotels, the team at Martha Eliot Health Center developed a six-week curriculum.
- Caregivers developed relationships with peers and learned skills for making the best of their situation.
- Topics included learning to cook healthy meals in a microwave and strategies for safe and engaging play for young children in confined spaces.



*Without a home, but not without HOPE.*  
Spanish-Speaking Group for Homeless Caregivers

**NOW ACCEPTING REFERRALS!!!!**

Topics to be covered:

- Coping with homelessness
- Learning from the experiences of others
- Concrete housing resources
- Self-care and building supportive community
- Caring for and having fun with your children
- Healthy cooking while in shelters

Project LAUNCH will be leading a 6-week group for homeless caregivers, beginning in early October. This group is open to ALL MEHC families!

- Priority given to those living in congregate shelters/motels, but you can refer those in scattered site shelters as well.
- Child-care is *not* planned, but we will explore with families if this is a barrier.
- Planning to hold group in SPANISH, but please contact us if this is a barrier.

Group Starts in Early October!!! Please send referrals via email or clinical messaging.

Questions? Call Natasha at x43419 or email [Natasha.byars@childrens.harvard.edu](mailto:Natasha.byars@childrens.harvard.edu)

## 4) NBO Training for Medical Home Staff

- Site staff at Boston Medical Center were trained in the Newborn Behavior Observations (NBO) System. This is a tool for providers to use to help parents interact with their new baby.
- Two pilot sites decided to bring the training to the larger medical home community, including primary care providers, nurses, social workers, case managers and medical interpreters.

## STAGE THREE: INTERVENTION LEVEL EFFORTS

As children struggle more, the interventions become more individualized and intense. This section includes four levels of intervention efforts.

- 1) Intensive individual and/or dyadic therapy
- 2) A group process that promotes attachment and nurturing
- 3) Referral to area wraparound, intensive home therapy programs.
- 4) Developing a Positive Behavior Support plan (PBS) with a family team.



## 1) Individual or Dyadic Treatment

The Core Team should be well versed in at least one trauma-focused treatment model.

Examples of these are:

- ARC (Attachment, Regulation and Competency)
- Trauma Focused CBT (TF-CBT)
- Child Parent Psychotherapy (CPP)

## 2) Group Processes

Either providing a group on site or having groups in the area to refer to can be an essential intervention. Groups generally will be more focused on parenting technique or dyadic intervention.

Groups to consider:

- **Circle of Security:** A relationship-based early intervention program designed to enhance attachment security between parents and children.
- **The Incredible Years:** The goal is to prevent and treat young children's behavior problems and promote their social, emotional and academic competence.
- **Triple P Parenting Program:** Prevent severe behavioral, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents.

## 3) Referral to In-Home Therapy

The medical home team cannot function at every level of treatment need, so there will be times that a higher level of care will be necessary. The next level of care to consider is some form of "In-Home Therapy." Keep in mind the following:

- Although home visiting should be part of the medical home protocol, it will be different than the intensive programming an in home therapy model will provide.
- Developing a relationship on the outset with the catchment area mental health program that provides these services is an important first step.
- Once a referral is made, stay engaged with the family until they are securely engaged in their new treatment.

## 4) Positive Behavior Support Plan (PBS)

- PBS is an evidence-based behavior intervention. Get a [full PBS tutorial here](#)<sup>5</sup>.
- It is proven to work with all types of concerns and diagnoses from ages 2-50.
- It is significantly more effective than most traditional behavior plans as it has multiple components and involves all important adults in a child’s daily experience.

### Sample Positive Behavior Support Outline



Trigger	Behaviors	Maintaining Consequences
Prevention Strategies	Targeted Teaching	New Responses to Old and New Behavior

### Key Steps in Positive Behavior Support Planning

- [Building a Behavior Support Team](#)<sup>6</sup>: PBS begins by developing a team of the key individuals who are most involved in the child’s life: the family and early educator, but also friends, other family members, therapists, and other instructional or administrative personnel.
- [Person-Centered Planning](#)<sup>7</sup>: This means bringing the team together to discuss their vision and dreams for the child. It is a strength-based process that celebrates the child and a mechanism of establishing the commitment of the team members to supporting the child and family.
- [Functional Behavioral Assessment](#)<sup>8</sup>: Data is collected to identify the function (purpose) of the behavior that the team wants to change.
- [Hypothesis Development](#)<sup>9</sup>: The behavior hypothesis statements summarize what is known about triggers, behaviors, and maintaining consequences and offers an informed guess about the purpose of the problem behavior.
- [Behavior Support Plan Development](#)<sup>10</sup>: The team can develop a behavior support plan, which includes prevention strategies, the instruction of replacement skills, new ways to respond to problem behavior, and lifestyle outcome goals.
- [Monitoring Outcomes](#)<sup>11</sup>: The effectiveness of the behavior support plan must be monitored. This monitoring includes measurement of changes in problem behavior and the achievement of new skills and lifestyle outcomes.

## PROJECT LAUNCH DIGITAL STORIES



### **YouTube Video Clip**

“Supporting Young Children’s Social and Emotional Health in Medical Homes”

[View the video here.](#)<sup>12</sup>

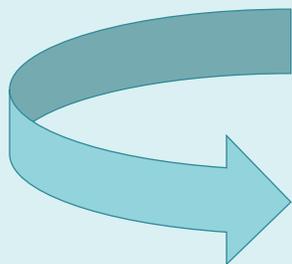
## 2) Prevention and Intervention: Creating Service Delivery Protocols for Family-Centered Care

At the heart of this model lies new prevention and intervention services to support children and families in healthy social and emotional development. The Core Team partners with each caregiver to deliver individualized clinical and family support services to meet the goals of each caregiver and child.

With leadership from the Core Team, each health practice must uniquely craft new services to the culture of their medical home. Integrating a Family Partner and Mental Health Clinician in primary care is challenging; it involves building new relationships between providers and new systems to facilitate communication between primary care and behavioral health staff.

### Five Service Delivery Phases

The following documents will help your medical home create a service delivery model that unites the FP, MHC and Primary Care Provider as one team for each family. The model is organized into five phases to illustrate the experience of families from initial relationship-building with the FP and Clinician through transition from these specialized services with ongoing primary care. Similar to the wraparound model of care, these include:



- 1) Referral System Development
- 2) Engagement and Assessment
- 3) Care Plan Development
- 4) Implementation of Services
- 5) Transition

First, check out a sample service delivery protocol for all five phases. Then, for each phase, the toolkit provides a summary of the key principles, team roles, and core systems components. These phases are unified in a sample protocol identifying steps providers and caregivers can take together to support the social, emotional and behavioral health of each child. The documents aim to provide a launching point for Core Teams when designing a service delivery model that integrates the caregivers, FP, Clinician, PCP and key community supports in a unified system accessible with the medical home as the hub.

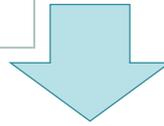
# Sample Service Delivery Protocol

## 1) REFERRAL PROCESS

### Identify Families

**Child and family attends pediatric visit.** The Primary Care Provider uses results from the Parents Evaluation of Developmental Status (PEDS)/Pediatric Symptom Checklist (PSC) screening tools and the social/family history to identify families for referral. He/she connects the family to a Family Partner or Mental Health Clinician based on screening tools, family account of child's behavior, brief observation of child's behavior, observation of parent/child interaction, and/or assessment of the family's exposure to stress.

**Family requests services.** The PCP makes a referral in response to a family's request for support with the child's behavior that indicates a high likelihood for engagement. Or, the parent calls the MHC or FP directly to self-refer after hearing about services from a peer or seeing program materials in the medical home or community.



### Make the Referral



1) **Warm Handoff:** FP or MHC introduces themselves to the family at the end of well visit or urgent care visit. Assessment is completed immediately by MHC or FP, or deferred until follow-up visit depending on staff availability and family's time.

**OR**

2) **CHC-Specific Referral System:** The referral is made through electronic medical record or communication in provider meetings. The FP or MHC calls the family to introduce services and schedule the engagement/assessment visit.

**OR**

3) **Family Calls MHC or FP:** The family calls contact on distributed materials (as posted in medical home, community or given by PCP) for self-referral. If they are not immediately available, the FP or MHC returns the call to family within 3 days and schedules the engagement/assessment meeting.

# Sample Service Delivery Protocol

## First Phone Call to Caregiver

**Resource Connection/Educational Need Met:**  
Family Partner or Mental Health Clinician provides connection to family resource aimed at caregiver stress reduction or education/activity emphasizing social and emotional health.

**Engagement/Assessment Visit Scheduled:**  
FP or MHC schedules follow-up visit to further assess the family's strengths and needs related to their child's social and emotional health.

**Family Does Not Engage with FP/MHC:**  
FP or MHC provides their contact information and emphasizes "open door" policy if the family would like to try services at a different time.

## Communicate with Referring Provider

**Notify PCP of Resource Connection:**  
FP or MHC notifies PCP of resource provided to family and the follow-up contact plan discussed with caregiver to ensure access.

**Notify PCP of Next Visit:**  
FP or MHC notifies PCP of the date of engagement/assessment visit scheduled and asks for additional concerns prior to visit.

**Notify PCP of Non-Engagement:**  
FP or MHC notifies PCP of family's choice and asks the PCP to encourage the caregiver to reach out to the MHC or FP when ready.

## 2) ENGAGEMENT AND ASSESSMENT

### Designate Provider(s) to Lead First Assessment Visit

Family Partner OR Mental Health Clinician OR both?

#### Consider:

- 1) **Reason for Referral:** Based on the referral and a brief phone call with the caregiver, where on the promotion, prevention or intervention scale are needs likely to be? Higher levels of need will likely need clinician involvement.
- 2) **Assets and Training of FP and MHC:** Which provider(s) can offer specific skills that will most likely meet the caregiver's goals? Will clinical therapy likely be part of the Care Plan?
- 3) **Capacity:** If the MHC is providing weekly therapy to some families, capacity may be more limited. Thus for referrals of the promotion or prevention nature, the FP may be better suited to lead those.
- 4) **Child and Caregiver?** If young children and the caregiver are coming to the visit, it may be helpful to have one provider who can discuss confidential information with the caregiver and another provider who can lead activities with the child and observe behaviors.

# Sample Service Delivery Protocol

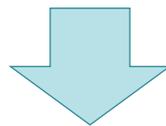
## Introduce this Program

### 1) Introduce Family Partner and/or Mental Health Clinician:

- Emphasize team approach with primary care provider
- Explain background of provider(s) and complimentary roles

### 2) Introduce Services To Family:

- Emphasize that services aim to support caregivers in defining and reaching *their* goals for their child's feelings, development, and behaviors
- Provide 1-2 concrete examples of a family's goal and services provided to meet it



## Assess Strengths and Needs Related to Social and Emotional Health

### 1) Listen First

- Elicit caregiver's story, a more detailed reason for referral from the family's perspective
- Discuss mandatory reporting
- Inquire about immediate crisis concerns (safety issues, basic needs), and if immediate response is necessary, connect with *crisis resource* as identified by health practice
- Initial exploration of child and family's strengths, needs and culture
- Inquire about family's involvement in and perception of existing medical home services (programs, care coordination, recreational activities)
- Inquire about family's involvement in community-based services; ask for written *consent* to contact other providers or agency staff

### 2) Observe

Throughout the visit, observe the child's behaviors, interactions with siblings, and caregiver-child interactions.

### 3) Use Assessment Tools

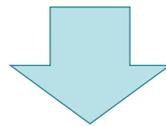
- **Child's Social and Emotional Health and Development:** Tools that identify developmental strengths and concerns, specifically focusing on childhood social and emotional health in the context of the family. These tools explore the child's relationships, feelings and behaviors.
- **Family Environment and Stress:** Tools that identify stressors the family faces that could affect the health and development of the child. This includes stressors faced at home (housing insecurity, food insecurity, poverty, caregiver mental health concerns, exposure to violence) and stressors faced in community (exposure to trauma, perception of safety, etc.).

# Sample Service Delivery Protocol

## Provide Caregiver with Immediately Useful Tool or Resource

After doing the assessment, offer the caregiver something that could be immediately useful to the family. While this will not be a deep-rooted solution to stressors, it should be something that demonstrates that the caregiver is being heard and the Family Partner/Mental Health Clinician services will be useful.

**Examples:** Organizational calendar/binder, connection to basic resource, educational handout on child development topic, invitation to local playgroup



## Summarize Assessment and Identify Next Step

**Summarize with Family:** Summarize with the family the strengths that surfaced by doing the assessment and also the needs. Ask for the caregiver's impression of your summary.

**Identify Next Step with Caregiver:** In partnership with the caregiver, determine a clear next step in care. Propose a next step with a clear target date, so that the plan for contact remains clear.

### Need Was Immediately Met by FP/MHC:

Caregiver feels need was immediately addressed in this visit (likely resource connection); assessment does not suggest other urgent needs. Plan for a follow-up phone call within 7 days to ensure the caregiver's resource was accessed or information given is sufficient.

### Follow-up Assessment Visit:

More than one visit needed to understand the initial strengths and needs of the family or complete useful tools. Schedule another engagement/assessment visit and consider whether the other provider (FP or MHC) should be present too.

### Schedule Care Plan Meeting:

As a caregiver-provider team, you are ready to move forward to make a Care Plan and identify service goals. Schedule this meeting in a location accessible to the family and support the caregiver in identifying natural supports.

### Family Chooses Not to Further Engage:

For families that do not want to continue with the FP or MHC, emphasize the open door policy, and notify PCP of family's choice.

# Sample Service Delivery Protocol

## Summarize with Providers

**Discuss Summary of Family Assessment at Family Partner-Mental Health Clinician Weekly Meeting:** Whether both providers did the visit together or not, briefly review the assessment together. This allows the other provider to offer additional perspective and be drawn into the next visit if needed (with caregiver consent).

**Notify Primary Care Provider of Next Step:** Notify the PCP of the next step with the family, so he/she can remain involved in care. This can be done through the electronic medical record, in person or in scheduled meetings. This is especially critical if the family chooses not to continue with the MHC or FP.



## 3) CARE PLAN DEVELOPMENT

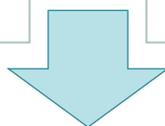
### Prepare for Care Plan

**FP and caregiver brainstorm family strengthening goals, caregiver skill-building goals, and family resource goals:**

- FP calls caregiver to brainstorm caregiver's goals for relationship building and education
- FP brainstorms possible community and medical home resources to support caregiver in meeting her resource and support goals
- FP comes to Care Plan meeting ready to offer specific strategy options (resources, education, skill building, workshops) for caregiver

**MHC brainstorms clinical goals:**

- With consent, MHC contacts previous behavioral health providers and key child-serving agencies (e.g. Dept. of Children and Families (DCF)) to identify any existing behavioral plans and the status
- MHC brainstorms potential clinical goals of family's participation, based on engagement and assessment visit(s)
- MHC identifies clinical practices and resources to address behaviors and social and emotional needs of the child and caregiver



# Sample Service Delivery Protocol

## Create the Care Plan with Caregiver

- 1) Review the family's vision and strengths as identified from assessments
- 2) Review goals, strengths and needs identified from assessments
- 3) Describe and prioritize goals as a team (caregiver, Family Partner and/or Mental Health Clinician, natural supports)
- 4) Determine indicators for each goal (How will you know the goal is accomplished?)
- 5) Discuss possible strategies and services to meet goals
- 6) Caregiver selects which strategies seem to best fit their family
- 7) Team identifies the next step to access chosen services, identifies the person responsible for completing that step, and a target date for completion
- 8) Caregiver and providers sign Care Plan as symbol of mutual understanding

### Care Plan Template

**Family Vision:** "We will..."

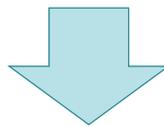
**Family Strengths:** "Parent is... Child likes to... Parent and child express..."

**Goal #1:**

**Services/Strategies:**

**Person Responsible:**

**Target Date:**



## Make the Care Plan Accessible

### Medical Home

The FP and/or MHC should document the Care Plan in a template where other medical home providers can see it – preferably in the electronic medical record (EMR) system, or on paper and scan it into the EMR.

### Caregiver and Natural Supports

The caregiver should be given a copy of the Care Plan to keep. A Family Log, a binder for families to monitor progress toward goals, can be a helpful place to maintain a Care Plan.

### Community Partners (consent required)

With caregiver consent, a copy of the Care Plan can be sent to any key partnering agency, such as a school or daycare.

# Sample Service Delivery Protocol

## 4) SERVICE IMPLEMENTATION

### Access Care Plan Services

**Designate Lead Family Contact:** Either the Family Partner or Mental Health Clinician is designated as the lead contact to follow up with the family on Care Plan tasks and service initiation. Consider the nature of the Care Plan goals and relationship with caregiver in designating the lead contact.

**FP and MHC:** Both complete the tasks they are responsible for on the care plan.

**Lead Family Contact (FP or MHC):** Within one week, call the family to check status of their designated tasks. Support caregiver in overcoming barriers to completing tasks.

### Family Participates in Care Plan Services

**Family Partner Services:** *For example:* Parent education, family strengthening evidence-based activities, connection to community resources, parent mentorship, skill building, care coordination of community-based resources and programs

**Clinician Services:** *For example:* Brief clinical interventions, ongoing clinical therapy, mental health consultation to local daycare/school, care coordination of clinical services and key agencies (schools, DCF, etc.)

**Community Services:** *For example:* Early Intervention, Family Nurturing Groups, playgroups, daycare, preschool, caregiver education classes, parent support groups

**Enhanced Primary Care:** FP and MHC can check in with family at well or sick visits with PCP. There is opportunity for re-engagement if caregiver chose not to participate with FP or MHC but identifies ongoing needs.

# Sample Service Delivery Protocol

Revise Care  
Plan

OR

Prepare for  
Transition



**Team Assesses Progress toward Goals**

## Documentation

1) **Progress Notes:** *(Written after every encounter with the family by the Family Partner or Mental Health Clinician)*

- FP and MHC: Use respective templates in medical record to make notes after all encounters.
- Caregiver: With support of the FP or MHC, use the Care Plan to monitor progress develop skills in care coordination for child and family.

2) **Care Plan Revision:** *(At least every 3 months, along with the Child and Adolescent Needs and Strengths [CANS] update if diagnosed with Serious Emotional Disturbance [SED])*

- Care Plans are revised by the FP, MHC or both to reflect progress family has made in reaching goals; strengths and needs of family are re-visited to determine if family should continue with current clinical and resource/support goals, define new goals, or transition from services

# Sample Service Delivery Protocol

## 5) TRANSITION

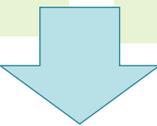
### Differentiate Transition vs. Disengagement

**Intentional Transition:**  
Families that achieve Care Plan goals or make significant progress such that the caregiver can continue to manage their child's care without formal services

- Some health practices might also have an upper age limit for services, at which point families transition to another provider.
- A **Transition Plan** should be created by the caregiver with the Mental Health Clinician and/or Family Partner.

**Disengagement:**  
Families that stop coming to visits and stop responding to contact by the FP and MHC

- Develop a protocol for how long the FP and MHC try to reach the family (e.g. 3 calls to re-establish contact then a letter with open door policy and provider contact info)
- MHC or FP then contacts the PCP to notify them of the caregiver's disengagement; this enables the PCP to follow up with the caregiver at the child's next medical visit. A PCP can re-refer a family after discussing the services again and identifying a change in the caregiver's readiness to participate.



### Plan for Intentional Transition in Each Phase

At every step of services, families should be encouraged to think about transition:  
*What will it take for this family to succeed without the FP or MHC's direct services?*

**Engagement/Assessment**

- What skills can we support caregiver in developing so that she can coordinate her families services?
- Who else in the caregiver's life can offer support long-term?

**Care Planning**

- What goals are specifically related to caregiver self-efficacy and skills?
- What goals are specifically aimed at strengthening the caregiver's existing supports or connecting her to other moms?
- What programs can the caregiver access on her own?

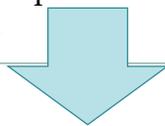
**Service Implementation**

- How can the caregiver take an increasing role in coordinating services for her own family?
- What information or skills does the caregiver need to identify ongoing supports and access them?

# Sample Service Delivery Protocol

## Create Transition Plan

- 1) **Discuss Reason for Transition**
- 2) **Update Strengths and Note Accomplishments**
- 3) **Update Crisis Plan If Needed**
- 4) **Identify Other Medical Home Services that Family Will Continue with:** Team identifies medical home services (e.g. Primary Care Provider care, playgroups, nutrition support, etc.) that the family will continue to engage in. Family should have scheduled appointment with PCP within 3 months to check in.
- 5) **Create Plan for Continued Participation or Linkage to Community-Based Services:** Team identifies community-based services that the family will continue to participate in. Ensures caregiver has all contact info for those programs. If specific consultation was provided to the agency, MHC/FP lets the contact know of the families transition and ongoing plan. If family is moving, FP/MHC connect the caregiver to community resources in new neighborhood as possible.
- 6) **Create Clinical Therapy Plan:** If the MHC provided clinical therapy to family, then the MHC and caregiver determine whether clinical care will be transitioned to another behavioral health provider or whether clinical therapy will cease as goals have been met.
- 7) **Create Plan for Ongoing Communication:** The FP and caregiver agree on a plan for subsequent contact that tapers off the FP support (e.g. 3 phone calls to ensure caregiver made transition plan linkages to other providers or programs).
- 8) **Celebrate Success:** The FP or MHC plans a personal “commencement” for the family that celebrates the goals accomplished and skills gained.



## Communicate with PCP for Continuity

- 1) FP or MHC documents Transition Plan in medical record and notifies PCP of plan
- 2) Ensure follow-up appointment with PCP within 3 months
- 3) FP or MHC completes agreed-upon contact plan with caregiver and notifies PCP of completion, at which time the PCP is the next follow-up contact
- 4) A PCP can re-REFER a family to the FP/MHC after discussing the services again. PCPs should first try to understand barriers to completing Transition Plans or sustaining engagement in services.

## SERVICE DELIVERY PROTOCOL IN DEPTH: SAMPLES AND INFORMATION ON ALL FIVE PHASES

Now that you've taken a look at the Sample Service Delivery Protocol information, keep reading to get an in-depth look at each step in the service delivery process. As a reminder, the phases are:

- 1) Referral System Development
- 2) Engagement and Assessment
- 3) Care Plan Development
- 4) Implementation of Services
- 5) Transition



## PHASE ONE

# Design your Referral System

A well-developed and clearly articulated referral system forms the foundation of the service delivery model. It is important that the system work well in the existing systems and culture of the practice. The referral system should be piloted and adjusted as the program is developed to allow for growth and development of the service delivery system.

Providers should be held to the standards of the set system and have a clear opportunity to contribute feedback. The referral system should not be changed on a whim but rather should include an intentional process for the core team to evaluate, reflect and adjust based on user feedback.

## KEY OBJECTIVES IN THE DESIGN PROCESS

- 1) Identify Principles, Team Roles and Key Components of Effective Referral Systems Integrating Primary Care and the Core Team
- 2) Develop Referral Documents: Templates, Clinic Posters and Introductory Scripts  
*(Samples Provided)*
- 3) Develop a Family Self-Referral Protocol to Promote Caregiver Self-Referral  
*(Sample Provided)*

### Referral System Checklist

- |   |  |
|---|--|
| <input type="checkbox"/> Referral Criteria  | <input type="checkbox"/> Tracking System for Referrals   |
| <input type="checkbox"/> Referral Template  | <input type="checkbox"/> Communication System for Informing Referring Provider of Referral Outcome |
| <input type="checkbox"/> Referral Protocol  | <input type="checkbox"/> System for Informing Referring Providers when FP-MHC Capacity is Full     |
| <input type="checkbox"/> Provider Awareness of Services                               |  |
| <input type="checkbox"/> Family Self-Referral Materials                               |  |
| <input type="checkbox"/> System for Designating Lead Contact for Each Referral Family |  |

## Objective 1: Identify Principles, Team Roles and Key Components

### Important Principles

- **Warm Handoffs:** Whenever possible, referrals should be “warm handoffs,” meaning the Family Partner or Mental Health Clinician is introduced to the family in person at the time of referral.
- **Self-Referrals:** Families should be empowered to self-refer. Materials introducing the program to families should be readily accessible in the medical home (e.g. brochure) and participating parents should be encouraged to talk about the services with providers and other parents.
- **Communication:** The MHC and FP should have clear communication systems with referring medical home providers, so that no family is lost in the referral process. Electronic medical records (EMRs) help facilitate this.
- **Accessibility:** Try to contact referred families within three days to ensure accessibility and build trust between families and providers.



- **Open Door Policy:** An “open door” policy for families that choose not to engage in services after referral is a good idea; these families can contact the FP or MHC for help when ready.

### Team Roles

- **Family Partner and Clinician:** Receive referrals in person, via EMR and directly from families. Either provider asks the caregiver a set of introductory questions to understand the caregiver’s reason for referral and brief goals. Depending on responses, either the FP or MHC may schedule the first engagement and assessment visit with either the FP alone, MHC alone, or with the team jointly.
- **Primary Care Provider:** The PCP makes referrals to the FP and MHC, designating a clear reason for referral (differentiating family concern vs. provider concern) and caregiver readiness to engage. The family must agree to the referral before a PCP makes it.
- **Primary Care Champion:** (*This person may also be the child’s PCP.*) The Champion fosters awareness of referral criteria and processes among other primary care providers. He/she should encourage providers to try warm handoffs when possible, and update PCPs on capacity of MHC and FP services.
- **Administrator:** Co-design and advocate for clinical systems that support the FP and MHC to efficiently receive and track referrals (i.e. referral template in EMR). The admin arranges training for the FP and MHC on scheduling and documentation systems, plus enables the FP and MHC to schedule their own patients and have access to each other’s calendars.

## Objective 1: Identify Principles, Team Roles and Key Components

### Key Components of Referral Systems

**Lead Contact For Each Referred Family:** For each referral, either the MHC or FP is designated as the “lead contact.” This provider contacts the family via phone or meets them in person during well visit and asks the caregiver a set of introductory questions (see example provided). Depending on the caregiver’s and provider’s concerns, the FP or MHC can provide immediate resource connection or schedule the family with a follow-up engagement and assessment visit to better understand the related strengths, needs and culture of the child and family. The MHC and FP must understand each other’s strengths and limitations as providers to effectively triage referrals to one provider or the other.

**Joint Scheduling Access:** The FP and Clinician schedule their own appointments and have access to each other’s schedules. It is also a good idea for the FP and MHC to designate joint visits slots per week that either provider can fill when contacting families. Visits should have flexibility in location (home, community or clinic setting) to optimize accessibility for families.

**Communication With Referring Provider:** After the FP or MHC contacts each referred family, inform the referring provider whether the family scheduled an engagement and assessment visit, chose not to pursue services, or could not be reached after several attempts. If a visit was not scheduled with a family, the referring provider may re-attempt to communicate with the family and encourage participation in the service. The door is always open for FP-MHC services in the future.

**Capacity Awareness:** Realistically, the MHC and FP can only serve a certain number of families at any time, depending on the distribution of promotion, prevention and intervention efforts. There may be brief periods of time where the FP and MHC are unable to take on new families. Communicate this to the rest of medical home staff so families can be supported through partnering services or receive additional supports through their PCP until the FP or MHC has openings.

## Example 1: Introductory Questions for Contacting Family after Referral

These questions can guide the first encounter between the Family Partner or Clinician and family after referral, whether in-person or on the phone. They help to better understand the reason for referral from the caregiver's perspective as well as identify a next step to support the family (or "triage" the level of need). These questions will help determine whether the family's need can be immediately met (e.g. resource connection) or whether an engagement and assessment visit should be scheduled involving the caregiver and either the FP, Clinician, or both providers.

### First, introduce yourselves:

I'm \_\_\_\_\_, the Family Partner from the \_\_\_\_\_ project at \_\_\_\_\_ health practice..."

### Then, explore the caregiver's familiarity with the referral:

"We received a referral for \_\_\_\_\_ to our project from Dr. \_\_\_\_\_. We wanted to see if there are ways we can support your family. Have you heard about our services? What have you heard?"

### Then, ask about the caregiver's reason for referral:

"Tell me a little bit about [child's name] and your family. Why do you think \_\_\_\_\_ connected us to your family?"

"Do you have any concerns about [child's name] development, behaviors, or ways that he interacts with others? Tell me about it."

"What type of support do you think would help your family?"

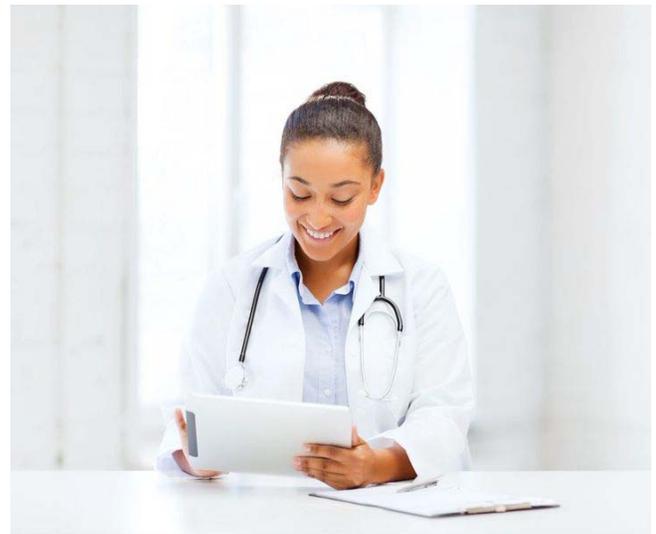
## QUICK LINKS TO REFERRAL DOCUMENT SAMPLES

<p><b>Clear Referral Criteria:</b> A written description of the target population for services within your health practice, including age range and spectrum of need (promotion, prevention, intervention). Guidance for creating your criteria is provided in section 1 of this toolkit, <i>Building a Core Team</i>.</p>	<p><a href="#">Referral Criteria, MYCHILD</a></p>
<p><b>Referral Template:</b> A standard referral template for medical home providers to use in referring families. Include the reason for referral and family's level of concern as well as indication that the referral was discussed with the family. This same template can guide the Family Partner and Mental Health Clinician in talking with families who call to self-refer.</p>	<p><a href="#">Referral Template, MYCHILD</a></p>
<p><b>Referral Protocol:</b> Evaluate the most effective way of communicating referrals between providers; use of the EMR system is ideal where possible. There should be a subsequent protocol on how many days the FP and MHC have to contact the family and what to do if the family cannot be reached.</p>	<p><a href="#">Clinic Room Cards, MYCHILD</a></p> <p><a href="#">Script for PCPs to Introduce the Referral, MYCHILD</a></p>
<p><b>Provider Awareness:</b> Providers need to be aware of this service, eligibility criteria, services delivered and protocols for contacting families referred. Providers need to be able to clearly articulate the service to the caregiver, so that families understand what the referral means and what to expect. Strategies to build awareness include sample Primary Care Provider introduction to services, clinic room poster, presentations at provider meetings, and co-location presence of FP/MHC during pediatric clinics.</p>	<p><a href="#">Referral Guidance to PCPs, LAUNCH</a></p> <p><a href="#">Referral Reminder Poster, LAUNCH</a></p> <p><a href="#">Referral Reminder Poster, MYCHILD</a></p>
<p><b>Tracking System:</b> Track referrals to ensure timely follow up and maintain a record of initial communication with families. This document can help the FP and MHC coordinate outreach efforts to newly referred families, as to enhance engagement and reduce duplication of efforts.</p>	<p><a href="#">Service Tracking Document</a></p>

## Sample 1: Referral Criteria for Primary Care Providers Project LAUNCH, Boston Medical Center (BMC)

As a reminder, referral criteria are:

- 6 months – 8 years old
- Boston residents or willing to come to Boston Medical Center for visits
- Family not getting other services like In-Home Therapy
- Prevention/Promotion cases (i.e. not families with PDD diagnosis or trauma-related concerns or in need of weekly or intensive behavioral health services)
- Family interested in services and aware that there is an intake process



\*Language Capacity: English and Portuguese

Referral Criteria (Support Around...)	Example	Possible Intervention
1) Normal Child Behavior	3 year old that has tantrums and mother reports not knowing what else to do	Brief intervention around parenting
2) Normal Parental Anxiety	Mother that has asked you several times the same question regarding baby's eating, sleep or crying	Parental support, normal child development information
3) Dyadic Relationship	Mother that reports opposite behavior than the one observed by you (e.g. "child is impossibly hyperactive")	Discussion about temperament, expectations, normal child development
4) Development	Child with possible language delay that concerns mother and/or might impact behavior	Referrals to Early Intervention, Boston Public Schools and workaround parenting strategies

## Sample 2: Referral Criteria for Primary Care Providers MYCHILD, Dorchester House Multi-Service Center

### Eligibility for MYCHILD Services:

- ✓ Infants and children ages birth through the end of 1<sup>st</sup> grade with a Serious Emotional Disturbance (SED) or at “Imminent Risk” of SED

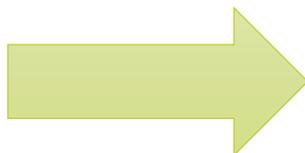
#### Who Should I Refer to MYCHILD?

- ✓ Infants and children ages 0-6 years old with SED or at Imminent Risk of SED, such as:
  - Atypical Behaviors
  - Child abuse
  - Concerning interactions or relationships with caregiver
  - History of behavioral or emotional health problems
  - Infants that have poor bonding with caregiver
  - Loss of caregivers
  - Depression
  - Changes in caregivers
  - Anxiety
  - Recent exposure to trauma
  - Emotional regulation problems
  - Self-harm

#### Two Types of Referrals:

##### 1) Warm Handoff

- Family in clinic
- Provider directly contacts MYCHILD Family Partner or Mental Health Clinician (by phone at ext. 2307 or ext. 2308)
- MYCHILD staff sees family at end of well visit
- If MYCHILD staff not available or patient not ready to meet with MYCHILD staff at this time, see option 2.



##### 2) Logician Referrals to MYCHILD’s Desktop

- Provider sends a referral with attached Patient’s Chart to the MYCHILD desktop using the MYCHILD referral form in Logician
- Find the form in Logician. While in the child’s chart, go to: Print > Letters > A-Referrals > MYCHILD referrals
- Complete form with as much info as possible, save as “document in chart” and route to MYCHILD desktop
- Provider will give family a MYCHILD brochure with MYCHILD staff business card stapled to brochure and inform them someone from this program will contact them\*

## Sample 3: Clinic Room Cards for PCP Referral Guidance

### What is MYCHILD?

MYCHILD is a program for young children (birth- 1<sup>st</sup> grade) with *significant* social, emotional or behavioral health needs. It provides these young children and their families with strength-based, comprehensive services that broadly address the behavioral needs of the child and associated family stressors.

### What Services Does MYCHILD Offer Families?

The MYCHILD Family Partner and Mental Health Clinician provide family-driven support services and therapy.

- **Family support and engagement** around the child's behaviors and caregiver-child relationship
- **Clinical therapy** for child or parent-child dyad
- **Linkages** to community-based family services
- **Care coordination** around clinical and community services
- **Consultation** to staff at the preschools/childcare centers where child attends

### Who Should I Refer to MYCHILD?

Children ages birth-1<sup>st</sup> grade who



Have a known behavioral health diagnosis and are not receiving adequate treatment services

**OR**

Display significant emotional needs or behavioral challenges that are not typical for their age

**OR**

Have concerning interactions or relationship with a caregiver that affects the child's social/emotional development

#### **Consider the following areas for referrals:**

- Known behavioral health history
- Emotional regulation
- Behaviors in preschool/childcare
- Anxiety, depression
- Atypical behaviors
- Hyperactivity, attention
- Exposure to trauma
- Self Harm, aggression
- Parent-child interaction
- Attachment to caregiver

## What Happens After I Refer a Child?

**Introductions:** Family will receive a phone call or will meet the MYCHILD team at end of the well visit

**Appointment:** If the family is interested, first MYCHILD appointment will be scheduled

**Assessment:** During first appointment, MYCHILD Clinician will do an assessment of the social and emotional needs of the child and determine eligibility\* for MYCHILD

**Feedback:** MYCHILD Clinician will communicate via EMR or in person if referred family enrolls in MYCHILD services

**Ongoing Communication:** MYCHILD team will update you on families goals and progress as they receive services; your valuable input on effectiveness of services will be sought

\* MYCHILD serves children ages birth- 1<sup>st</sup> grade with Serious Emotional Disturbance (SED) or at “Imminent Risk” of SED.



## How Do I Refer to MYCHILD?

**There are 2 ways to refer a child:**

### **1) Referral During Well Visit**

- Primary Provider directly contacts MYCHILD Family Partner or Mental Health Clinician
- Provider briefly explains the reason for referral
- MYCHILD staff meets family at end of well visit

### **2) Referral via Electronic Medical Record**

- Provider sends a note, with the attached medical record, to the MYCHILD staff. Note contains reason for referral
- MYCHILD staff reviews chart and clarifies questions with provider regarding reason for referral
- MYCHILD Family Partner contacts the caregiver by phone to introduce program

## Sample 4: Referral Template for Primary Care Providers

MYCHILD, Bowdoin Street Health Center

Date \_\_\_\_\_ Referring Provider \_\_\_\_\_

Child's Name \_\_\_\_\_ MR # \_\_\_\_\_

**Reason for Referral:**

Concern	Yes	No
Known behavioral health history/ diagnosis		
Concerning behaviors in preschool/childcare		
Hyperactivity/Inattention		
Atypical behaviors		
Aggression		
Depression		
Anxiety		
Self harm		
Exposure to trauma		
Concerning caregiver-child interactions/relationship		
Issues with attachment to caregivers		
Caregiver mental health issues		
Emotion regulation problems		
Psychosocial stressors (Please describe below)		

**Other (please describe):**

\_\_\_\_\_

**Has the family been informed of the referral to MYCHILD?**

- Yes
- No

**Best way to reach caregiver (please circle):** Number in OMR   Other number   Text   Letter  
Other

\*Please list **any other information** that is important for the MYCHILD team to know about this referral:

\_\_\_\_\_



## Want to refer a patient to LAUNCH?



### Please take into consideration the following:

- ✓ Children ages **6 months – 8 years old**
- ✓ **Boston residents** or willing to come to Boston Medical Center to see LAUNCH staff
  - ✓ **No DCF involvement**
  - ✓ **No current issues related to trauma** (e.g. child witness to violence, sexual assault)
- ✓ **Not already getting other services** like Behavioral Health, In-Home Therapy, School Counseling, Therapeutic Mentoring, etc.
  - ✓ **Parent is aware** of the referral and wants extra support
    - ✓ Family is aware that there is an **intake process**

### Which families could benefit from project LAUNCH?

#### **Those needing:**

- Support around **normal child behavior**: tantrums, sleep, limit setting, parenting strategies, etc.
- Support around **normal parental anxiety**: information regarding normal child development, temperament, etc.
- Support around **dyadic relationship**: mismatch in temperament or other non-trauma-related issue
- Support around **development**: concerns around language, gross motor skills, etc. that need screening and referrals to EI and BPS, with no suspicion or diagnosis of Autism Spectrum Disorders.

To refer, please **page x3555** with child's name, MRN, room # and call back #

**OR**

flag LAUNCH referrals on EMR after 5:00 pm with a brief description of the referral.

*When in doubt, please contact staff to consult around possible referral!*

# Put MYCHILD on Your Mind

Joseph Smith Community  
Health Center

## Who should I refer to MYCHILD?

Consider the following areas for referrals:

**M**aternal or child abuse

**Y**oung children with atypical behaviors

**C**oncerning interactions or relationship with caregiver

**H**istory of behavioral or emotional health problems

**I**nfants that have poor bonding with caregiver

**L**oss of caregivers

**D**epression

**C**hanges in caregivers

**A**nxiety

**R**ecent exposure to trauma

**E**motional regulation problems

**S**elf-harm



**MYCHILD is  
a program for:**  
*Young children (birth-1<sup>st</sup>  
grade) with significant  
social, emotional or  
behavioral health  
needs.*

## Sample 7: Script for PCPs to Introduce the Referral

### For an infant:

"I'd like to refer you to a new program here at Bowdoin Street Health Center. The program is called MYCHILD. It's a team of two people, a Clinician and a Family Partner, who can help support you.

We know that being a new parent can be stressful. The Family Partner [name] and Clinician [name] can help support you when things are stressful, answer your questions about what to expect as your baby grows up, and give you tips about things to try. They can also help connect you to resources or other things that you might need help with (daycare, Head Start, school for mom, ESL classes, housing application, etc.).

They can meet with families once a week. Would you like to talk to them? I can call them now to see if they can come to meet you or I'll can ask them to give you a call."

### For an older child:

"I'd like to refer you to a new program here at Bowdoin Street Health Center. The program is called MYCHILD. It's a team of two people, a Clinician and a Family Partner, who can help support you.

We know that being a parent can be stressful, and that all parents need support. Our Family Partner [name] and Clinician [name] can help support you when things are stressful, and give you ideas about things to try to help with [child's name] feelings and difficult behaviors (e.g. temper tantrums, not listening to caregivers, hyperactivity, anxiety, depression). They can also help connect you to resources or other things that you might need help with (daycare, Head Start, school for mom, ESL classes, housing application, etc).

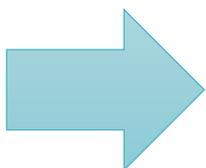
They can meet with families once a week. Would you like to talk to them? I can call them now to see if they can come to meet you, or I'll can ask them to give you a call."

## FAMILY SELF-REFERRAL MATERIALS



Families in the medical home need to be aware of new Family Partner-Mental Health Clinician services so they can self-refer. The services must be described using family-centered language so it reduces stigma against asking for help regarding a child's feelings or behaviors.

Strategies to build awareness among families include waiting room and clinic posters/brochures, periodic information tables in reception, and parent ambassadors who spread the message among peers. Contact information must be accessible to families so they can directly call the FP and/or MHC.



**Click here to view a sample LAUNCH family brochure and a sample MYCHILD family brochure.**

## PHASE TWO

# Engagement and Assessment Visits

Engagement and assessment visits are the initial visits with a family to build a trusting provider-caregiver relationship as well as identify the child's and family's strengths, needs and culture that relate to the social and emotional health of the referred child.



## KEY OBJECTIVES IN THE DESIGN PROCESS

- 1) Identify Principles, Team Roles and Key Components of Engagement and Assessment Visits
- 2) Develop Written Intake Forms and Protocols (*Samples Provided*)
  - ❖ Identify Strategies to Improve Family Engagement on Children's Social and Emotional Health
  - ❖ Recognize the Value of the CANS as a Monitoring Tool for Children Receiving Mental Health Services
  - ❖ Create an Intake Form to Organize and Guide Engagement and Assessment Visits for the Family Partner and Mental Health Clinician
  - ❖ Review Options for Screening and Assessment Tools for Children's Mental Health and Family Basic Needs; Select Specific Tools for Your Service Model
- 3) Develop Protocol for using the DC 0-3R as a Resource in Formulating Early Childhood Mental Health Diagnoses

## Objective 1: Identify Principles, Team Roles and Key Components

### Important Principles

- **Accessibility:** It is best for these visits to occur in the child's natural environment (home, community) whenever possible and preferable to the parent.
- **Caregiver's Perspective:** The assessment process aims to identify the caregiver's strengths, concerns and individualized goals regarding their child's social and emotional health.
- **Immediately Useful Tool:** Assessment visits still provide the caregiver with an immediately useful resource (interaction tool, educational toy, connection to community program, etc.) as the broader goals of services are being identified.
- **Clear Next Steps:** All visits end with a plan for next steps, including a date for next contact and plan of tasks to be done beforehand by the caregiver and provider(s).

### Engagement and Assessment Visit Checklist

- |   |   |
|---|---|
| <input type="checkbox"/> Service Delivery Tracking System and Weekly Family Review Meetings | <input type="checkbox"/> Crisis Resources and Protocol  |
| <input type="checkbox"/> Intake Forms for Engagement/Assessment Visit(s)                    | <input type="checkbox"/> Collection of Immediately Useful Tools or Resources                      |
| <input type="checkbox"/> Selected Child and Family Screening and Assessment Tools           | <input type="checkbox"/> Consent Forms for Contacting Community Providers                         |
| <input type="checkbox"/> Caregiver's Mental Health Screening Tool                           | <input type="checkbox"/> System for Third-Party Billing for Clinician (and maybe Family Partners) |
| <input type="checkbox"/> System Storing Completed Assessment Tools                          |   |

## Objective 1: Identify Principles, Team Roles and Key Components

### Team Roles

*\*Depending on the reason for referral, the target population, and the experience of the Family Partner and Clinician, the initial engagement and assessment visit may be led by the FP, the Clinician, or both providers together.*

**Family Partner:** For families where the reason for referral is prevention-focused, the FP may lead the initial engagement and assessment visit and involve the Mental Health Clinician only if higher levels of clinical assessment are needed. If the engagement and assessment visit is led by the FP and MHC together, the FP's role should first focus on building a trusting relationship with the caregiver. Using their lived experience, FPs are critical in building a relationship with the caregiver, especially when meeting those with distrust in the medical system. With training, the FP can use standardized tools to assess the child's development (i.e. ASQ-SE) and identify significant family stressors (i.e. PSI, basic needs assessments).

**Clinician:** For families where the reason for referral suggests that a higher level of intervention is needed, the MHC may want to lead the initial engagement and assessment visit(s) either alone or with the FP, depending on availability. The FP's lived experience is a particular asset in engaging families who have experienced other mental health services, so some families may be best served with the provider dyad from the very beginning. The MHC can use standardized tools to assess the child's social and emotional health and identify significant family stressors.

**Primary Care Provider:** The PCP encourages the family to engage in initial visit(s) with the MHC and/or FP. If the family does not show up to the engagement/assessment visit, the PCP can follow up with the family to identify barriers, and

motivate participation or connect the family to a community service that better fits their needs.

**Primary Care Champion** (*may also be the child's PCP*): The Champion guides selection of the screening tools for social and emotional health that PCPs use in all primary care visits (e.g. PSC, PEDS). He/she informs selection of the secondary assessment tools the FP and MHC use during engagement and assessment visits. He/she also educates other PCPs about the general format of the engagement and assessment visit, tools used, and the roles of the FP and MHC in this process. This person should also provide PCP feedback to Core Team on FP/MHC communication systems with PCPs.

**Administrator:** The Administrator assures that the tools the FP and MHC need to complete assessments are readily available and able to be securely stored in medical records. Ensure the FP and MHC are appropriately trained on administering assessment tools, and support the FP and MHC to document their assessments in a way that facilitates care coordination with PCPs but also respects confidentiality of mental health visits. The Admin maintains safety protocols for home visiting and facilitates training on these protocols. He/she also ensures crisis protocols are up to date and emergency resources are accessible for the FP and MHC when conducting assessments in home and community settings. Also ensure family consent forms are in accordance with health practice policies and guidelines.

## Key Components of Engagement and Assessment Visits

**Consent Forms for Contacting Community Providers:** The Family Partner and Mental Health Clinician partner with families to coordinate medical home and community-based resources, thus optimizing supports to their family. The combination of complimentary medical home and community services will best meet the broad needs and interests of families without duplicative or redundant services. It also enables consistency in approaches and strategies to foster healthy behaviors and social interactions in multiple settings, including home, schools, and daycare. Note that FP and MHC need consent to contact community partners involved in the child's care. Have consent forms available to discuss with families during the initial visit.

**Screening Tool for Caregiver's Mental Health:** A caregiver's mental health can have a tremendous impact on the social and emotional development of a child. Identifying and responding to the mental health needs of mothers is critical in a family-centered model of care and must be done early. So, part of the engagement and assessment visit includes a screening for caregiver's mental health. Demonstration sites used the PHQ-9 for caregiver depression screening, as it is available in many languages and free. Health practices must also devise a strategy for how and where to store caregiver's mental health information. Depending on the practice, this may be in the child's behavioral health notes, the caregiver's chart, or a separate file. See the information on Supporting Child-Caregiver Integrated Services in Medical Home Systems for details on caregiver screening and documentation.

**System For Storing Completed Assessment Tools:** Each medical home needs a system for securely storing the assessment tools completed by the FP and MHC. This may vary based on the status of the electronic medical record and your ability to scan information into the EMR. Likely, some assessments will be completed on paper given the range of locations that engagement and assessment visits may occur, including home and community locations. Scanning these assessments into the EMR works best so that information is not lost; some health practices choose to lock these notes as behavioral health records if information requires higher levels of confidentiality within the medical home. Alternatively, you can devise a system for locking these paper records in files and recording a brief summary of results in an electronic note so that the appropriate information can be accessed by other medical home providers for care coordination purposes.

## Objective 1: Identify Principles, Team Roles and Key Components

### COMPONENTS CONTINUED ...

**Crisis Resources:** Some families referred may be experiencing crises related to mental health or safety. The FP and MHC may be the first to recognize the emergent needs of these families through their assessment process and must be equipped with appropriate resources to respond. This means connection to existing emergency services, as the FP and MHC should not serve as an emergency mental health service. Medical homes may have a behavioral health department with an on-call provider that could be available to the FP and MHC when crises emerge. All health practices should have or develop crises protocols to guide an employed provider to emergency resources.

**Third-Party Reimbursement:** Assessments and subsequent collateral contact with community partners may be billable in the current fee-for-service model. An independently licensed, credentialed clinician may bill for this time if the child is diagnosed with DSM diagnosis. There may be alternative routes to billing for the time of the Clinician and FP as co-visits with a nurse or primary care provider. See section 4 of this toolkit *Financing and Sustaining the ECMH Model* for more information.

## QUICK LINKS TO WRITTEN MATERIALS AND PROTOCOLS

**Intake Forms:** The Family Partner and Mental Health Clinician must have intake forms which guide the direction of the initial engagement and assessment visit and ensure completeness of required components of these visits. These forms do not have to be scripted questions; rather, they are checklists to ensure all key topics are covered regarding strengths, needs and culture.

There are two types of intake forms:

**Family Partner-Mental Health Clinician-Specific Forms:** Develop an intake form that helps guide the FP and/or Clinician during their initial visit with a family. It should contain basic family demographic information as well as a checklist of the specific screening or assessment tools selected by your health practice. Some sites choose to assemble intake packets that include the intake form followed by accompanying assessment tools to be completed. The intake form could be a template in the EMR system or a paper form that is scanned into the EMR if visits are completed in home or community settings.

**Clinician-Specific, Massachusetts Required Form:** The CANS (Child and Adolescent Needs and Strengths) is a communication and monitoring tool required for any clinician completing a behavioral health assessment with a child receiving MassHealth ages birth-21. This form should be completed using family information gathered during the engagement and assessment visit(s).

[CANS: MassHealth Communication and Monitoring Tool for Children's Mental Health Services](#)

**Family Partner and Mental Health Clinician Tracking System and Weekly Family Reviews:** Since the FP and MHC may individually lead the engagement and assessment visit with a family, it is critical that these providers have a clear communication system to inform each other on the status of all families referred. One possible system is a Microsoft Excel sheet uploaded on a shared computer drive. Both providers can then update the sheet to reflect all contact with referred families and status of visits (i.e. date completed). In addition, the FP and MHC should have regular weekly meetings to review the status of all families referred to ensure all families are receiving optimal support.

[Creating a Service Tracking Document](#)

## Objective 2: Develop Written Materials and Protocols

### QUICK LINKS CONTINUED ...

<p><b>Screening and Assessment Tools:</b> The FP and MHC should use validated screening and assessment tools to understand the child’s social, emotional and behavioral health as well as related family environment and stressors. Use of formal tools ensure you’re asking meaningful questions in the clearest way. There are many validated tools to chose from, so the Core Team should decide which to use as a group based on your target population for services.</p>	<p><a href="#"><u>Childhood Mental Health Screening and Assessment Tools</u></a></p>
<p><b>Collection of “Immediately Useful” Tools:</b> Parents consistently report that when engagement and assessment visits include an immediately useful tool or resource, they are more likely to come back to services. Relationship-building takes time, and the immediate tool will not be the solution to a caregiver’s biggest concern; rather, it will be a tool that reflects the family was heard and that demonstrates that the FP and/or MHC can respond with action.</p> <p>Tools may be a behavioral management strategy to try at home, the phone number of a local community center, a handout on handling temper tantrums, a backpack for school, etc. Based on the reason for referral, the FP or MHC may anticipate what type of resource of tool could be immediately useful to a caregiver and come to the first visit equipped with possibilities. Building a collection of these materials is key; while some may be handouts that can be printed, others may be donated resources that can be acquired from community partners.</p>	<p><a href="#"><u>Resources and Contacts Guide</u></a></p>

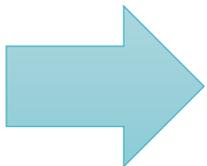
## OVERVIEW OF INTAKE FORMS



The intake form serves as a guide for the initial engagement and assessment visit. It guides the exploration of child and family strengths, needs and culture by serving as an organizational tool for key family information and screening/assessment tools. The intake form is not a script that needs to be exactly followed; rather, it's a guide and checklist to ensure that all the relevant information is explored with a caregiver before a Care Plan is made.

Intake forms will vary across health practices based on the demographic information needed and the target population of the new services delivered by the Core Team. Included here are samples of intake from demonstration sites. These sample forms reflect information essential for providing family-centered care as well as information required by funding grants. Nonetheless, the formats and examples may help your practice develop an intake form that meets the needs of your providers and families.

The intake forms should be securely stored in the medical record system at your practice. Ideally, these forms can be templates on the electronic medical record (EMR) system or scanned into the EMR system if printed as paper copies for home and community visits.



**[Click here to view a sample intake form.](#)**

## CANS TOOL FOR INTAKE

**CANS, the Child and Adolescent Needs and Strengths form, is a MassHealth communication and monitoring tool for children's mental health services.**



MassHealth requires behavioral health providers to complete a comprehensive assessment at the start of working with children and youth ages birth-21 years old. For clinicians, this assessment must be recorded in the CANS, a comprehensive multisystem tool developed by John Lyons, PhD to facilitate individual service planning and evaluation of service systems. The CANS is a communication tool that enables providers to use a common language in service planning and track a child's progress in care by using consistent domains to understand child and family functioning.

The CANS contains multiple sections on the life domains of the child, as well as sections on the family's beliefs and the family's general stressors. It must be updated every 90 days for children with MassHealth regularly seeing a behavioral health provider. The following websites provide more information about the use of the CANS and training for providers.

- 1) [User Guides, Tools Forms, and Race/Ethnicity Implementation Data](#)<sup>13</sup>
- 2) [Provider Training and Certification in CANS](#)<sup>14</sup>
- 3) [Overview and National Use of the CANS](#)<sup>15</sup>

## CREATING A SERVICE TRACKING DOCUMENT

Demonstration sites used an Excel file placed on a shared drive for Family Partner and Mental Health Clinician individual communication with families and milestones that were met in the process.

### With a service tracking document, you can:

- Have one updated document that the FP and MHC can use to continuously inform each other of contact with families between FP-MHC weekly reviews
- Let the FP and MHC monitor total enrollment and phases of services for families.
- Use color coding text on the Excel sheet to designate which provider updated each box

### The key components of the service tracking sheet are:

- Participant Name
- MRN Number
- Referral Date
- Child's Age
- Referral Source
- Referral Reason (one line)
- Date of First Contact (phone or warm handoff)
- Date of Engagement/Assessment Visit
- Date Care Plan Written
- Date Care Plan Updates (if relevant)
- Date Transition Plan Written (may be a section of Care Plan if met)
- Date of Last Contact with FP/MHC (transition or disengagement)
- Date of Scheduled PCP Follow-up
- Date of Closure Communication with any Designated Key Community Providers



## DEVELOP YOUR TEAM INTRODUCTION

What you say in the earliest encounters with a family really matters. Telling families they have been referred to your service is not enough to grab interest.

Be able to clearly describe how you support families and your principles of care, especially partnering with caregivers. Portray yourselves as a **team**, whether or not all providers are present (Family Partner, Clinician and Primary Care Provider).

Family Partner

example:



“In our project, we are a team—you, me, the Clinician and your Pediatrician. We work together for you and your child together. Your goals guide the work and our direction as a team. As a Family Partner, I’m here to support you in dealing with all the things that come up for you as a parent. To help you manage the stresses and challenges you face so that you can focus on your relationship with your child and your goals. Stress and problems will always come up; I can relate to that as a parent. But I can support you in figuring out how to pursue your goals for yourself and family, and to develop the skills to overcome your challenges.”

**Be patient. Families won’t engage immediately, but most will with time:**

Give caregivers time to think. If they don’t want to participate right away:

- Ask if you can check in with them in a few weeks.
- Provide them with some useful handouts or materials so they see that you are helpful.
- Ask if you can stop by on their child’s next primary care appointment to say “Hi.”
- When you next pass them, use their name in conversation and say something special about their child.

**Remind families, “I am thinking of you.”** In time, the caregiver will trust you.

## DRAWING OUT A FAMILY'S VISION AND STRENGTHS

### Be Creative!

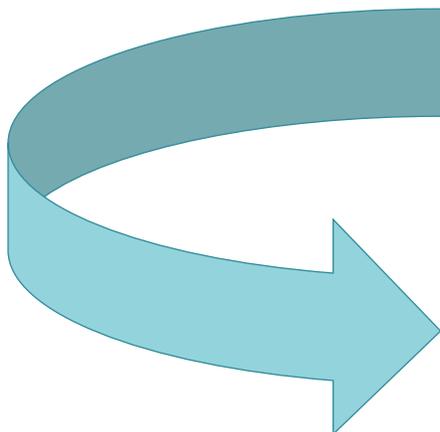
After introducing yourself to the family, be creative in how you ask questions about vision and strengths with caregivers. Many caregivers have never been asked their strengths or their vision before, so those terms might not be familiar. It may take several different questions to help caregivers appreciate their own strengths.

### Asking Caregivers their "Family Vision"

- What do you ultimately want for your family?
- How would you like to see your family 3 months from now? One week from now?
- If you woke up tomorrow and everything is perfect, what would your family look like?

### Identifying Family's Strengths:

- What things do you like to do?
- What qualities do you like in [child's name]? Which of these does he/she get from you?
- What kinds of things do you do to help feel safe or calm?
- How do you relieve stress?
- What kinds of things do you and [child's name] do together?
- Who would you go to for advice?
- What traditions does your family have?
- What are the best things about yourself? Your family? Your community?



### Turn "Assessment Tools" into Conversation Starters:

Many times, families do not complete a mental health intake process. Families may be asked to complete multiple assessment tools in early visits, which can feel overwhelming. It *is* possible to use assessment tools as "engagement" tools. Explain the value of the tool to families from the start. Listening to lists of questions can be hard, so try using visual diagrams with assessment tool questions to help parents focus. If parents seem overwhelmed by questions, take a break!

## MAXIMIZE YOUR CORE TEAM'S RESOURCES

### Delegate between the Family Partner and Clinician

Family Partners and Mental Health Clinicians could have consistently unmet need given the prevalence of social, emotional and behavioral health concerns among families. So be prudent when allocating provider resources. There are great benefits to both the FP and MHC doing all engagement and assessment visits as a team, but that will not always happen depending on your target population.

**Consider this when deciding which provider(s) should lead the engagement/assessment visit:**

- 1) **Reason for Referral:** Based on referral and a brief phone call with caregiver, where on the promotion, prevention or intervention spectrum are services likely to be?
  - Has the family tried mental health services in past and disengaged?
  - Is it a family known to the PCP to face many complex stressors?The more stressors the family faces, the more helpful it is to have both providers involved in care from the start, as likely medical home and community services will be part of the Care Plan.
- 2) **Assets of FP and MHC:** Which provider(s) offer the services or skills that will most likely be helpful to the family? This may vary across all Family Partner-Mental Health Clinician dyad pairs, given the background and training of each provider.
- 3) **Capacity:** Is one provider's capacity full? Can the other provider do the assessment, or is their a need (e.g. clinical need) that only one provider can fulfill?
- 4) **Child and Caregiver?** If young children and the caregiver are coming to the visit, it may be helpful to have one provider who can discuss confidential information with caregiver while the other leads activities with the child and observes behaviors.
- 5) **Talk with the PCP:** The provider can elaborate on the referral, their experiences with the family, and often help what level of assessment and which provider(s) the family is likely to engage with.
- 6) **When in Doubt...** And especially when first launching services, do most visits together to optimize your understanding of each other's assets and broadly meet families. As time progresses, you'll be able to triage referrals to one provider or the other earlier.

**Remember:** The Family Partner or Mental Health Clinician can join the care team of the family at any point if needs arise that require the specialty of the other provider!

## IDENTIFYING FACTORS THAT INFLUENCE FAMILY ENGAGEMENT

QI Project: LAUNCH, Boston Medical Center

### Improvement Goal

To explore service engagement factors, such as the value of warm handoffs, so that our team could better engage families.

### Rationale

Understanding engagement and disengagement factors can help implement strategies to increase patient engagement in services.

### Strategic Approach

#### 1) Tracked Percent of Warm Handoffs

- Performed retrospective chart analysis of the patient caseload from Oct. 2010 – Sept. 2012 to determine the percent of warm handoffs (88 charts in total)
- Stratified data to examine the relationship between warm handoffs and service engagement level (never met family, met but no intake completed, or completed intake)
- Did statistical analysis to look at results of data

#### 2) Developed Parent Questionnaire

Based on the results from the data collection and the literature on engagement, we developed a parent questionnaire to look into potential reasons why parents engaged or did not engage

with LAUNCH services.

#### 3) Feedback from Parent Council

- Attended May 2013 Parent Council to get feedback on questionnaire
- Parent Council answered questionnaires in their roles as parents engaged in services



### Data Analysis

#### Retrospective Review: Warm Handoffs Results

- Among families seen Oct. 2010 through Sept. 2012:
  - 52% received a warm handoff at the time of referral
  - 48% did not receive a warm handoff at time of referral

## Objective 2: Develop Written Materials and Protocols

### RESULTS CONTINUED...

After stratifying data, results showed that:

- If one had a warm handoff then:
  - 58.7% of these families completed the intake
  - 23.91% of these families were seen once or more, but did not complete the intake
  - 17.39% of families were never seen
- If one did not have a warm handoff then:
  - 47.62% of these families completed the intake
  - 23.81% of these families were seen but no intake
  - 28.57% of families were never seen

Statistical analysis performed by the LAUNCH evaluation team revealed the following:

- A 9% difference in the category of warm handoff and zero contacts with staff
  - **(Families that did not receive a warm handoff were 9% more likely to not have a visit with staff)**
- An 11% difference in the category of warm handoff and completing and intake
  - **(Families that had a warm handoff were 11% more likely to complete the intake)**
- There was no statistical significance for the above findings (Chi Square =1.71, df = 2 (86)

- However, there was a small effect size ( $p=0.43$ , Cohen's  $d = 2.82$ ) indicating that this may be clinically important

### Parent Council Feedback and Survey Results

- Seven families completed the Parent Questionnaire (7 LAUNCH):
  - 85.7% of families were aware that their pediatrician made a referral to LAUNCH or MYCHILD
  - 57.1% of families were informed about what the projects were and what services were provided
- During the visit, at time of the referral with the pediatrician:
  - 100% of parents expressed concerns about child's behavior
  - Less than 50% also had concerns about school performance, child development, sleep, toileting, feeding or eating issues
  - 71.4% were interested in getting support for the above
  - 85.7% were informed that the team would contact them to schedule an intake
  - 28.5% met a team member the day of their pediatric visit
    - 100% of *these* families said that this made a difference in their decision to enroll (did not specify if positive)
  - 14.2% reported they did not agree with the referral and had other stressors that hindered them from engaging in services
  - 71.4% did not consider it a burden to do the intake paperwork.

## Objective 2: Develop Written Materials and Protocols

Qualitatively, reasons why parents called staff included:

- They were looking for information and/or resources
- They needed help with a particular task

Services valued most by parents included:

- Emotional support
- Connecting to resources
- Being helpful
- Taking time to listen

Areas identified as in need of improvement:

- One parent reported the need for a shorter time frame in returning phone calls.
- Another family reported that the pediatrician could be more detailed about the referral.

Parents described our services as grants that could help with:

- Enrollment in services, behavior strategies, resources, school and childcare
- Family needs in a caring and understanding environment

### Outcomes

Statistical analysis of the data showed a small effect size, meaning their warm handoffs could be clinically significant, even though they were not statistically significant. With the qualitative information from the Parent Council that warm handoffs had an influence on 100% of families enrolling, more exploration would be needed to

determine if this was a positive effect.

To further look into reasons for engagement and disengagement, our goal was to administer a parent questionnaire to all LAUNCH families. Unfortunately, due to logistical constraints, our team was unable to administer the survey to the remaining LAUNCH families in a timely fashion.

One limitation of our study is that the parents on the Parent Council are self-selected and are most likely our most engaged parents. This may result in survey results which may not be indicative of the majority of the parent population.



### Conclusion

Our QI Team feels that even though we did not complete our goal of sending out questionnaires to all our LAUNCH families, we learned more about the value of some factors in the engagement process of patients. Warm handoffs probably affect engagement; however, further investigation is needed to determine what the actual engagement components are.

## Lessons Learned

- There is a small effect size on receiving a warm handoff at the time of referral and engaging in services.
- Per parent report, warm handoffs affect whether one enrolls in LAUNCH and MYCHILD services.
- Pediatricians and LAUNCH/MYCHILD team members may want to determine the readiness for when a parent is ready to engage. Families may have more stressing issues to address.
- Pediatricians and LAUNCH/MYCHILD team members may want to determine if a parent agrees with the need for a referral. A parent may not want to engage because they disagree that their family needs the service.
- LAUNCH and MYCHILD teams may want to set a goal for how quickly they return phone calls.
- There are a number of logistical obstacles to administering surveys to families: Confidentiality, honesty, obtaining completed surveys and determining a mode of administration (in person, phone, mail).

### ***LAUNCH Team Members***

*Andrea Goncalves Oliveira, MA – ECMH Clinician*

*Erica DaSilva, BA – Family Partner*

*Robert Sege, MD - Primary Care Champion*

*Margot Kaplan-Sanoff, Ed.D. - Administrator*

## CHILDHOOD MENTAL HEALTH SCREENING AND ASSESSMENT TOOLS



There are a large number of childhood mental health screening and assessment tools that have been developed to assess different domains for children of different ages. This section provides links to summaries of existing screening and assessment tools for all pediatric ranges, as well as summaries focusing on early childhood mental health resource for children ages 0-5 years old. There is also a brief list of the tools used by demonstration sites for service planning and for evaluation (many required by grants) to highlight the tools our sites have experience administering.

### All Pediatric Ages:

**American Academy of Pediatrics:** [Mental Health Screening and Assessment Tools Chart](#)<sup>16</sup>

- Chart of screening and assessment tools for children of all ages and their families
- Categorizing tools into: Surveillance tools, General Psychosocial Screening Tests, Screening for Environmental Risk Factors, Assessing Child and Family Functioning, Assessing Emergencies, and Primary Care Mental Health Assessment
- For each tool, offers brief description, age range, administration/scoring time, psychometric properties, cultural considerations, and cost/developer

## Objective 2: Develop Written Materials and Protocols

### **Northern California Training Academy: Mental Health Screening and Assessment Tools for Children, Literature Review**<sup>17</sup>

*UC Davis, Center for Human Services*

- Identified 95 screening or assessment tools for children's mental health, social and emotional functioning or related areas. Does not include tools limited to one dimension (e.g. just depression.)
- Tables of just screening tools, just assessment tools, and tools that can be used for either.
- Provides a discussion that compares and contrasts the advantages and disadvantages of select tools with recommendations provided to child welfare agencies in Northern CA.

### Early Childhood Mental Health (ECMH):

### **Developmental Screening and Assessment Instruments with an Emphasis on Social and Emotional Development for Young Children Ages Birth through Five**<sup>18</sup>

*NECTAC (National Early Childhood Technical Assistance Center), 2008*

- Screening tools that focus on the multiple developmental domains as well as those specific to the social-emotional development domain. Tools are differentiated into those that must be administered by professionals and those that may be completed by family members or caregivers.
- For each tool, provides a brief description, the age range in which the tool was validated, the time to administer, the scoring procedure, psychometric properties, requirements for administrations, and link or address for the publisher or source of the tool.

### Tools Used by MA Partnership for ECMH Demonstration Sites:

*(These tools were used for either service delivery OR evaluation purposes)*

#### **Child:**

- PEDS: DM: Parents Evaluation of Developmental Status: Developmental Milestones
- PSC: Pediatric Symptom Checklist
- M-CHAT: Modified Checklist for Autism in Toddlers
- ASQ SE: Ages and Stages Questionnaire-Social Emotional
- BITSEA : Brief Infant-Toddler Social and Emotional Assessment
- CANS: MA Child and Adolescent Needs and Strengths
- CBCL: Child Behavior Checklist

#### **Parent:**

- CES-D: Center for Epidemiological Studies-Depression
- PSI-3: Parenting Stress Index (short form)
- AAPI-2: Adult, Adolescent Parenting Inventory-2



## BASIC NEEDS ASSESSMENTS

Identifying the stressors families face in accessing basic resources (i.e. food, housing, heat) contributes to a greater understanding of the environment in which a child develops. A key aspect of supporting a child in healthy development is working with families to mitigate stressors that affect the child's health directly and indirectly.

Asking families about the most essential components of daily living can be hard. Providers may hesitate to ask questions about basic needs for many reasons—uncertainty about how to ask, fear of offending families, or inability to respond with helpful resources. Families may feel ashamed to disclose such needs with healthcare providers, fearing they will be judged as “inadequate” parents.

Medical homes need to breakdown such barriers by equipping providers with the tools to ask families these difficult questions and the resources and supports to respond to the needs identified by families. A basic needs assessment is a key component of the introductory visit between a Family Partner/Clinician and caregiver so that interventions and supports can be offered that reduce family stress. Furthermore, a validated basic needs assessment assists a Clinician in more accurately completing the final sections of the CANS that focuses on environmental stressors.

This section provides specific tools that can be used by the Family Partner or Clinician to inquire about a family's basic needs and respond with resources. Two tools are provided: One used by LAUNCH demonstration sites that was adapted from the Dulce Project at the Boston Medical Center, and the other a validated screening tool to identify housing, food and energy insecurity developed by Children's Health Watch with the support of MYCHILD funding. (Children's Health Watch is a national initiative headquartered in Boston that monitors the impact of economic conditions and public policies on the health and well-being of very young children.)



## Sample 1: LAUNCH Needs Assessment Tool\*

Ask all questions in the context of what you already know about the family. If you are certain the family has no immigration concerns, skip these questions. If you know the family has been exposed to trauma, do not screen further. Ask questions accordingly.

### **The Family Partner should begin the needs assessment with an explanation to the caregiver covering:**

- The purpose of gathering this information is to allow LAUNCH to best meet the family needs.
- Information about family needs will be shared within the LAUNCH/medical home team.
- The caregiver must understand: Do not share information with your FP that you do not want shared with the LAUNCH clinician or primary care physician.
- The caregiver must know that the FP is a mandated reporter and understand what that means regarding shared information concerning a child's welfare.
- The caregiver must know that LAUNCH staff are not required to report immigration status information.
- Any questions that cause the caregiver to feel uncomfortable can be skipped.
- Skipped questions may be revisited in future sessions.
- If any needs change the caregiver is encouraged to bring them to the attention of staff at that time.

\*This tool is adapted from the Dulce Project Legal Screening tool. Dr. Robert Sege is Principle Investigator for the Dulce Project at Boston Medical Center.

## 1. Income Screening

“In these challenging economic times, many families are struggling to put food on the table or to pay the rent or utilities.”

- Do you have enough food to adequately feed your self and family this week?
- What do you do when you find yourself running out of food for the child(ren)?
- Do you have any type of income? (prompt for public benefits income information)
- If no income: do you have any concerns about applying for public benefits?
- Many of my patients are denied income supports or housing benefits because of birth certificate documentation or custodial status. Is this a concern for you?

## 2. Employment

“In these challenging economic times, many persons have lost or are at risk of losing their job.”

- Is anyone in your household currently working?
- Has anyone in your household lost a job within the past year?
- Are you concerned about him / her losing your job?
- Is childcare a challenge to maintaining your job(s)?

*\*If Family Partner already knows some or all of the household’s employment situation, frame these questions in that context. Example:*

- You shared with me that your mother works at BMC and you stay home with your daughter. Does anyone else in the household currently work?
- You mentioned your husband lost his job in December. Has anyone else in your household lost their job in the last year?
- You said you work at CVS. Are you concerned you may lose your job?

## 3. Housing and Utilities Screening

“I know that affordable, healthy and safe housing is hard to come by.”

- Do you have your own apartment or do you share with other people?
- Are you up to date in the payment of your rent and utility bills?
- Are you concerned about the safety or stability of your housing?
- Does your housing have any unhealthy conditions? (lead paint, mold, pests etc.)
- Is it hard to keep rodents, insects or mold away?
- Do you owe any money on your rent or utility bills?
- Do you have utility shut-off protection?
- Do you have a low income utilities discount?

## 4. Family Strengths

“All families have strengths that help them care for their children such as supportive family or friends, religious or community connections.”

- What would you say are your family’s strengths?
- Do you have family or friends who can help you with the baby?
- Who would you call if you need someone to watch the baby for you?
- Who can you call if you have questions about the baby?

## 5. Family Health Concerns

“Massachusetts lawmakers provide for all residents in the state to have proper health insurance.”

- Do you and your child(ren) and other family members have health insurance? What type?
- Have you been discouraged from applying for health insurance because of your immigration status?

“Many of my patients care for other family members, some of whom have a chronic illness or disability. The strain of these responsibilities can impact the way patients take care of themselves.”

- Are you concerned that a family member cannot take care of him or herself because of illness or disability?
- Have you identified someone who will make decisions about his/her health care in the event that he/she becomes too ill or hurt to express his/her wishes?
- Are you concerned about your family’s health and stability for any immigration-related reason?

## 6. Family Incarceration

“The newest information we have suggests that there are over 2 million children in the U.S. who have a parent in prison or jail. If your child has a parent or close family member who is incarcerated, we have materials that can help with coping...”

- Is this true for your family? (*If yes, continue*)
- Do your children know about the incarceration?
- Are your children in touch with the incarcerated parent by phone or mail?
- Have your children visited your family member in jail?

## 7. Guns in the home

“We are asking *all* our patients about guns...”

- Do you have any guns currently stored in your home?
- Where are they stored? How are they stored?

## 8. Education

*\*Include all school-aged children/teens in the household for this question.*

“We ask our families about all school-age children’s experiences in school.”

- Are you concerned about your child’s learning, performance or behavior in school?
- If you have any of these concerns, have you asked that the school conduct a special education evaluation? *(If no, offer to assist in requesting one immediately.)*
- If your child has qualified for special education or reasonable accommodations, are you satisfied with the special help or accommodations that your child receives?
- If your child has a medical problem, are you satisfied with the support provided by the school?
- Are you concerned about discipline or safety issues at school?

## 9. PEDS/PSC

“I know you filled out the PEDS/PSC questionnaire for Dr. \_\_\_\_\_. I like to look back over it with caregivers to be sure I understand any concerns you have, even if you already shared them with your doctor. If you have any additional questions or concerns, we can talk about them now.”

## 10. Exposure to Trauma

*Skip this question if you judge it to be inappropriate at the time. Inform the Clinician that the question remains to be asked. It must be asked prior to making the Care Plan.*

“All families are tested by difficult experiences. Has anyone in your household experienced one of the following:”

- Witness to or victim of violence
- Victim or participant in war or terrorism
- Exposed to a natural or manmade disaster (including hurricane, flood, fire, car accident, dog attack, etc.)
- Loss of someone close or significant (due to death, divorce, prison, war, refugee status, etc.)

*If yes, ask who has impacted and when the event occurred. Find out the basic information but do not probe for details. A child exposed to trauma should receive a follow-up evaluation which could include the TESI assessment.*

*Encourage the caregiver to share with the LAUNCH staff any future events that fit into one of these categories if/when they happen.*

## 11. Alcohol/Substance Abuse

*Skip this question if you judge it to be inappropriate at the time. Inform the Clinician that the question remains to be asked. It must be asked prior to making the Care Plan.*

“Did you know that drugs impact the part of your brain that affects decisions you make even about things that are important to you? ”

- How much alcohol do you drink? Do you think you should cut down?
- In the past year have you or your partner had a problem with alcohol and or drug use?
- How often is your child (are your children) exposed to smoke?

*If caregiver reports exposure to smoke, follow up with:*

“Many families struggle with what to do about secondhand smoke around their children.”

- Where do people smoke?
- Have you noticed that your child has a lot of ear infections or frequently has colds and coughs?
- Have you considered cutting down, quitting or smoking outside?
- Are you interested in information about how to quit smoking?

## 12. Other Stressors

“I have asked you a lot of questions. Now it’s your turn to tell me what I’ve missed. Is there something else going on with your family that causes you to worry?”

# Sample 2: Caregiver Response Record

Use this Sample to record findings from Sample 1.

The Family Partner should use the need assessment questions to identify strengths and areas of need for the family. Some of the information is transferred into the LAUNCH Access file for program monitoring. All of the information is to be used to serve the family and inform the LAUNCH Care Plan.

## 1. Income Screening

LAUNCH ID # \_\_\_ - \_\_\_ - \_\_\_

**Notes/Response:**

**Action to be taken:**

Check if area of concern:

- Food security
- Income/public benefits concerns
- Rent and utility payments
- Affordable childcare
- Health Insurance
- Immigration status

**Involvement in Public Programs:** Select one box per program/service

Y-Yes the family uses this service

W-No, but the family wants to apply/get more information

N-No, not interested in this service

Y	W	N		Y	W	N	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Section 8/Housing Voucher
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food Stamps/SNAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Public Housing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SSI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other rent/housing assistance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cash Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Utilities Discount/Shut-off
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fuel Assistance				Protection

## 2. Employment

**Notes/Response:**

**Action to be taken:**

### 3. Housing and Utilities Screening

**Notes/Response:**

**Action to be taken:**

### 4. Family Strengths

**Notes/Response:**

**Action to be taken:**

### 5. Family Health Concerns

**Notes/Response:**

**Action to be taken:**

## 6. Family Incarceration

**Notes/Response:**

**Action to be taken:**

## 7. Guns in the Home

**Notes/Response:**

**Action to be taken:**

## 8. Education

**Notes/Response:**

**Action to be taken:**

## 9. PEDS/PSC

**Notes/Response:**

**Action to be taken:**

## 10. Exposure to Trauma

Witness to/victim of violence

WHO (exposed):

WHEN:

War or terrorism

WHO (exposed):

WHEN:

Natural or manmade disaster

WHO (exposed):

WHEN:

Loss/death

WHO (exposed):

WHEN:

**Notes/Response:**

**Action to be taken:**

## 11. Alcohol/Substance Abuse

**Notes/Response:**

**Action to be taken:**

## 12. Other Stressors

**Notes/Response:**

**Action to be taken:**

## Objective 2: Develop Written Materials and Protocols

When children live in households without food, energy, and housing security, they are less likely to be healthy. Children's Health Watch at Boston Medical Center has developed a tool to assess hardship in these areas. The following tool, from Children's Health Watch, is another way to measure the basic needs of a child and their family. For more, visit [www.childrenshealthwatch.org](http://www.childrenshealthwatch.org).

### CUMULATIVE HARDSHIP ANALYSIS

Children's Health Watch

#### Energy Insecurity Questions:

- 1) Since [name of current month] of last year has the [gas/electric] company sent [you/the primary caretaker] a letter threatening to shut off the [gas/electricity] in the house for not paying bills?
- 2) In the last 12 months since last [name of current month] [have you/has the primary caretaker] ever used a cooking stove to heat the [house/apartment]?
- 3) Since [name of current month] of last year were there any days that the home was not [heated/cooled] because [you/the primary caretaker] couldn't pay the bills?
- 4) Since [name of current month] of last year has the [gas/electric/oil] company [shut off/oil company refused to deliver] the [gas/ electricity/ oil] for not paying bills?

#### Housing Insecurity Questions:

- 5) [Are you/Is the child's caregiver] temporarily living with other people even for a little while because of financial difficulties?
- 6) How many bedrooms are there in the child's home?
- 7) Including this child, how many people ages 0-17 are in your [home/family]?
- 8) Including yourself, how many people 18 and over live in your [home/family]?  
(*crowding = #household/#bedrooms (>2/BR)*)
- 9) How many places has the child lived since [name of current month] of last year?  
(*2 or more = multiple moves*)

#### Food Insecurity Screen:

- 10) "Within the past 12 months we worried whether our food would run out before we got money to buy more"
- 11) "Within the past 12 months the food we bought just didn't last and we didn't have money to get more."

## CUMULATIVE HARDSHIP ANALYSIS

Children's Health Watch

### SCORING THE SCREEN

Use the following scoring method to determine the family needs regarding energy, housing, and food insecurity.

To score, first follow directions within each environmental risk area:

- 0 for no risk
- 1 for a moderate risk
- 2 for severe risk (except the Food Insecurity screener)
- The Food Insecurity screen is given a code of 0 or 2 only



Please note: only assign a 0, 1, or 2 as described below.

Assign the greatest number that applies in each case, but do not add numbers (if a response would be scored with a 1 or 2 in more than one case, only choose the higher number of the 1 or 2; do not add the numbers together).

Where we refer to a question number, we are referring to the accompanying screening guide.

**After scoring each individual indicator, sum the scores across all environmental risk areas. A score of 0 is no hardship, 1-3 is moderate and 4-6 is severe.**

#### Energy Insecurity Questions:

If response to all questions is no, score is 0 (energy secure).

If response to question 1 only is yes, score is 1 (moderately energy insecure).

If response to one or more of the following questions: 2, 3 or 4 is yes, score is 2 (severely energy insecure).

## Objective 2: Develop Written Materials and Protocols

### Housing Insecurity Questions:

If response to question 1 is yes, but response to question 5 is no, score is 1 (moderately housing insecure).

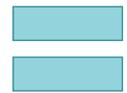
To score questions 2-4, add the number from answer 3 to the number from answer 4.  
Divide that number by the number from answer 2.



If the result is greater than 2, but response to question 5 is no, score 1 (moderately housing insecure).

For example, if a home has 2 children and 2 adults living in two bedrooms, this item would not be scored (because  $2+2=4$ ,  $4/2=2$  and 2 is not  $> 2$ ). However, if a home has 2 children and 3 adults living in two bedrooms, and the family answered no to question 5, the score would be 1 (moderately housing insecure).

If the response to question 5 is yes, score is 2 (severely housing insecure).



If no response is scored, score is 0 (housing secure).

### Food Insecurity Screen:

If the response to either item is yes, score is 2 (food insecure). If the response to both items is no, score is 0 (food secure).

## Making Referrals

If a family has a score of 0, the family does not require any specific referrals based on the results of the screener. Nevertheless, if the interviewer has extra time, the interviewer may want to ask if the family would like to learn more about available resources described in the resource guide.

If a family has a score of 1 on any item, we recommend asking if the family would like to learn more about services available to address that item. The resource guide has relevant referral information.

If a family has a score of 2 on any item, we recommend encouraging the family to seek assistance for that item. The resource guide has relevant referral information.

If a family has a total cumulative hardship score in the severe range (4 or higher), we encourage spending additional time with the family to talk about the available types of referrals and to connect the family with a group that can provide further guidance and counseling.

## IDENTIFYING THE FAMILY'S STRENGTHS, VISION AND CULTURE



An essential part of engagement and assessment visits is identifying a family's vision and strengths for both child and the whole family unit.

While most providers recognize that strengths and vision add an important dimension to the provider-caregiver relationships, many feel uncertain about how to ask such questions. Also, many families may have difficulty responding to the question "So what are your child's strengths?", as they may have never had the opportunity to reflect on their strengths or their vision of what they want for their child and family. Thus, it is important ask these questions creatively to support families in genuinely identifying the strengths and assets that can be used to achieve Care Plan goals.

For many families, cultural values and practices are key strengths that can drive a family's goals and understanding of health. While providers often identify the ethnicity and primary language of a family, it can be hard to ask about cultural practices beyond that demographic information due to both difficulty in asking and time constraints. To be culturally responsive, we must ask the right questions, better understand the beliefs that influence our behaviors, and appreciate the values which govern our lives.

This section provides sample questions to help the Family Partner, Clinician and other medical home providers effectively engage families on vision, strengths and culture. Rather than a validated tool, these questions reflect the experience of FPs from MYCHILD and LAUNCH demonstration sites.

## Sample 3: Example Strength, Vision and Culture Questions

### Vision Questions

What do you ultimately want for your family?

How would you like to see your family 3 months from now? One week from now?

If you work up tomorrow and everything is perfect, what would your family look like?

How do we get to that point?

### Strength Questions

What things do you like to do?

What qualities do you like in [child's name]? Which of these does he/she get from you?

What kinds of things do you do to help feel safe or calm?

How do you relieve stress?

What kinds of things do you and [child's name] do together?

Who would you go to for advice?

What traditions does your family have?

What were you like as a kid?

Who has been the biggest influence on your life?

What are the best things about yourself? Your family? Your community?

## Cultural and Linguistic Questions

### Values:

Do you prefer to be called Ms., Mrs., or by your first name?

What values were passed on to you from your family of origin? (For example, my family passed on the value of saving the last portion of food for Mr. Manners. This was meant to teach us to be courteous and respectful of others' needs.)

What values are you passing on to your family?

What is your most happy memory and why?

### Customs:

Did your family have special traditions that were honored?

Was there time when those traditions were not followed?

Which was your favorite tradition?

What courtesies and customs would you expect from someone visiting your home?

When you experience a loss how do you respond?

### Beliefs:

Were you raised in a specific religion?

Does your family hold high certain cultural beliefs? (Such as "children should be seen and not heard")

What are yours?

What do you most believe in?

### Social/Emotional Well Being:

What social skills did you learn as a child?

Which skills *are* you trying to pass on to your children? How do you do this?

What does emotional well being mean to you?

What does emotional disability mean to you?

Who do you seek help from?

Do others seek help from you?

### Linguistics:

What language do you prefer?

What language is used primarily at home?

Are your children bilingual?

Which language do you encourage your children to use at home? In school?

Which language do you prefer to read in?



## RESOURCES AND CONTACTS GUIDE

### Children's HealthWatch



You may need to try places many times to get the help you are looking for. Case workers, Primary Care Providers, City Hall and state legislators can be helpful. **If you are in danger, call 911.**

#### DIAL 2-1-1 for confidential help with:

**211 or (877) 211-6277**

\* Food \* Shelter \* Rent \* Utility bills \* Child care \* Counseling \* Other needs \*

**Hours:** 24 hours a day, 7 days a week

**Website:** [www.mass211.org](http://www.mass211.org); many languages spoken!

#### HelpSteps: A Project of The Online Advocate (Available free online)

Enter your zip code and find resources near you. Complete a survey to determine what services you are eligible for or search for specific resources in your community.

**Website:** <http://www.helpsteps.com/>

#### Mayor's HealthLine (Multi-lingual)

**(617) 534-5050 or Toll Free: 1 (800) 847-0710**

-Have them speak in your community -Find free health programs and clinics, dentists  
-Health insurance and medication help -Help with applications (e.g. Women, Infants and Children or HeadStart)

**Hours:** Mon.-Fri. 9:00am – 5:00pm

#### City of Boston: Mayor's Hotline/Constituent Services

**(617) 635-4500**

24/7 in-person phone line to report concerns anonymously; issues can also be submitted online.

**Website:** [http://www.cityofboston.gov/online\\_services/default.aspx](http://www.cityofboston.gov/online_services/default.aspx)

**Location:** Mayor's Office, 5<sup>th</sup> Floor, City Hall, Mon.-Fri. 9:00am-5:00pm

#### Action for Boston Community Development (ABCD)

**(617) 348-6000**

\* Huge variety of programs, training options: Housing, job training, utilities, child care.

**Hours:** Vary by location [www.bostonabcd.org](http://www.bostonabcd.org); major locations below

Boston: Mon.-Fri. 9:00am - 5:00pm

**(617) 357-6012**

South End Neighborhood Action: Mon.-Fri. 9:00am - 5:00pm

**(617) 267-7400 x227**

Roxbury/Dorchester: Mon. 10:00am - 5:00pm; Tues.-Fri. 9:00am - 5:00pm

**(617) 288-2700x204**

**Housing:** <http://www.bostonabcd.org/1housing.aspx>

**call the switchboard, (617) 348-6000**

**Fuel Assistance:** <http://www.bostonabcd.org/fuel-assistance-liheap.aspx>

**(617) 357-5012**

**Head Start (3years+):** [www.bostonheadstart.org](http://www.bostonheadstart.org)

**(617) 348-6272**

**Early Head Start (up to age 3):** <http://bostonabcd.org/early-head-start.aspx>

**(617) 348-6272**

**Financial Literacy:** <http://www.bostonabcd.org/financial-futures.aspx>

**(617) 348-6588**

**Find Your MA State Legislators/Constituent Services****(617) 727-3676**

For advocacy and help in connecting to appropriate governmental resources.

**Website:** <http://www.malegislature.gov/people/findmylegislator>

**Phone:** Main State House Number

**Community Resource Facebook Page and Group**

View or post free events, job postings, trainings and resources for everyone in the Boston community. "Like" the page or join the conversation through the group.

**Website:** [www.facebook.com/bostonandbeyond](http://www.facebook.com/bostonandbeyond)

**More Info:** [BostonCommunityResources@gmail.com](mailto:BostonCommunityResources@gmail.com)

## Food Programs and Emergency Food

**Rosie's Place (For women and children up to age 12)****(617) 442-9322**

Choose your own groceries once/month at food pantry (bring ID)

**Hours:** *Pantry:* Tues.-Fri.: 8:30am-11:00am

*Meals:* Daily, Lunch: 11:30am-1:00pm; Dinner: 4:30-7:00pm (no ID needed)

**Location:** 889 Harrison Ave (at Massachusetts Ave), Roxbury, walk-ins welcome

**Website:** [www.rosiesplace.org](http://www.rosiesplace.org)

**Food Source Hotline (Project Bread)****1 (800) 645-8333**

SNAP (food stamp)/food program screening, information about meal sites & school programs, pantries, farmer's markets that accept EBT

**Hours:** Mon.-Fri. 8:00am-7:00pm and Sat. 10:00am-2:00pm

**Website:** <http://www.projectbread.org>

**Farmer's Market and Bounty Bucks Program****(781) 893-8222**

Most open June-November; many accept EBT at a discount rate

**Website:** [www.massfarmersmarkets.org](http://www.massfarmersmarkets.org)

**Boston Women, Infants and Children Offices****(800) 942-1007**

Walk-in hours available, office hours vary by location. Call for appointment.

**Website:** <http://www.mass.gov/eohhs/consumer/basic-needs/food/wic/>

-Free healthy food and nutrition counseling to pregnant women, new mothers and children 0-5

-Bring proof of current household income, MA residency, ID, birth certificates and immunizations of kids. TAFDC, SNAP, or MassHealth recipients are automatically eligible.

**Boston Public Schools Department of Food Services****(617) 635-9144**

-Find out if your child qualifies for free or reduced-price meals

**SNAP (Food Stamp) Office at DTA****1 (866) 950-FOOD (3663)**

- You can get screened for SNAP eligibility through DTA hotline or Food Source Hotline
- To apply for SNAP, you need household financial information and proof of identity

**Hours:** Mon.-Fri. 8:00am-7:00pm and Sat. 10:00am-2:00pm**Website and Locations:** [www.gettingsnap.org](http://www.gettingsnap.org) and [www.mass.gov/DTA](http://www.mass.gov/DTA)**The Greater Boston Food Bank****(617) 427-5200**

Offers help finding food assistance options in your community and other information you need to access food for you and your family.

**Hours:** Mon.-Fri.: 8:00am-4:30pm**Location:** 70 South Bay Avenue, Boston, MA 02118**Website:** <http://gbfb.org/>**Two-Dollar-A-Bag Groceries (Fresh Produce)****(617) 288-6185**

No ID required. Bring your own bag(s) and choose groceries for \$2/bag

**Website:** [www.fairfoods.org](http://www.fairfoods.org)**Hours:** Call or see website for specific hours

## Housing Assistance

**Housing and Urban Development – Boston Homes and Communities****(617) 994-8200**

\*For FHA loans or programs: 1 (800) 225-5342; HUD rental programs: 1 (800) 955-2232\*

- Provides help with FHA loans make it easier for people to qualify for a mortgage
- Provides help specific to Housing Choice (Section 8) Vouchers

**Hours:** 8:00am-4:00pm**Location:** Thomas P. O'Neill, Jr. Federal Building 10 Causeway Street, 3rd Floor Boston, MA**Website:** <http://www.hud.gov/local/index.cfm?state=ma&topic=offices>**Boston Housing Authority and 24hr Civil Rights Hotline****(617) 695-3531**

Application/Waiting List Status Line:

**(617) 988-4200**

- List of apartments available to voucher holders is updated in their offices
- Application for Boston Housing Authority housing
- 24 Hour Hotline for Housing Discrimination Issues

**Location:** 52 Chauncy St, Boston, MA 02111**Website:** [www.bostonhousing.org](http://www.bostonhousing.org)**Mass Legal Housing Help Website:** <http://www.masslegalhelp.org/housing>

- Information about tenants' rights in Massachusetts, self-help, handbooks, forms, etc
- Eviction, bad conditions, discrimination, domestic violence, foreclosure, utilities information.

**Department of Housing and Community Development (DHCD)****(617) 573-1150**

Professional assistance and financial resources to promote safe, decent affordable housing opportunities, public housing/rental assistance

**Hours:** 8:45am-5:00pm

**Location:** 100 Cambridge Street, Suite 300, Boston MA 02114

**Website:** <http://www.mass.gov/hed/economic/eohed/dhcd/>

**Metropolitan Boston Housing Partnership (MBHP)****(617) 425-6700**

Offers housing search workshops. You can also search for apartments on their website (click on the Apartment Listing tab from their homepage). Call to make a workshop reservation.

**Hours:** Mon.-Fri., 8:45am-5:00pm

**Location:** 125 Lincoln St, 5th Floor, Boston (near South Station)

**Website:** [www.mbhp.org](http://www.mbhp.org)

**Traveler's Aid Family Services – Homeless Shelters****Weekdays (617) 542-7286**

\*For inquiries after hours/weekends, call Mayor's Hotline

**(617) 635-4500\***

**Hours:** Mon.-Fri., 9:00am-5:00pm

**Location:** 727 Atlantic Avenue, Boston, 02111

**Website:** <http://www.familyaidboston.org/Home.aspx>

**MetroList****(617) 635-3321**

- Keeps a list of private subsidized housing units and applications for Section 8 and public housing in Boston. Information is provided ONLY to Boston residents. Must go in person.

- Offers housing search workshops. You can also search for apartments on their website (click on the Apartment Listing tab from their homepage). Call to make a workshop reservation.

**Hours:** Mon.-Fri., 9:00am-4:00pm

**Location:** Boston City Hall, Room 966-A

**Website:** [www.bostonhousing.org/detpages/rservices119.html](http://www.bostonhousing.org/detpages/rservices119.html)

**HomeStart, Inc.****(617)-542-0338**

Holds walk-in hours in their Boston and Cambridge offices where you can get help with the affordable housing application process

**Hours:** Wed. 3:00 pm-5:00pm

**Location:** 105 Chauncy Street, Suite 502, Boston, MA 02111 (To enter 105 Chauncy Street, you must present a valid ID)

-678 Massachusetts Ave., Suite 502, Cambridge, MA 02139

**Website:** <http://homestart.org/>

**Private Subsidized Housing****1 (800) 882-1154**

**Website:** [www.mhfa.org](http://www.mhfa.org)

Privately owned apartments for 30% of a tenant's income or lower than market rate housing

## Local Section 8

These housing authorities are not part of the centralized section 8 waiting list  
**Boston** (617) 988-4200; **Cambridge** (617) 864-3020; **Brockton** (508) 588-6880;  
**Lynn** (781) 581-8611; **Randolph** (781)-961-1400

## Energy Assistance

### Citizens Energy Corporation

(617) 338-6300

Apply Online: [www.citizensenergy.com](http://www.citizensenergy.com)

This program re-opens every December and provides one-time help with an oil bill.

### ABCD Fuel Assistance/LIHEAP

(617) 357-5012

Heating bill payment assistance to low-income residents of Boston, Brookline and Newton

Website: <http://www.bostonabcd.org/fuel-assistance-liheap.aspx>

### Heatline Energy and Utility Assistance

1 (800) 632-8175

### Mass Energy Consumer Alliance

1 (800) 287-3950

Call for low annual fee and reduces heat, gas and electric costs for consumers in Greater Boston.

Website: <http://www.massenergy.org/>

Email inquiries: [info@massenergy.org](mailto:info@massenergy.org)

### NSTAR Discount Rate Program

1 (800) 592-2000

- Requires verification that person named on NSTAR bill meets income eligibility criteria

- Email [customer.service@nstar.com](mailto:customer.service@nstar.com) or call 800-566-2080 for more information

Hours: Mon. to Fri. 8:30am-5:00pm

Website: [http://www.nstar.com/residential/customer\\_information/financial\\_assistance/](http://www.nstar.com/residential/customer_information/financial_assistance/)

### Salvation Army: Good Neighbor Energy Fund

1 (800) 334-3047

For energy assistance; household cannot qualify for state/federal energy assistance. Availability varies; applications typically open each December

Website: <http://www.magoodneighbor.org/>

### Citizens Energy: Energy Oil Heat Program (JOE-4-OIL)

1 (877) 563-4645

- Offers free heating oil to people in need. Each eligible household is allowed a one-time delivery per heating season of 100 gallons of home heating oil for free.

-After applying over the phone, an income information form will be sent and must be signed and returned.

Website: <http://www.citizensenergy.com/english/pages/OilHeatProgram>



## Health Insurance and Healthcare Assistance

**Masshealth, Commonwealth or Health Safety and Children’s Medical Security** 1 (888) 665-9993

**Member or Applicant Details**

- Provides case status (approved, closed, etc.), key eligibility dates (e.g. next review date)
- Plan information, items still needed to process your case
- Provides children and adolescents with access to primary care and preventative services

**Hours:** Open anytime except Sat. 10:00pm-Sun. 6:00am

**The Fenway Connector Walk-in Program** (617) 927-6000

- Provides help with getting enrolled with Commonwealth Care, MassHealth and other programs
- Bring any of the following: proof of annual household’s income, proof of citizenship or immigration papers (can still apply without, but is preferred)
- No appointment needed

**Hours:** Wed. 4:00pm-7:00pm

**Location:** Fenway Health, 1340 Boylston Street

**MA Dept of Mental Health Information and Referral Line** 1 (800) 221-0053

Information for mental health services available throughout Massachusetts

- Information regarding Massachusetts health insurance options

**Hours:** Mon.-Fri. 8:00am-5:00pm

**Website:** [www.mass.gov/masshealth](http://www.mass.gov/masshealth)

**MA Health Insurance Support-Health Connector** 1 (877) 623-6765

**Website:** <https://www.mahealthconnector.org/portal/site/connector>

## Mental Health Support

**MA Dept of Mental Health Information and Referral Line** 1 (800) 221-0053

Information for mental health services available throughout Massachusetts

**Boston Emergency Services Team (B.E.S.T.)** 1 (800) 981-4357

- Part of the MA Behavioral Health Partnership (MBHP). Potential alternative to hospital emergency departments for individuals seeking behavioral health services when use of the ED may be avoided and/or is not voluntarily sought. They provide in-person behavioral health crisis assessment, intervention and stabilization services.

-Information for mental health services available throughout Massachusetts

## Drug Free Helpline

1 (855) 378-4373

- Provides help for parents with adolescents/young adults who may be abusing drugs/alcohol.
- Provides experienced social workers to help parents through the situation and offer help.
- Can talk about appropriate treatment options, encouraging your involvement in the recovery process, intervention and how to approach your child with your concern.

Website: <http://timetogethelp.drugfree.org/>

## Legal Support and Advocacy

### Greater Boston Legal Services (GBLS) (617) 371-1234 or (800) 323-3205 or TDD (617) 371-1288

If you need legal help, call GBLS and an advocate will determine if GBLS can help. If they cannot help, they may be able to refer you to someone who can.

**Main Office:** 197 Friend St, Boston, MA 02114

**Cambridge/Somerville:** 60 Gore St, Ste 203, Cambridge, MA 02141

**Office Hours:** Mon.-Fri., 9:00am-5:00pm

Website: [www.gbls.org](http://www.gbls.org)

### Legal Advocacy and Resource Services

(617) 603-1700 or 1 (800) 342-5297

The Legal Advocacy Resource Center provides free legal assistance on bankruptcy, divorce & other issues to low-income consumers who are Massachusetts residents.

**Hotline Hours:** Tues. 5:00pm-7:30 and Wed. 9:00am-12:30pm

**Office Hours:** Mon., Tues., Thurs., Fri. 9:00am-1:00pm and 2:00pm-3:15pm

Website: <http://larcma.org/home>

### MassLegal Help - <http://www.masslegalhelp.org/>

\*Part of the MA Legal Websites Project, funded by the MA Legal Assistance Corporation  
Information about MA laws and resources for self-advocacy

## Domestic and Community Violence

### SafeLink Domestic Violence Hotline

1-877-785-2020 or 1-877-521-2601 TTY

(24 hours and multilingual, support is confidential)

Support, confidential, crisis intervention, resources, access to shelter, referrals, safety planning.

### Louis D. Brown Peace Institute

(617) 825-1917

Serves families impacted by homicide

**Location:** 1452 Dorchester Ave, 2<sup>nd</sup> fl, Dorchester, MA 02122

Website: <http://www.ldbpeaceinstitute.org>

Email : [info@ldbpeaceinstitute.org](mailto:info@ldbpeaceinstitute.org)

**Boston Area Rape Crisis Center****(617) 492-8306****24-Hour Hotline:****1 (800) 841-8371**

Provide comprehensive, free services including a 24-hour hotline, 24-hour medical advocacy, individual and group counseling, and legal advocacy.

**Mailing Address and Cambridge Office:** 99 Bishop Allen Drive, Cambridge, MA 02139

**Boston Office:** 989 Commonwealth Ave, Boston, MA 02215

**Website:** <http://barcc.org/>

## Job Training and Financial Support

**Job Training At Goodwill Industries****(617) 445-1010**

Various job training programs for all levels; childcare often available

**Location:** 1010 Harrison Ave, Boston Ave, 02118

**Website:** [www.goodwillmass.org](http://www.goodwillmass.org)

**The Work Place Boston****(617) 737-0093**

- Offers skills training, recruitment fairs, job search help, and specialized services for homeless clients, veterans and young adults

- Career counselors work with clients on a drop-in basis

- Call or go online to schedule an orientation session and to view a full list of events

**Hours:** Mon. 9:00am-7:00pm; Tues., Wed., Fri. 9:00am-5:00pm; Thur. 10:00am-5:00pm

**Location:** 29 Winter Street (4th floor), Boston, MA 02108

**Website:** [www.theworkplace.org](http://www.theworkplace.org)

**Languages available:** English and Spanish

**Career Collaborative****(617) 424-6616**

- Job search and job readiness courses

- Helps with job retention and career goals post-employment

**Hours:** Mon.-Fri. 8:30am-5:30pm

**Location:** 77 Summer St, 11<sup>th</sup> Floor, Boston, 02110

**Website:** <http://careercollaborative.org/>

**Boston Career Link****(617) 536-1888 ext.560**

- Provides access to a broad range of career counseling and training services

- Connects directly to employers

**Hours:** Mon., Thurs., Fri. 9:00am-5:00pm; Tues. 9:00am-7:00pm; Wed. 9am-2:30pm

**Location:** 1010 Harrison Avenue, Roxbury, MA 02119

**Website:** <http://www.bostoncareerlink.org/>

**Career Source****1 (888) 454-9675**

- Offers free training workshops, career fairs, provides computers, printers, internet access, and a multimedia career library for employment and job search
- Some services, such as personal consultations and photocopying, are fee-based.
- Social Security Number is required

**Hours:** Mon.-Fri. 8:30am-4:30pm; open Wed. until 7:30pm**Location:** 186 Alewife Brook Parkway (Suite 310), Cambridge, MA 02138**Website:** [www.yourcareersource.com](http://www.yourcareersource.com)**Languages available:** English and Spanish**Job Net Boston****(617) 338-0809**

- Mostly a resource center
- The center provides workshops (resume, interview, and computer skills) and access to job search databases.
- Offers a re-entry program for clients recently released from prison

**Hours:** Mon. 9:00 am-7:00pm; Tues., Wed., Fri. 9:00am-5:00pm; Thurs. 10:00am-5:00pm**Location:** 210 South Street, Boston, MA 02111**Website:** [www.jobnetboston.org](http://www.jobnetboston.org)**Languages available:** English, Spanish, Haitian-Creole, Mandarin, German**Asian American Civic Association****(617) 426-9492**

- Offers a variety of job training programs, as well as job search help.
- Classes are free for low-income clients. Call to set up an orientation.
- Social Security Number is NOT required

**Hours:** Mon.-Fri. 9:00am-5:00pm**Location:** 87 Tyler Street (5th floor), Boston, MA 02111**Website:** [www.aaca-boston.org](http://www.aaca-boston.org)**Languages available:** English, Mandarin and Cantonese**La Alianza Hispana****(617) 427-7175**

- Provides a wide variety of job training services
- Programs include English fluency in the work place, job skills programs, computer workshops, and other services. Call to set up an orientation session.
- Social Security Number is NOT required

**Hours:** Mon.-Fri. 9am-5pm.**Location:** 409 Dudley Street, Roxbury, MA 02119**Website:** [www.laalianza.org](http://www.laalianza.org)**Languages available:** English and Spanish

**Salvation Army: Family Services Bureau and Emergency Needs Program****(617)-536-1888**

Helps individuals and families with utility payments, clothing, prescription costs, grocery vouchers, and/or rental/mortgage assistance. Availability of funds varies, and is provided on an as-needed basis.

**Location:** 147 Berkeley Street, Boston, MA 02116

**Website:** <http://www.use.salvationarmy.org/mas>

- South End Corps – Boston **(617) 236-7233 x260**
- Cambridge Corps **(617) 547-3400**
- Chelsea/East Boston Corps **(617) 884-0260**
- Lynn Corps **(781) 598-0673**
- Brockton Corps **(508) 583-1896**

**Catholic Charities: Basic Needs Emergency Services**

Offers assistance to people in need of food, fuel, rental, and/or utility assistance. As the availability of funds varies, and funding is not available at all times, please check by calling the location(s) in your area.

**Website:** <http://www.ccab.org/basicneeds/index.html>

- 275 West Broadway, South Boston **(617) 268-9670**

**Massachusetts Adult Literacy Hotline****1 (800) 447-8844**

Provides contact information on GED preparation classes in your neighborhood

**Website:** <http://www.getrealmass.info/hotline/>

- 117 North Common Street, Lynn **(781) 593-2312**
- 686 N. Main Street, Brockton **(508) 587-0815**

## Education Resources

**College Bound Dorchester—Adult Basic Education****(617) 282-5034**

- Prepares you for the GED through advising and coursework
- Additional courses can assist you in advancing to college

**Hours:** Mon.-Fri. 9:00am-5:00pm

**Location:** Dorchester Place: 18 Samoset Street, Dorchester, MA 02124 and Alternative location at Log School: 222 Bowdoin Street, Dorchester, MA 02122

**Website:** <http://www.collegebounddorchester.org/programs/adulteducation/abe>

**Dimock Adult Basic Education and GED Services****(617) 442-8800 x1219**

- Individual programs to help prepare students for all areas of the GED exam
- Helps students improve basic reading, writing and math skills

**Hours:** Classes held Mon.-Fri. 9:30am-12:30pm

**Location:** 55 Dimock Street, Roxbury, MA 02119

**Website:** <http://dimockcenter.org/news/page/Adult-Basic-Education-GED-Services.aspx>

## **Boston Public Schools (BPS)**

**Registration:** [www.bostonpublicschools.com/register](http://www.bostonpublicschools.com/register)

**Boston Public Schools Family Resource Centers** (multi-lingual)

<http://www.bostonpublicschools.org/FamilyResourceCenters>

East Zone, 1216 Dorchester Ave, Dorchester - (617) 635-8015

North Zone, 75 Malcolm X Blvd, Roxbury – (617) 635-9010

West Zone, 515 Hyde Park Ave, Roslindale – (617) 635-8040

**Getting involved, sending feedback to BPS via Boston School Quality initiative;**

<http://bostonschoolquality.org/>

**English Language Learners/Newcomer Assessment Center:** (617) 635-1565;

<http://www.bostonpublicschools.org/ELL>

**Special Education:** [spedpac@boston.k12.ma.us](mailto:spedpac@boston.k12.ma.us); 617-635-8600; [www.bostonspedpac.org](http://www.bostonspedpac.org)

**Parent University:** available to all BPS student caregivers; 617-635-7750;

<http://bpsfamilies.org/parentuniversity>

## **Massachusetts Adult Literacy Hotline**

**1 (800) 447-8844**

Provides contact information on GED preparation classes in your neighborhood

**Website:** <http://www.getrealmass.info/hotline/>

## Government Cash Resources

### **Transitional Aid to Families with Dependent Children (TAFDC)**

**1 (800) 249-2007**

-Cash assistance for low-income families with dependent children and pregnant women within their last four months of pregnancy

-Applicant must be a citizen or eligible noncitizens. The benefit amount depends on income, household size, housing situation and whether work requirement is fulfilled.

-To apply, go to your local Department of Transitional Assistance office.

**Website:** <http://www.masslegalhelp.org/income-benefits/welfare>

### **Emergency Aid for the Elderly, Disabled, and Children**

**1 (800) 249-2007**

-Cash assistance and other benefits for low-income elders, disabled individuals, and children who do not qualify for other public cash assistance programs

-To apply, go to your local Department of Transitional Assistance

**Website:** <http://www.masslegalhelp.org/income-benefits/eaedc>

### **Supplemental Security Income (SSI) and**

**1 (800) 772-1213**

### **Supplemental Security Disability Insurance (SSDI)**

-Cash assistance those 65 or older, or for people of any age with a documented disability.

-Children whose parent(s) are deceased may also qualify

-To apply, go to your local Social Security Administration office, or apply online.

**Website:** [www.socialsecurity.gov](http://www.socialsecurity.gov)

## Earned Income Tax Credit (EITC)

- Income tax credit for low or moderate income people who worked, and who have earned reportable income
- To be eligible you must have worked within the past year, meet the income guidelines and be a citizen or resident alien.
- Married people must file their taxes jointly in order to qualify.

**Website:** [www.irs.gov/EITC](http://www.irs.gov/EITC)

## Unemployment Insurance (UI)

**1 (877) 626-6800**

**Hours:** Mon.-Fri.: 7:30am-5:30pm

- Helps workers who lost their jobs through no fault of their own by providing temporary income and job placement supports
- Unemployed workers who quit their jobs voluntarily, or were fired for a good reason, are not eligible for benefits.
- To apply, call the TeleClaim center during normal business hours.

For area codes 351, 413, 508, 774, and 978, call **1 (877) 626-6800** (toll-free)

All other area codes, call **(617) 626-6800**

**Website:** <http://www.mass.gov/lwd/unemployment-insur/>

## Free Diapers and Diaper Banks

### Diaper Bank Networks

**Websites:** <http://diaperbanknetwork.org/?q=what-diaper-bank-0>  
<http://www.babybasicsnational.org>

### Baby Basics, Inc. (Serves South Boston, Needham, and Dedham)

Must have one working parent/guardian, child under 3, family cannot be receiving federal or state cash assistance and must meet the financial guidelines for WIC

**Website:** <http://babybasics.org>

Needham, Dedham: **(617) 305-6899**

South Boston: **(617) 464-5850** or **(617) 269-7500**

### Allston Brighton Baby Diaper Bank

**(857) 344-3347**

Must be an Allston Brighton resident, must show WIC or MassHealth card and proof of residency or letter from shelter manager

**Contact:** [sabagup@gmail.com](mailto:sabagup@gmail.com)

### Family Van

**(617) 442-3200**

- Diaper availability varies. All are welcome for free health services and available resources.
- Located in Dudley Sq, Upham's Corner, Hyde Park, Codman Sq, Roxbury, and East Boston

**Website:** [www.familyvan.org](http://www.familyvan.org)

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**Diaper Depot of Waltham****(781) 891-6012**

- Provides 30 free disposable diapers per month per child
  - Should have referral from WIC, homeless shelter, other agency, or self-referral, for Waltham
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**Northeast Massachusetts: Giving Diapers, Giving Hope**

- A program that loans cloth diapers at no cost to low income families.
- Families must wash diapers themselves and those living outside of Northeast MA must pay shipping costs

**Location:** 8 Beckford St, Gloucester MA 01930**Website:** <http://www.givingdiapersgivinghope.org>

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**Lowell Diaper Bank Collaborative****(978) 454-5407 ext 137**

Provides free disposable diapers to low income families in Lowell

**Website:** <http://lowellalliance.wordpress.com/lowell-diaper-bank-collaborative/>

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**A Baby Center****(508) 771-8157**

- Provides free diapers every 30 days for infants and toddlers up to age 3
- Must meet WIC income guidelines and live on the Cape or islands

**Location:** 81 Willow Ave, Hyannis MA 02601**Website:** <http://www.ababycenter.org/index.html>

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**Baby Basics of Hyde Park**Free disposable diapers to Hyde Park working families *not* receiving public assistance**Contact:** [Barbara.j.baxter@state.ma.us](mailto:Barbara.j.baxter@state.ma.us)

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**Anchor of Hope Diaper Banks (Haverhill)****(978) 314-2254**

Provides free disposable diapers to families in need through existing service agencies

**Website:** <http://www.aohdiaperbank.org/>

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**Cradles to Crayons****(617) 779-4700**

- Diaper availability varies but helps out with clothing, toys, and other needs
- Requires referral from Cradles to Crayons authorized provider (ask PCP or social worker if they are registered)

**Website:** <http://cradlestocrayons.org/boston>

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## FORMULATING EARLY CHILDHOOD MENTAL HEALTH DIAGNOSES FROM ASSESSMENTS: DC 0-3R

The Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood, revised edition (DC: 0-3R) is a diagnostic classification system that aims to support clinicians in preventing, diagnosis and treating mental health challenges for children ages birth-3 years old.

Unlike the Diagnostic and Statistical Manual (DSM), the DC 0-3R takes into account the rapid development of young children, the importance of early relationships, the individual developmental trajectories of young children, and the impact of caregiver environment on child development.

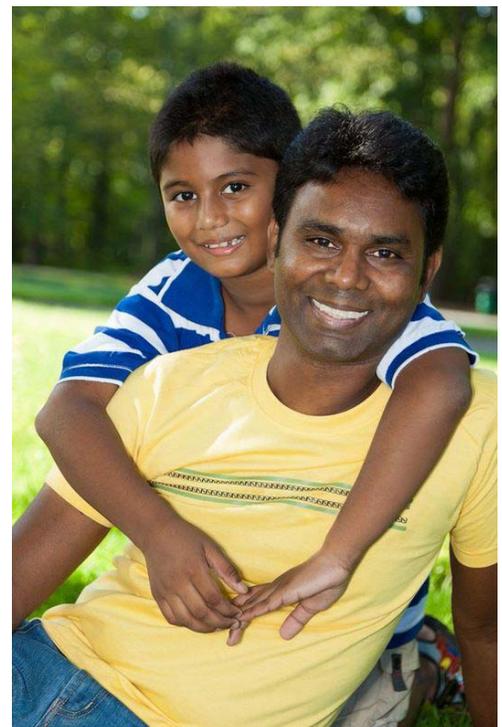
Though these diagnostic codes are not reimbursable through insurance in the current healthcare system, they provide clinicians with a better language to communicate concepts of infant and early childhood mental health to families and colleagues across agencies. These codes can be “cross-walked” with the DSM codes for reimbursement purposes, as other states have done.

### Online Resources

➤ Information regarding the DC 0-3R is available on the [Zero to Three website](#)<sup>19</sup>:

The website provides overview of the development of the DC 0-3R, research supporting the diagnostic criteria, and information on how to access training and the actual DC 0-3R forms. Sample forms are available through the website with further information on purchasing the DC 0-3R materials for use in your healthcare practice.

➤ Information regarding the DC 0-3R Crosswalk with ICD and DSM Codes is available through the [Illinois Association for Infant Mental Health](#)<sup>20</sup>



## PHASE THREE

# Developing Care Plans with Families

The Care Plan summarizes the caregiver's specific goals related to supporting the social and emotional health of the child and reducing the impact of stressors on the family. The Care Plan identifies actionable strategies and services that will be implemented to meet those goals and indicators to track progress toward goals.



## KEY OBJECTIVES IN THE DESIGN PROCESS

- 1) Identify Principles, Team Roles and Key System Components of Developing Care Plans
- 2) Develop Written Care Plan Documents and Protocols
- 3) Define Strategies to Include Caregivers for Care Plan Development to Ensure his/her Voice Guides Services for the Child
- 4) Select Evidence-Based Interventions for Children's Mental Health and Clinical Subspecialty Referrals as Potential Components of Care Plans

## Objective 1: Identify Principles, Team Roles and Key Components

### Important Principles

- **Family Voice:** A Care Plan reflects the strengths, needs and individualized goals of the caregiver as identified in the engagement and assessment visit(s). It reflects the caregiver's words, so caregivers should have a copy. Family Partners should ensure that the voice of the caregiver drives Care Plan development.
- **Preparation:** The whole team should prepare for the Care Plan visit. Based on information from the engagement and assessment visit(s), the FP and/or Mental Health Clinician should brainstorm possible service strategies to offer caregivers in developing the Care Plan. Also ask the PCP for input, given the PCP's longstanding relationship with the caregiver. Prior to meeting to make a Care Plan, the FP or MHC should help caregivers brainstorm their vision for their family and goals for their child.
- **Natural Supports:** Caregivers are encouraged to bring any "natural supports" they want to help plan their services. Natural supports may not be obvious to caregivers; FPs can help caregivers identify natural supports by asking creative questions about the people the child and family encounter in different settings.
- **Accessibility:** It is a good idea for the Care Plan visit to occur in a location convenient to the family; possibilities include home or community settings.

### Care Plan Checklist

- Service Delivery Tracking System and Weekly Family Review Meetings
- Care Plan Template
- Summary of Available FP and MHC Services and Strategies
- System for Storing and Accessing Care Plans
- System for Third-Party Reimbursement

## Objective 1: Identify Principles, Team Roles and Key Components

### Team Roles

**Family Partner:** The Family Partner or Mental Health Clinician may lead Care Plan development with the caregiver, depending on the caregiver's needs and the background of the FP and Clinician. For families where the Care Plan consists of prevention strategies and connections to community resources, the FP may do the Care Plan independently with the caregiver and his/her natural supports. If there are any clinical needs identified in the assessments or behavioral concerns that require specialized care, then the MHC should be involved.

The FP's lived experience and knowledge of community resources make her a clear asset in proposing creative strategies to meet Care Plan goals. Also, for families who have not had experience in advocating for their child, the FP may be particularly helpful in ensuring family voice underlies all Care Plan goals.

**Clinician:** For families where clinical needs are identified either for the child, parent-child dyad, or caregiver, the MHC should lead the Care Plan development process either alone or with the FP, depending on the family. For these families, Care Plan strategies will include regular therapy, brief therapeutic interventions, or referrals to specialized clinical providers in the community, all of which the MHC facilitates.

The FP's skills will be a useful compliment in all Care Plan visits for families that have clinical needs, but the FP's capacity may be limited. Again, their lived experience and knowledge of community resources make them a clear asset, and they would also be able to advocate for the family's voice.

**Primary Care Provider:** Given their ongoing relationship with the family, the PCP can offer input to the MHC or FP on what services or strategies may be most useful to the caregiver. The PCP also reviews the Care Plan when completed so they can encourage the family to pursue their identified goals in primary care visits, demonstrating a team approach to care.



**Primary Care Champion** (*may also be the referred child's PCP*): The Champion assists in developing a Care Plan template that can be used by FP/MHC with all families. He/she supports development of effective, feasible communication systems between PCPs and the FP and/or MHC so that all medical home providers involved with a family are offering coordinated, consistent services in response to Care Plan goals.

**Administrator:** This person assists in development of a Care Plan template. He/she aligns this template with other services within the medical home and ensures the template is easily accessible to all medical home providers. He/she also enables the Care Plan template to be both on the electronic medical record as well as printable for caregivers.

## Objective 1: Identify Principles, Team Roles and Key Components

### Key Components of Care Plan Development

**Care Plan Template:** The Family Partner and Mental Health Clinician need a common Care Plan template that can be used with caregivers. This includes the family's vision, caregiver and child's strengths, and the caregiver's specific goals for promoting their child's social and emotional health and reducing stress. Create an indicator for each goal to monitor progress, a strategy/service to meet the goal, a task list of what needs to be done, a person responsible for the tasks, and a target date for completion. Care Plans vary in number of goals depending on each family's situation. Keep the template in the medical record and give a copy to the caregiver.

#### **Provider Summary of Available Strategies and Services for Care Plans:**

Care Plans can include a range of services and strategies; the greater the breadth of options for families, the more individualized the Care Plan is. Services span clinical care, family strengthening and education activities, caregiver mentoring and flexible support, caregiver self-care, linkage to community resources, and underlying care coordination. Care Plans should also aim to support caregivers in developing skills to effectively advocate for their child.

Care Plan services may be provided directly by the FP or MHC or by a medical home or community colleague. A clear recognition of what services the FP and MHC will offer families as individuals and a team is pivotal. The FP and MHC should have self-awareness as to the strengths and limitations of themselves and each other as providers. Just as importantly, clarity on the roles and services of the FP and MHC will enhance partnership with caregivers and other medical home providers. Together, the FP and MHC should develop a summary of services they directly offer families and resources they facilitate access to. This should be shared with other medical home providers to help providers refer families who are ready to engage.

**System for Storing and Accessing Care Plans:** A system for storing and accessing these plans enables caregivers to have a copy of their Care Plan, other medical home providers to see it, and the MHC and FP to modify it. Care Plans can be written on a paper template and scanned into EMRs where possible. Alternatively, after drafting it with the caregiver, the provider can type the Care Plan in an electronic medical record (EMR) template and print a copy for the caregiver.

**Third-Party Reimbursement:** Similar to assessments, time spent by credentialed, licensed clinicians on forming Care Plans, collateral contact and care coordination is billable in a fee-for-service model. The MHC should be trained on effective coding for their services, inclusive of collateral and care coordination by an administrator in the practice. Feedback should be provided to the MHC on claims submitted that were denied by insurance companies and reasons for denial, so that the MHC can correct errors in billing. For particular health practices, the FP's time may also be reimbursable. See section 4 of this toolkit *Financing and Sustaining the ECMH Model* for more details.

## WHAT IS A CARE PLAN?

The dyadic work of the Family Partner and Clinician work differs from the traditional clinical work of solo mental health clinicians. The team-based model requires health practices to create documentation templates that reflect the family-centered, team-based approach of the Family Partner-Clinician team.

Specifically, while health practices likely have templates for behavioral health treatment plans, the dyad additionally requires a Care Plan template that reflects the comprehensive nature of the services, the family's voice (vision, strengths, and goals), and an outcomes-based approach (indicators, tasks, timelines).

Care Plans are more comprehensive than traditional treatment plans, often taking into account the broader needs and strengths of the whole family rather than just the narrower medical or mental health needs of a patient. For MYCHILD and LAUNCH demonstration sites, the concept of a comprehensive Care Plan was shaped by the principles and practices of the Wraparound Process and the experience of the Children's Behavioral Health Initiative in supporting Family Partner-Clinician teams.

### What's the Wraparound Process?

The [Wraparound Process](#)<sup>21</sup> refers to "a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family." As demonstration site teams, the FP and Clinician were able to broadly identify and respond to the individual goals, strengths and needs of families in multiple life domains, including the child's emotional health, family activities, basic needs, cultural resources, sibling needs and caregiver mental health.

Care Plans were designed to reflect the family's vision and strengths, prioritized needs broadly related to the child's social and emotional health, and specific strategies and interventions chosen to reach those goals. They became a communication tool between the caregiver, FP, Clinician and Primary Care Provider to monitor the progress toward goals and the skills caregivers acquired in the process.

*This section provides examples of Care Plan templates, frequently asked questions regarding Care Plans in this model, and systems to effectively write, maintain and update Care Plans in partnership with families.*

## CARE PLAN FREQUENTLY ASKED QUESTIONS



1.

### **Should every family enrolled in services have a Care Plan?**

Yes, every family enrolled in services, either with the Family Partner-Clinician dyad or one of the individual providers, should have a Care Plan. Without it, services are not clearly defined. The Care Plan may be quite brief if the service needed is quick resource connection. Nonetheless, a Care Plan with one clear goal should still be written.

2.

### **Does the Clinician have to write a Treatment Plan that differs from the Care Plan?**

For demonstration sites where the clinician provided clinical therapy (either individual or group), a clinical treatment plan was documented in the medical home EMR system separate from the Care Plan.

There were two main reasons for this separate documentation:

1) **Confidentiality:** The Care Plan can be disseminated to medical home and community partners, with caregiver permission. Thus, there may be confidential behavioral health information discussed in clinical therapy that the caregiver would not want disseminated along with the broader Care Plan goals. In these situations, that Care Plan can contain a summary of clinical goals from the Treatment Plan or merely reference the Treatment Plan for clinical goals related to the child or child-caregiver dyad.

2) **Reimbursement:** Many demonstration sites needed Clinicians to document a clinical Treatment Plan in the medical records to enable the site to appropriately bill insurance for clinical services provided.

3.

### **Who should have access to a family's Care Plan?**

Care Plans should be accessible to the caregiver, FP, Clinician, Primary Care Provider, and any other community-based agency staff (teacher, daycare provider, etc.) the caregiver designates and provides written consent to share this information with. The FP and/or Clinician should support the caregiver in deciding if there are community providers whose access to the Care Plan (or components) would enable them to better support the child. Ensure that partnering community-base staff have the capacity to maintain confidential records prior to providing a Care Plan after caregiver's consent.

4.

### **Where should Care Plans be kept? And how do we communicate Care Plan updates across the team?**

As above, the primary caregiver and the key medical home providers should have access to the enrolled child's Care Plan. In developing a system for maintaining and updating Care Plans, remember that there is a team approach to implementing services. Thus, the caregiver may be working toward multiple goals with multiple providers. A clear system for provider communication on Care Plan goal progress is critical to coordinating services in this comprehensive approach. Below are descriptions of how Care Plans are stored and updated across demonstration sites:

**Medical Home:** In the medical home, Care Plans are best maintained in an electronic medical record template that allows for continuous updates. However, as this is not always possible, some health practices may maintain paper copies of Care Plans, which are at designated intervals scanned into the electronic medical system so updates can be viewed by the Primary Care Provider. When a caregiver consents to a community provider accessing the Care Plan, the best system for confidentially providing a copy of the Care Plan should be discussed with the partnering agency.

**With Families:** A Caregiver should have continuous access to their child's Care Plan. This is critically important to enable families to be partners, and ultimately leaders, in managing their family's care. Depending on your medical record system and family access to Internet, a family may access Care Plans electronically. The FP or Clinician can email a copy of the electronic Care Plan to a caregiver or the Care Plan can be accessed through an electronic medical record patient access system, as some health practices currently have.

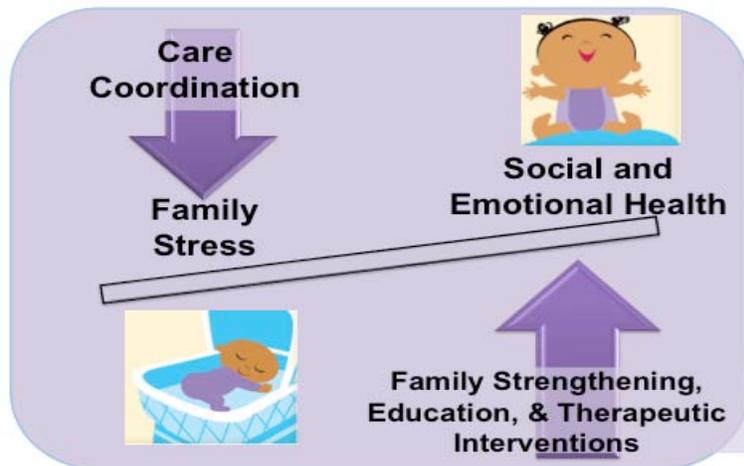
5.

### **What if families have limited Internet access?**

Given limited family access to the Internet, the strategies above are not used by demonstration sites. Instead, multiple sites employed a carbon copy system and paper records. Sites printed Care Plan templates and progress notes on paper with three carbon copies. The FP or Clinician would write the Care Plan or progress note during the visit with the family and provide a carbon copy of the note to the caregiver at the end.

They brought the remaining copies to the medical home, where one was submitted to be scanned to the electronic medical record system, and one was held by either the FP or Clinician to bring to the next Family Partner-Clinician case review meeting. Having a carbon copy at this meeting enabled the FP and Clinician to communicate their individual work with each family to the other provider, thus keeping both providers updated on the Care Plan goal progress.

## CARE PLAN DEVELOPMENT TIP SHEET



### Tip #1

#### **Strengths belong on the front page of the Care Plan:**

The strengths should be the starting point from which your Care Plan blooms. When writing the Care Plan, start by reviewing vision and strengths. Go in a circle and have all team members articulate a strength of the child or family. The Family Partner or Mental Health Clinician can start: "I know for certain that one of your strengths is that...."

### Tip #2

#### **Prepare caregivers to have a voice in care planning:**

After the engagement and assessment visit, the next meeting between the caregiver and FP/MHC will likely be to develop the Care Plan that will define services and supports for their child and family. For families whose Care Plans will have multiple goals, the FP should prepare the caregiver for this Care Plan development meeting.

The FP can talk through what to expect from the meeting, review what a Care Plan is, go over forms and terms that might be used, and even do some role playing with the family around articulating strengths, needs and goals. The FP can support the caregiver in developing a list of questions they will want to ask the Clinician and FP in developing the Care Plan. Most importantly, the FP can just emphasize the importance of the caregiver's voice in guiding all decisions for their child.

## Objective 2: Develop Written Care Plan Documents and Protocols

### Tip #3

### Organize and prioritize goals with families

After completing thorough assessments, it may seem daunting to brainstorm and prioritize 2-3 specific goals with caregivers.

It may be helpful to think about goals in two different categories:

#### ➤ Goals related to reducing family exposure to risk factors

Goals designed to reduce exposure to risk are primarily met by connecting families to resources in the community. This implies an initial emphasis on care coordination, coaching and support, with the ultimate aim of enabling the family to meet resource needs independently.

These goals are often guided by the “Do for, Do with, Cheer on” approach to care coordination. Early in service involvement, families often need staff to do care coordination for them. Later, families develop capacity to do their own care coordination with the support of the Family Partner and Mental Health Clinician. The ultimate goal is for families to do care coordination independently.

#### ➤ Goals related to promoting social and emotional development and healthy behaviors

Goals of this type may be met by strategies that fall into **four categories**, reflecting child and family needs and the judgment of the caregiver, FP and Clinician about the best approach to meeting those needs.

#### These needs may be characterized as:

- 1) **Brief treatment needs**, which call for individual and/or dyadic work with the FP or MHC making use of evidence based practices
- 2) **Family strengthening needs**, including parenting education, parenting skills practice, and/or household stabilizing strategies that can be implemented by the FP or MHC
- 3) **On-going mental health needs** of the child, parent, or family unit that require a facilitated referral to a mental health provider in the medical home or community
- 4) **Mental health consultation needs**, requiring technical assistance to and/or collaboration with a teacher or other child care provider to assure optimal management of the child in an out-of-home setting.

Try to support families in choosing important and feasible goals from each category, as both are critical in supporting the social and emotional health of children. Think closely about the feasibility of accomplishing goals; help the caregiver prioritize one goal that is challenging and one goal that is more immediately attainable so you foster early success and self-efficacy.

## Objective 2: Develop Written Care Plan Documents and Protocols

### Tip #4

#### **Be clear on available services and strategies.**

#### **Know yourselves as a team.**

There are many types of services and strategies that can be used to support caregivers in meeting their goals. The Family Partner, Mental Health Clinician and PCP must be skilled in evidence-based practices to support healthy social and emotional development as well as connected to community-based resources that provide family support services.

The more strategies or services the FP and MHC can offer, the more individualized each Care Plan will be. The caregivers decide what services and strategies they want to try for their family, but they are dependent on the FP and MHC to propose a breadth of creative options. As a dyad, invest in the early stages of the initiative, defining as a provider team exactly what services you can offer as individuals, as a team and in partnership with other medical home and community providers. Be specific, as it will help you both understand each other's assets, strengths and limitations.

#### **Ask yourselves the following 3 questions and consider examples of services:**

1.

#### **What services can we as a Family Partner-Clinician team directly offer families?**

- Evidence-based therapy
- Family education materials on children's health and development
- Caregiver support on career planning, job training, goal setting
- Peer support groups for moms
- Consultation to childcare or schools regarding a child
- Linkage to partnering services and care coordination of multiple services

2.

#### **What services can we connect families to within the medical home?**

- Adult behavioral health services for caregivers
- Specialized behavioral health services for a child (e.g. trauma specialist)
- Social work for support with housing insecurity
- Children's playgroup hosted by volunteers

3.

#### **What services can we connect families to in the community?**

##### **Clinical:**

- Developmental pediatrician at local hospital
- Trauma specialist at local hospital
- Adult psychiatrist
- Child psychiatrist

##### **Non Clinical:**

- Early intervention
- Childcare
- Schools and special education liaisons
- Food assistance programs
- Local family recreational events

## EXAMPLES OF SERVICES SPANNING PREVENTION AND INTERVENTION

### Prevention

- Flexible individualized support in accessible locations (*e.g. home visits, accompanying families to services*)
- Mentoring for caregivers to achieve personal resource/support goals and develop skills in care coordination
- Education on child development
- Resources connection to meet family's basic needs (*food, heat, car seats etc.*)
- Linkage to culturally relevant family
- Activities (*community centers, events*)

### Intervention

- Linkage to community-based early childhood programs (*e.g. Early Intervention, Headstart*)
- Nurturing programs to strengthen parent-child interactions
- Center on the Social and Emotional Foundations for Early Learning Pyramid Model activities
- Mental health consultation to childcare, preschool, and shelter staff
- Brief parent-child therapy
- Linkage to parent mental health services
- Weekly parent-child therapy or individualized child therapy
- Referrals to specialized behavioral health services (*core service agencies, Wraparound, trauma centers, psychiatrists*)
- Problem-solving education as evidence-based practice
- Coordination of medical home and external behavioral health services

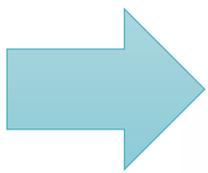
**Tip #5**

**Offer choices to ALL families, even ones with “mandates” to participate**

At times you will have a family that has to participate in therapy as required by their involvement with the child welfare system. For these families, **still offer a choice.**

They have to fulfill the requirement, but they have options for ways to do so. Don't force a family to participate in your specific service; give them the option of a couple other services as well. But most importantly, when the family *does* engage with you, give them lots of options for specific strategies to meet their goals (weekly therapy in group vs. individual, visits at community center vs. clinic, etc.).

**The Care Plan is a way to give the caregiver a voice and choice (even within the boundaries set).**



**Click here to view a sample Care Plan.**



## Parent Worksheet: Preparing for Care Plan Meetings

Take some time before your child's appointment to consider your concerns and questions. Below are some areas to consider in your notes:

**It can be helpful to write it down!**

General updates and things I need: *(forms completed, referrals made, etc.)*

---

---

My child's strengths are:

---

---

Things about my child that I wonder or worry about right now:

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---

---

Things about my child that I wonder or worry about that may be in the future:

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---

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My child's behavior: *(Is it improved? Would I like it to be different?)*

Home: \_\_\_\_\_

School: \_\_\_\_\_

Other settings and concerns: \_\_\_\_\_

My child's routine is: *(Consider eating/sleeping/transitions/relationships)*

---

---

Things I wish for my child/family:

---

---

## EVIDENCE-BASED INTERVENTIONS AND SUBSPECIALTY REFERRALS AS CARE PLAN STRATEGIES



There are resources from the American Academy of Pediatrics (AAP) that may be helpful in identifying effective strategies for Care Plan social, emotional or behavioral health goals. These include guidance on evidence-based psychosocial interventions for children and sources of subspecialty referrals for children with mental health needs.

The information on evidence-based practices can also be used by the Core Team to identify training opportunities for the Clinician and Family Partner on specific practices that improve the quality of services offered.

### Links to Resources

- [Evidence-Based Child and Adolescent Psychosocial Interventions](#)<sup>22</sup>
- [References for Evidence-Based Programs for Young Children](#)<sup>23</sup>
- [Sources of Subspecialty Services for Children with Mental Health Problems and Their Families](#)<sup>24</sup>

## PHASE FOUR

# Care Plan Implementation

Implementation is when the services and strategies on the Care Plan are accessed and applied to support families in achieving their goals for their child's social and emotional development. The caregiver and providers should monitor progress toward goals using the Care Plan and revise services as needed.

### KEY OBJECTIVES IN THE DESIGN PROCESS

- 1) Identify Principles, Team Roles and Key System Components of Implementing Care Plans
- 2) Organize Group Interventions to Foster Peer Support
- 3) Develop Care Coordination Protocols: Critical Component of Implementation and Access Resources to Support the Family Partner and Mental Health Clinician in Coordinating Care
- 4) Develop the Family Log: A Tool for Caregivers



## Objective 1: Identify Principles, Team Roles and Key Components

### Important Principles

- **Family Voice:** As services are implemented on the Care Plan, the Family Partner or Mental Health Clinician must ensure that services empower caregivers to voice their perspective on the usefulness and goodness of fit of services.
- **Dynamic Revision:** As family's lives change, Care Plans will also. The FP and/or MHC should revise Care Plans to try new strategies or identify new goals when progress is not being made. Caregivers and providers should recognize that some goals take a longer time, especially if the goal is related to changing behaviors or strengthening relationships between the child and caregiver.
- **Natural Supports:** Caregivers should be encouraged to continuously include "natural supports" in their services and visits.
- **Accessibility:** As families face multiple barriers to accessing care, make continued efforts to meet families "where they are" and identify services in convenient locations.
- **Persistence:** Promoting social and emotional health and changing behaviors takes time and perhaps many different strategies. Persistence in relationship-building and support with caregivers is key, especially when new challenges arise.
- **Skill Building:** Services and strategies should aim to support caregivers in developing the skills (organizational and communicative) and knowledge needed to advocate for their child's health.

### Implementation Checklist

- Progress Note Template
- System for Identifying Well Visits of Children Enrolled in Family Partner/Mental Health Clinician Services
- Strategies for Caregiver Empowerment & Skill Building
- System for PCP Champion Communicating FP/MHC Service Capacity to Other Medical Home Providers
- Liaison to Community Networks
- System for Third-Party Reimbursement for MHC (and maybe FP)

## Objective 1: Identify Principles, Team Roles and Key Components

### Team Roles

*The FP or MHC may be the lead with a family in implementation, depending on the goals of the Care Plan. Some families may receive services from only one provider, while others may have both providers involved.*

**Family Partner and Clinician:** Both take the lead on implementing services for which they are the responsible person on the family's Care Plan. One provider is the lead family contact, who regularly supports the caregiver in accomplishing his/her designated tasks to access services.

Depending on the services chosen, the Family Partner and/or Mental Health Clinician meets with the family at a regular interval (at least every 3 months to align with CANS requirement). This may be more frequent if regular therapy with the clinician is one of the strategies on the Care Plan. With each visit with the FP or MHC, the provider writes a progress note in the medical record. At least every 3 months, the Care Plan with the FP or MHC should be reviewed and updated to discuss progress toward goals, need for continued services and next steps in care. At weekly meetings, the FP and MHC review all families enrolled in the project's services and the contact each provider has had with all caregivers, to keep the FP/MHC united in services and information.

The MHC or FP may draw upon the expertise of the other provider at any point in serving a family. They should be aware of when enrolled families are coming to well visits, to couple visits or simply do a quick check-in in primary care. Keep other medical home providers aware of community events focusing on social/emotional health, child development or mental health.

**Primary Care Provider and all Medical Home Providers:** The PCP reviews the Care Plan and progress notes in the medical record. That way, when they see children for well visits who have a relationship with the FP or MHC, they can encourage the family to continue working on

their goals. This consistent support from multiple providers in a coordinated medical home best supports the family in achieving goals.

**Primary Care Champion** (*may also be the referred child's PCP*): The Champion assists in developing progress note templates that can be easily reviewed by PCPs, and advocates for PCPs to include the FP or MHC in their well visits, particularly for families facing multiple mental health challenges. He/she advocates for strong communication systems between the PCP and FP/MHC and proposes suggestions for improvement. He/she communicates with colleagues about the capacity of FP and MHC services, and can offer alternative referrals if it is temporarily full. He/she shares information with other PCPs about relevant community events that promote social/emotional health, as he/she learns about them from FP/MHC.

**Administrator:** He/she assists in development of progress notes templates and pays attention to developing a template with the FP that captures the types of services they provide, as the FP differs from other providers in the medical home. He/she ensures templates are easily accessible to all medical home providers involved in the family's care, and enables the notes to be on the EMR as well as printable. He/she finds an efficient way for the MHC/FP to be aware of PCP appointments, ideally through an EMR or scheduling system. He/she provides MHC (and possibly FP) with billing information (forms, codes, process) so they can bill for their services, including therapy and care coordination, and tracks billing data to determine why claims are rejected and fix errors to improve revenue. See section 4 of this toolkit.

## Key Components of Care Plan Implementation

**Progress Note Templates:** There should be progress note templates for the Family Partner and Mental Health Clinician to use in the medical record. Pay particular attention to designing an effective FP template, as this is likely a new role in the health practice and differs from clinicians and case managers. The Core Team should design this template together, and make sure progress notes are accessible to other medical home providers.

### **System For Identifying Well Visits of Children Enrolled in FP/MHC**

**Services:** There should be a system for which the FP and MHC are aware of the primary care visits scheduled for families they follow. This way, they can check in with families during well visits, especially families that may be hard to contact or schedule appointments with. This also reinforces the team approach between the MHC, FP and Pediatrician.

Two systems used by piloting sites are:

- 1) The pediatric receptionists send EMR messages biweekly to the FP and MHC with lists of well visits for their patients
- 2) The FP and/or MHC alternate looking through the weekly schedules of PCPs and pulling out well child visits of their patients.

Discussing this need with the IT staff at your health practice may help identify time efficient electronic systems that save staff tremendous amounts of time. Also, having a FP/MHC designation on the *front page* of the medical record will enable staff to easily identify who is enrolled in FP/MHC services.

**Strategies for Caregiver Empowerment and Skill Building:** Part of the Care Plan should include goals related to caregiver education and empowerment. These goals are linked to the health of the child because caregivers must develop skills and knowledge to effectively navigate health care systems and advocate for their child.

There are trainings that can help the FP and MHC support caregiver efficacy and skill development (e.g. Problem Solving Education. See the training information in section 1 of this toolkit, *Building A Core Team*). The FP may be particularly well positioned to support caregivers in skill development, given their experience in navigating health systems and advocating for their own child. A Family Log (organizational binder) can be a useful tool to give caregivers to support caregivers in managing their child's multiple appointments, progress toward goals and provider contact information.

## Objective 1: Identify Principles, Team Roles and Key Components

### COMPONENTS CONTINUED ...

#### **System for PCP Champion Communicating FP/MHC Service Capacity to**

**Medical Home Providers:** The need for services supporting social, emotional and behavioral health is increasing. Depending on health practice utilization of the FP and MHC, the FP and MHC may reach full capacity in serving families. Have a clear system for communicating full capacity to the PCPs and other referring medical home providers, so referrals can be temporarily directed toward other services. The Core Team should have a resource list of other services that can support families until capacity opens, and these other support services should be accessible to PCPs in clinic rooms. During times of full capacity the FP and MHC should pay particular attention to families who are close to transition.

**Liaison to Community Networks:** As families participate in Care Plan services, there will constantly be new community events or resources related to social and emotional health that arise for families. Each medical home should designate a person (either the FP, MHC, or ideally an existing outreach coordinator or community resource specialist) who joins community listservs, networks with key community partners, and keeps updated on the latest events and resources. This liaison then informs the FP, MHC and all medical home providers about upcoming opportunities for children and families. The Community Integration information in this section offers more guidance on accessing these networks.

**Third-Party Reimbursement System:** The MHC can bill for services delivered (therapeutic interventions, care coordination, collateral contact). Designate a system for this, considering who will complete billing paper work, what codes will be used, and how reimbursement will be tracked. There may also be opportunities for FP reimbursement; see section 4 of this toolkit, *Financing and Sustaining the ECMH Model*, for more guidance.

## Objective 2: Organize Group Interventions to Foster Peer Support

### ORGANIZING GROUP INTERVENTIONS



Delivering services and supports in group settings can have many benefits. Groups can facilitate a level of peer support and empathy on parenting and social and emotional health that is not typically experienced through an individual relationship with a provider. Furthermore, groups can be an efficient use of resources, enhancing provider productivity and depending on the group, enabling third-party reimbursement for multiple patients.

Demonstration sites have piloted multiple types of groups as an additional service or strategy to meet the needs of individual families.

Tips below are quick reflections of providers on those experiences.

#### Define the Group's Purpose

Many interventions can be delivered via group. Groups of caregiver-child dyads, children or just caregivers can all be forums to support children's healthy social and emotional development. It is important to clearly define the group's purpose and your goal. Running a group for drop-in parent support is very different than having a weekly, selected group of families who participate in an evidence-based curriculum. Think carefully about size, enrollment criteria, family commitment (drop-in vs. regular attendance), and recruitment to ensure that you are reaching your target population without overextending the group. Be able to articulate the goals to potential participants, medical home colleagues and community partners.

#### Explore Group Curriculums

There are a variety of group evidence based-practices to support children's social and emotional development. Many involve separate child and parent groups that can co-occur at the same time. Demonstration sites have used the Center for Social and Emotional Foundation of Early Learning (CSEFEL), The Family Nurturing Program, Incredible Years, and Circle of Security as curriculums for group interventions. These interventions span promotion, prevention and interventions levels of care for early childhood.

## Objective 2: Organize Group Interventions to Foster Peer Support

### **Partner with Medical Home/Community Colleagues**

Since running a group requires the presence and expertise of multiple staff, think carefully about who else within your medical home participates in implementation. One demonstration site partnered with two family behavioral health providers to run a group using the CSEFEL curriculum with caregivers. This had an additional benefit: Caregivers met behavioral health providers who could also provide individualized therapy for adults, thus facilitating caregiver warm handoffs between pediatrics and family/adult providers. For groups run in partnership with community agencies (e.g. housing shelter), staff of the partnering agency were involved to build awareness of early childhood mental health in community settings.

### **Expect Administrative Time and Consider a Volunteer**

It takes a significant amount of time administratively to plan and implement a group. In addition to planning each session's activities, there are a multitude of logistical arrangements to arrange, including space, transportation, childcare and food. For one demonstration site, running a group required three staff members for kids group, two staff for adults, two rooms, childcare for siblings, donated books and cradles, and food (lunch or dinner). Calls were made to parents prior to each session as both reminders and encouragements. Sites recommend a volunteer who can assist in the arrangement of logistics, freeing leading facilitators (Core Team, Partners) to focus on session content planning.

### **Set Ground Rules as a Group**

Invest time the first meeting to setting ground rules as a group. Have participants express the values that are important to them in a group setting (respect, listening, etc.). Emphasize peer confidentiality as a core value of the group, especially given that caregivers will likely share intensely personal experiences regarding parenting, stress and mental health.

### **Designate a Parent Representative**

Consider identifying a parent representative who can assist in planning the group and recruiting peers to participate. This may be a parent who has experienced individual or group services through the Family Partner or Clinician. This parent should be compensated for their work as an "engagement specialist." A call from a parent regarding the value of the upcoming group is likely to be more effective for parent engagement than any outreach from staff.

## Objective 3: Develop Care Coordination Protocols



### CARE COORDINATION: DEFINITION, EXAMPLES AND RESOURCES

Care coordination is a critical aspect of care in the medical home, particularly for children with special healthcare needs.

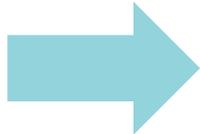
*“Pediatric care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness outcomes.” - (The Commonwealth Fund, 2009<sup>25</sup>)*

Care coordination is particularly important in supporting children with mental health needs, as Care Plans contain a broad range of services to support the child and whole family in multiple life domains (child health family activities, caregiver health, basic resources etc.). In the implementation phase of services, after a Care Plan is developed, care coordination is particularly important to ensure that all services are linked and that providers and caregivers form one team on behalf of the child.

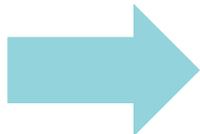
At demonstration sites, the Family Partner, Mental Health Clinician and caregivers were partners in care coordination. The FP often led care coordination efforts regarding family resource and support goals, particularly with non-clinical community partners (childcare, special education, Dept. Transitional assistance, family activity initiatives) and caregiver supports (job training programs, GED programs, etc.).

Clinicians led care coordination efforts regarding clinical goals of the child and caregiver, particularly with clinical providers within the medical home and the community. Both the FP and MHCs supported caregivers in developing skills on care coordination, thus enabling caregivers to assume care coordination responsibilities for their child prior to transition from services.

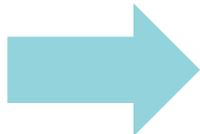
## Care Coordination Efforts by the Family Partner and Clinician



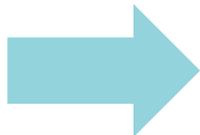
Co-developing the child's Care Plan with specific "action steps" assigned to all team members



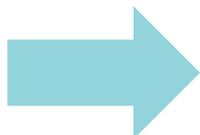
Clinician and caregiver discussing a Care Plan with key community partners (e.g. lead childcare provider) so that specific behavioral strategies can be implemented at childcare as well



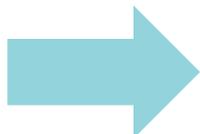
The Clinician, Family Partner and Primary Care Provider sending charts messages to each other with updates on a child's participation in services and progress in meeting behavioral goals



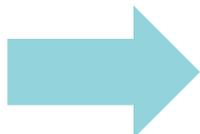
Effectively linking a caregiver to an adult behavioral health provider with the support of the FP; ongoing communication between the Clinician, FP and Adult Behavioral Health Provider regarding progress in therapy and new challenges that arise



Family Partner providing information regarding local child play groups and free family activities to a caregiver



Caregiver completing applications for employment or job training with the support of a FP



Clinician and FP reviewing a Child's Transition Plan with the PCP to facilitate ongoing PCP support for the family in reaching their defined goals

### Training and Support for Care Coordination

Care coordination is a skill acquired with training and experience. A new Family Partner may have limited experience coordinating care between medical homes and community partners. Furthermore, while most behavioral health clinicians have some experience with care coordination, many have not partnered with a FP or caregiver in these efforts.

There are a variety of resources and trainings to support the FP and Mental Health Clinician in developing competencies in care coordination.

However, before examining external resources, consider the internal expertise at your practice.

- Do you have an experienced Care Coordinator who can support the FP and MHC in developing relationships with community providers?
- Who can advise the FP and MHC in recording and communicating care coordination efforts?
- Who has strategies to support caregivers in acquiring care coordination skills in the team process?

### External Care Coordination Resources

#### National Center for Medical Home Implementation<sup>26</sup>:

Videos, descriptions and forms to help define care coordination and competencies.

#### American Academy of Pediatrics<sup>27</sup>:

Reproducible templates, including request for consultation services, referral form to Early Intervention, template for managing lists of community resources.

#### National Wraparound Initiative<sup>28</sup>:

Provides descriptions, overviews, and concrete tools on the Wraparound Process—an intensive, individualized care planning and management process that utilizes a team approach, inclusive of Family Partners.



## FAMILY LOGS: AN ORGANIZATIONAL TOOL FOR CAREGIVERS

**1. What is the purpose of the Family Log?**  
The purpose for the Family Log is to have a designated place for families to keep all relevant information concerning their family. (*Gathering the information to be included in the Family Log could be one of the tasks on the Care Plan.*)

**2. What are the main objectives in issuing Family Logs to enrolled families?**

- A tool for caregivers to keep track of appointments
- A tool to organize and plan for effective communicating with providers
- A place to keep track of goals the family creates
- A place to record any changes in family
- A tool to support caregivers' skill development in managing resources
- To meet families' individual needs (*financial info, templates to help caregiver manage care*)

**3. How should I advise families to use the Family Log?**

It should be used as an organizational tool to manage family's care, goals that the family has worked on, copies of children physicals, Individualized Education Programs (IEPs), report cards, birth certificates, a place for referral to support family, note taking and a section to record upcoming appointments.

**4. Should the Care Plan be in the Family Logs?**

Yes, Family Logs should contain a Care Plan at all times. Care Plans are road maps for families that include goals for parents and goals for children.

**5. When I visit with a family, should I update the Family Log?**

Yes, it is really helpful to have notes on what you have worked on with them. Notes may include goal for the week, a reflection or even a congratulation on accomplishments.

**6. When should the Log be given out?**

During the follow up engagement/assessment meeting, introduce the Family Log and explain the purpose and intent for the Log (as noted in the service delivery model). Ask families to bring to every visit with either the Clinician or Family Partner.

**7. Are there certain sections the Family Log should have?**

Yes, below are recommendations that all Logs should have:

- Family History
- Upcoming Events/  
Appointments
- Child Clinical Plans
- Health Care Center  
Documentation
- Care Plan
- Pocket Calendar
- Update
- Miscellaneous

## PHASE FIVE

# Transitioning Families from Services

**Transition** is the planned exit from formal Family Partner/Mental Health Clinician services. Transition means the FP/MHC is no longer providing direct services to the family; however, the family should continue to participate in other medical home and community-based services that have been part of their Care Plans.

The goals of transition\* are:

- 1) Families transition with an intentional plan for sustained engagement in medical home and community-based services.
- 2) Each family perceives the medical home as a family-centered, culturally-responsive linkage to resources to meet their family's comprehensive needs.

\*Transition differs from disengagement, where families stop engaging with the FP and/or MHC without a planned exit.



## KEY OBJECTIVES IN THE DESIGN PROCESS

- 1) Identify Principles, Team Roles and Key System Components of Transitioning Families from FP/MHC Services
- 2) Recognize Factors that Suggest a Family is Ready to Transition from Services, Emphasizing Caregiver Skills and Self-Efficacy
- 3) Develop a Standard Process for Transitioning Families with Emphasis on the Role of Primary Care Providers in Follow Up
- 4) Develop a Template for Transitioning Families Using Samples Provided

## Objective 1: Identify Principles, Team Roles and Key Components

### Important Principles

- **Start Early:** Transition planning starts from the very beginning of working with families. The team should always be thinking ahead about the skills and supports caregivers' can acquire to manage their child's health without the Family Partner and/or Mental Health Clinician in the future. A critical aspect is identifying and involving the caregiver's natural supports early on.
- **Caregiver Skills and Self-Efficacy:** A key part of preparing for transition is developing Care Plan goals and strategies that support caregivers in developing the skills they need to manage their child's care. Transition is dependent on the caregiver learning to advocate for their child.
- **Medical Home Continuity:** Transition does not mean families are left without support. The medical home provides continuity in care via the Primary Care Provider, who should receive a clear "sign out" from the FP/MHC during the transition phase. This enables the PCP to follow up with families on their transition plan, successes, and any new challenges that arise regarding their child's social and emotional health.
- **Community-Based Service Continuity:** In addition to continuity in the medical home, families should continue to participate in key community-based services, playgroups, parent support groups, Early Intervention) that are supportive of the family. The caregiver should be prepared to access these services without the support of the FP and/or MHC.
- **Open Door:** After families transition, they may still be re-referred to the MHC or FP if new challenges arise that require more intensive support, as recognized by either the caregiver or PCP. This applies for families that disengaged in services too, as those families may move forward in readiness to participate over a series of months.

### Transition System Checklist

- Transition Template Form
- Communication System with Primary Care Provider For Transitioning Family
- PCP Education Regarding Transition Plans
- Communication System with Key Community Providers
- Tracking System for Monitoring Family Progress Through Transition (*Use Same Tracking Sheet for Referrals, Engagement, Care Plan Development, Implementation Phases*)

## Objective 1: Identify Principles, Team Roles and Key Components

### Team Roles

**Family Partner and Clinician:** Transition involves either one or both providers, depending on who was involved in the care planning and service implementation phases. One or both providers are designated responsible for creating the formal transition plan with the caregiver, including tapering follow up communication and directly communicating with the Primary Care Provider. The responsible provider records the Transition Plan in the medical record using a set template. They are also responsible for communicating the plan to key community-based agencies for which mental health consultation was provided (e.g. childcare or school).



**Primary Care Provider:** The PCP reviews the Transition Plan prior to next visit with the caregiver and child. He/she follows up with the family within three months, as scheduled by the caregiver with Mental Health Clinician/Family

Partner support. At the visit, he/she checks in with the family on the Transition Plan to ensure the family is still engaged in the community and clinical services planned. If not, barriers are identified and the PCP provides additional support as needed. This support should initially be close follow-up with PCP (either visit or phone call). If needs are significant enough to warrant FP/MHC services, the caregiver can be re-referred.

**Primary Care Champion:** The PCP Champion supports development of the transition template that is accessible to PCPs. He/she encourages PCPs to review Transition Plans and follow up with families accordingly. He/she educates PCPs on how to best support families on Transition Plans and when to re-refer to MHC or FP vs. schedule a follow-up with the PCP. PCPs are encouraged to help families overcome barriers to transition plans before automatically re-referring, given the capacity of FP and MHC and amount of need for these services.

**Administrator:** The Administrator supports development of the Transition Plan template and mechanism for documentation in medical records, ideally electronically. He/she helps foster strong partnerships with community agencies on behalf of the health practice to promote continuity in community based services. He/she supports development of effective FP/MHC-PCP communication systems regarding disengagement and transition, plus develops tracking systems to monitor the percentage of families who disengage vs. transition, to help the team improve this process.

## Objective 1: Identify Principles, Team Roles and Key Components

### Key Components of Transition Systems

**Transition Template:** Create a transition template that is incorporated into the child’s medical record and is accessible to providers throughout the medical home. The template includes the following components: reason for closure, updated strengths, accomplishments made, plan for ongoing services (medical home and community based), and crisis plan as needed.

**Communication System with Primary Care Providers:** As with other phases, a system for communicating with PCPs is pivotal, especially at the point of transition. This is the “warm handoff” back to the PCP and requires closed-loop communication with the PCP, either verbal or written. PCPs should acknowledge receipt of Transition Plans to ensure that the caregiver and family continues to be supported in their goals. Having the PCP follow up on the Transition Plan is critical for continuous, coordinated care.

**PCP Education Regarding Transition Plans:** PCPs should be trained on the contents of the Transition Plan and how to respond to families who are facing barriers to continued engagement in Transition Plan services. Rather than immediately re-refer to the Mental Health Clinician and Family Partner, the PCP should first try to support the caregiver in continuing with the Transition Plan with techniques such as motivational interviewing and close follow-up.

**Communication System with Key Community Providers:** For each family, there may be one to two key community providers whom the FP/MHC and caregiver have worked closely with to promote the child’s social and emotional health. During the transition phase, the caregiver, FP or MHC should discuss the Transition Plan with the key community providers so that they can continue to best support the caregiver after transition. This is particularly important if mental health consultation was provided to childcare or school settings. The MHC and FP should have a system for designating who follows up with the community provider and a date for completion.

**Tracking System:** Have a tracking system that notes when the family’s Transition Plan was created, subsequent follow-up contact, closure communication with key community provider, and the follow-up appointment with the PCP. Note the percentage of families that disengage before formal transition, because that could be informative for improvement. It is a good idea to have this be the same tracking sheet used for managing referrals, assessments and Care Plans.

## TRANSITION PLAN TIP SHEET

### Tip #1

#### **Not All Goals Have to Be Accomplished Prior to**

**Transition:** Care Plans are dynamic documents that reflect changing goals, strengths and needs. Not all goals have to be met for families to transition from Family Partner or Mental Health Clinician services, as not all the caregiver's "problems" or challenges will be solved. **Instead, view transition as a process dependent on child and caregiver skills.**

Transition should occur when the family has made progress toward its priority therapeutic or resources goals *and* has the skills to coordinate the child's care and advocate for the services they need. For older children, this occurs when the child has skills and strategies to use to practice healthy behaviors and manage stress. Such skills will allow ongoing participation in community and medical home services to keep working toward goals. So, focus on caregiver **skill building** as a core component of the Care Plan.

### Tip #2

**Start Preparing for Transition Early:** At every stage of serving families, starting with contact after referral, think about transition.

Specifically, what supports and skills will this caregiver need to foster a healthy home environment and support their child's social and emotional health? Start discussing this question with caregivers early on and having caregivers assume responsibility for implementing tasks on their child's Care Plans. Reflect with the caregiver on skills acquired throughout the process.

### Tip #3

**Make Transition a Big Deal:** Celebrate transition as a sign of accomplishment and growth. Have the FP and/or MHC set up a celebratory meeting, inviting the child's and caregiver's supports to participate. Give a certificate and recognize the specific achievements of the child and caregiver. Inform the Primary Care Provider so that at the scheduled PCP follow-up visit, they can celebrate too.

## Objective 1: Identify Principles, Team Roles and Key Components

### Tip #4

**Expect a Learning Curve as a Core Team:** It takes time as a Core Team, and particularly as a Family Partner-Mental Health Clinician dyad, to figure out how to plan for successful transitions. Expect a learning curve in identifying readiness factors with caregivers and successfully transitioning families who then rely on their PCPs and other medical home/community services for ongoing support. You will learn from the early experiences in transitions and over time, the families that transition from FP/MHC services will leave with the skills and resilience they need to thrive. Expect that some families will “bounce back” quickly after transition in the early stages of launching services.



### Tip #5

**If You Believe in Readiness, a Parent Will Too:** You are likely to encounter caregivers who are hesitant to transition for many reasons. Some may not feel ready to manage their child’s care without a FP or MHC to provide ongoing support or services. These may be parents who have had few experiences that foster a sense of self-efficacy. When the time comes, emphasize your belief in the caregiver and child’s readiness to transition, acknowledging all the successes along the way. Your belief in a family’s readiness will foster the parent’s belief as well.

**[Click here to view a family self-efficacy and advocacy brochure.](#)**

## TRANSITION PLAN FAQs

1.

### How Will We Know When a Family is Ready to Transition from Family Partner/Mental Health Clinician services?

- The child or child-caregiver dyad have made significant progress toward achieving top priority **Care Plan goals**, both therapeutic and/or resource goals.
  - Note: The child may still need behavioral health care from another medical home or community clinical provider.

**AND**

- The family has **self efficacy, knowledge and skills** to coordinate their child's care and advocate for the services they need as a family. The caregiver has demonstrated these skills through progress in Care Plan.

2.

### How Do We Close Relationships with Families When Ready to Transition?

This varies by demonstration site; for some demonstration sites, the MHC/FP transition with families together. At some sites families continue to meet with FPs for a set number of times after formal transition. There are three **Key Components of Transition**:

- 1) **Transition Plan:** The family has a written plan that recognizes accomplishments and identifies next steps:
  - Resources family will continue to participate in or newly access
  - Scheduled follow-up appointment with Primary Care Provider
  - Defined plan for how long FP will be working with the family, with clear boundaries (if FP did not already transition with family when clinician did). (*Example: Family Partner will contact family 2 times per month for 3 months to ensure family connected to certain resources. Afterwards, family will contact PCP if more support needed.*)
- 2) **Celebration:** Each site does a small celebration/graduation and makes a certificate for families that recognizes accomplishments.
- 3) **After Transition:** The FP can still communicate with families about community events or other events that any family in the neighborhood could benefit from. This can be done through mail, quick phone calls or email if possible. Better yet, the FP can give the material to a caregiver at the next well visit with the PCP.

## INCREASING THE PERCENTAGE OF FAMILIES WHO LEAVE SERVICES WITH FORMAL TRANSITION PLANS

QI Project: Bowdoin Street Health Center, MYCHILD  
Mira Kelsey, ECMH Clinician – October 2012



### Improvement Goal

To increase the overall number of families discharged with a formal Transition Plan from 23% to 50%.

### Rationale

Formal transition planning increases the likelihood that families meet their Care Plan goals. Transition Plans also support families to sustain involvement in medical home and community services when MYCHILD is no longer needed. Furthermore, they offer an opportunity to celebrate accomplishments with families.

### Strategic Approach

#### 1) Obtained Provider Reasoning: Why Premature Discharge

- Attended provider team meetings to obtain feedback
- Some of the patients referred were in the midst of crises
  - Third trimester of pregnancy, homelessness, etc.

- There was variability in how MYCHILD was introduced
  - Intensive mental health vs. support resource

#### 2) Chart Review Regarding Why Premature Discharge

- Categorized level of family participation
  - Low: 2 or fewer visits, Moderate: avg. 2 visits/mo. and High: 3-4 visits/mo.
- Categorized reasoning for discharges

#### 3) Created Program Introduction Tips for PCPs

- Language for introducing MYCHILD
- Tips on assessing family readiness for the program

#### 4) Facilitated Improved Communication With Referrals

- Encouraged warm handoffs
- Encouraged information sharing at time of referral to address PCP's and families' specific concerns

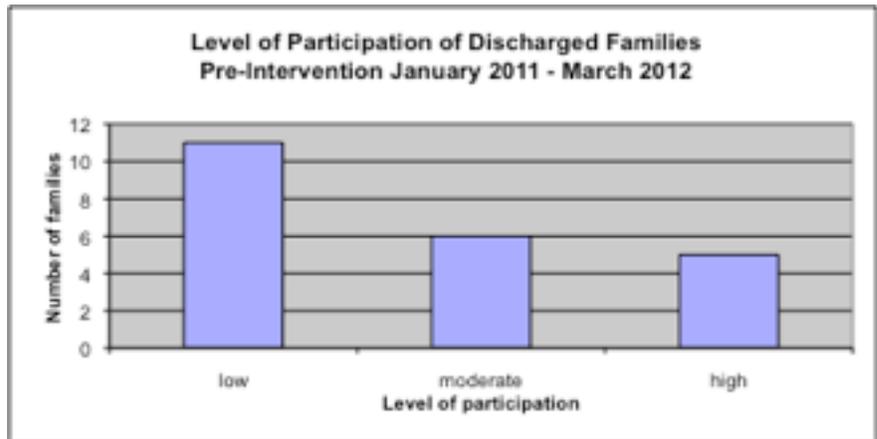
#### 5) Satisfaction Survey to Prematurely Discharged Families

- Created and administered a satisfaction survey to the nine families who had a low level of engagement and fell into the "did not want intensive services" category
- Non-MYCHILD social worker administered survey over the phone

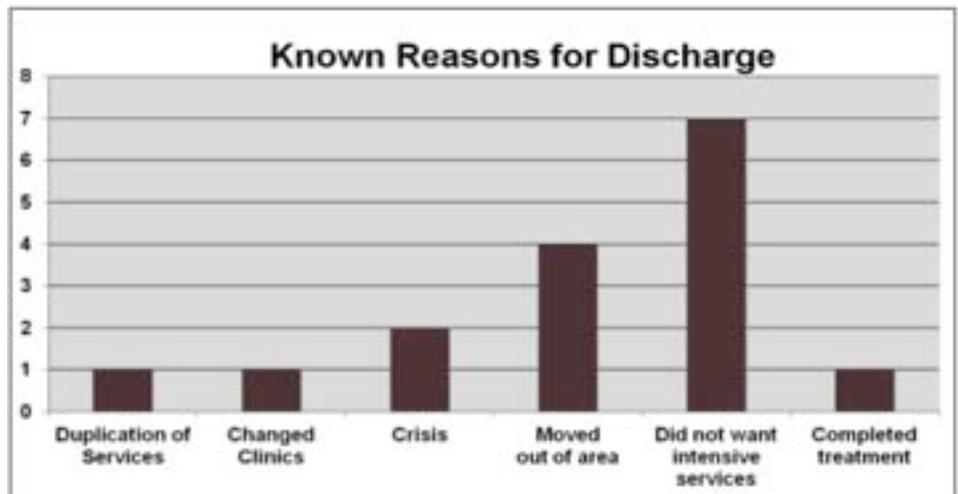
## Objective 3: Develop a Standard Process for Transitioning Families

### Data Analysis

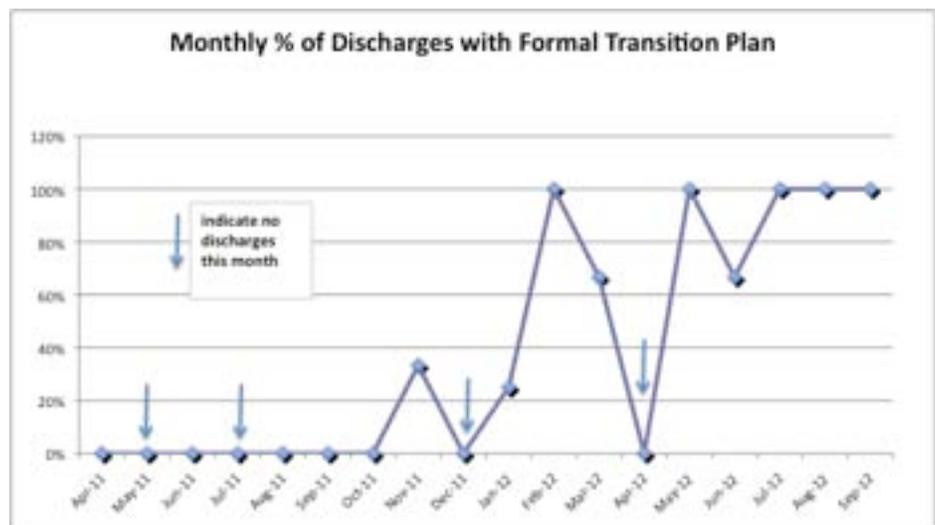
On chart review, we noted that 48% of the families enrolled in MYCHILD were discharged prior to meeting Care Plan goals. Also, 77% of discharged families were discharged without a formal discharge Transition Plan. Baseline data regarding engagement levels of discharged families is pictured to the right.



The graph to the right depicts the known reasons for premature discharge among lowly engaged patients. These were the patients that were more likely to discharge from the program prematurely.



We also tracked monthly progress of formal discharge plans. This is depicted to the right.

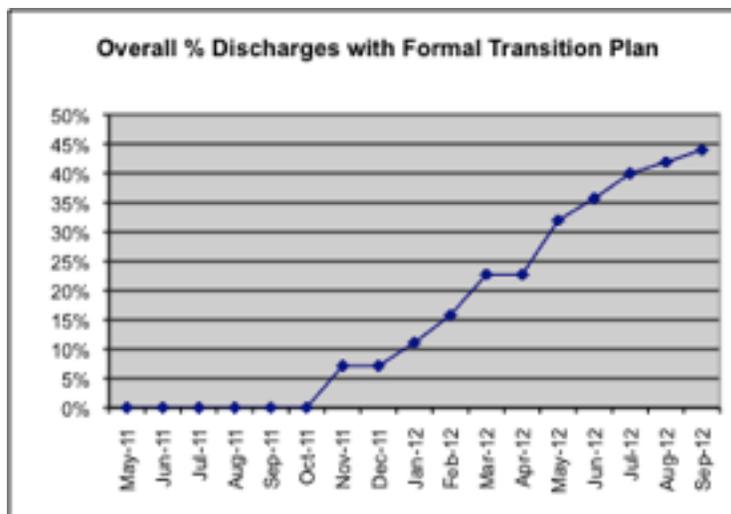


## Objective 3: Develop a Standard Process for Transitioning Families

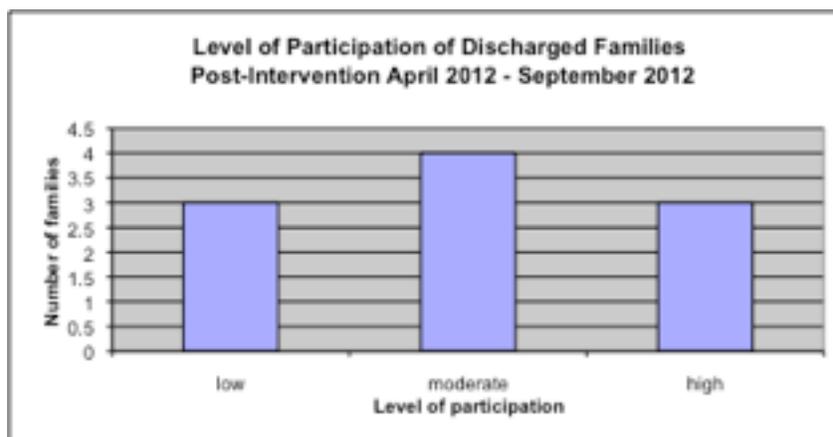
### Outcomes

Half of our Satisfaction Surveys were completed (5 out of the 9). All responses were positive. Everyone agreed or strongly agreed with our statements, which were all positively framed. The only differentiated feedback was that one family felt pressured to join the program. Also, all 5 families felt strongly or agreed that MYCHILD taught them skills even though they only met with MYCHILD once or twice.

As of September 2012, we increased our percentage of total discharges with a formal Transition Plan to 44%. This is slightly below our goal of 50%. (See table below.)



We also increased our percentage of patients who engage at moderate and high levels. (See table below.)



## Objective 3: Develop a Standard Process for Transitioning Families

### Conclusion

Overall, we feel that our goal was successful. We learned about reasons why some of our families have not engaged in the program. We developed tools to make the program introduction consistent across providers and pediatric staff.

We now have a survey tool that we can use when families are being discharged. We are also in the process of determining the best way to distribute it to solicit honest and open feedback.



#### MYCHILD TEAM MEMBERS

*Mira Kelsey, LICSW - Clinician*

*Noemia Monteiro-DoCanto - Family Partner*

*Kathy Cook, NP - Primary Care Champion*

*Charlotte Herrmann, LICSW – Administrator*

### Lessons Learned

- Guiding Primary Care Providers on introducing services improved family engagement.
- Offering warm handoffs among providers and Mental Health Clinicians aided in accurate program introduction.
- It is difficult to obtain unbiased feedback from surveys if one is not using a third-party agency to distribute and analyze surveys.
- It is difficult to draw conclusions from survey feedback that is all positive. It raises the suspicion that information gathered may be inaccurate.
- Although we viewed premature discharge negatively, patient expectations may differ from those of program staff and this may explain high levels of program satisfaction.
- The longer patients are engaged in the MYCHILD program, the more likely a formal Transition Plan will be in place at their time of discharge.
- We found follow-up phone calls with discussions about barriers to engagement, expectations for participation and procedures for un-enrollment helpful in encouraging re-engagement.

## Sample 1: Transition Plan Template

Date of Closing:	Reasons for Closing:
MYCHILD Team Members:	Team Members Present for Transition:
Accomplishments Made by Child and Family:	
Updated Strengths:	
Support Services Child and Family will Continue to Participate in ( <i>with Contact Info</i> ):	
Follow-up Plan ( <i>Plan for Final Check-ins and Schedule Appointment with PCP</i> ):	
Crisis Plan Attached?	
Completed by: Date:	

### 3) Promotion: Promoting Social and Emotional Health for *All Families and Providers*

#### **Building Capacity of the Medical Home on Children's Social and Emotional Health**

Aside from delivering new services to families, the Core Team should strive to build capacity on early childhood mental health (ECMH) throughout the whole medical home. ECMH is a relatively new field where knowledge and experience often lacks. When demonstration sites were asked the greatest impact of this initiative on their medical home, multiple sites responded that it was the increased knowledge and awareness of the importance of early childhood relationships.

The model strives to have the whole medical home feel more equipped to support families in healthy social and emotional development, not just specific families enrolled in services. This means that families experience this support with every interaction, from checking into their appointment to leaving the clinic. Increased awareness of the emotional capacity of infants and toddlers can ensure the youngest members of each family are supported in managing stress, as they can often be overlooked by providers more focused on adults or older siblings. Principles of ECMH may also lend perspective to all staff when encountering families considered “challenging,” as it may foster new compassion for caregivers and children.

#### **Strategies to Build Capacity**

Strategies to build capacity on children's social and emotional health in the medical home include equipping the environment with cues and information, educating all medical home staff on social and emotional health, using the quality improvement process to frame efforts, and bringing external expertise on mental health to medical home meetings.

Materials demonstrating these strategies are provided in this section, with particular emphasis on ECMH, since young children and their families were the focus of all demonstration sites.

## KEY OBJECTIVES IN THE DESIGN PROCESS

- 1) Access Social Marketing Materials that Can Equip Your Medical Home with Promotion Messages
- 2) Access Quality Family Education Materials Aimed at Providing Information of Children's Social and Emotional Development
- 3) Identify Strategies to Build Staff Awareness of Children's Social and Emotional Health and Capacity to Respond to Families with Mental Health Needs



## Overview of Promotion Materials for the Medical Home

It's essential to have promotional materials available that effectively communicate key messages on early childhood social and emotional development to diverse families and providers in the medical home. Materials should be accurate in information, accessible, easily understood, visually appealing, available in multiple languages, and culturally appropriate for the community.

There are a wide variety of materials medical homes can access as educational handouts for families and providers on early childhood mental health (ECMH), with specific focus on the importance of caregiver-child relationships to set the foundation for health. These materials include informational handouts and family activities that caregivers can try with children to foster healthy development and relationship-building. Here is what you will find in the following pages:

### **1) Social marketing campaign materials (MA Partnership for ECMH)**

- These materials were specifically designed to build provider and family awareness that ECMH matters and the medical home is a place to access support.
- They messages reflect the collaboration of families, medical providers, early childhood educators, communication experts and public health officials.
- These posters and flashcards can be disseminated broadly in the medical home and community.

### **2) Links to external websites that specialize in early education and development**

- These sites are either at a city, state or national level.
- Of particular note are the Center for the Social and Emotional Foundations of Early Learning (CSEFEL) and Talk, Read, Play, which have been supported by MA Partnership for ECMH and widely used by demonstration sites in promoting ECMH.
  - This section includes a small subset of handouts from Talk, Read, Play and CSEFEL, in addition to links to the website for more free, reproducible materials.
- The websites also provide lists of early childhood resources (education, childcare, family activities, healthcare) that are specific to the Boston area (Talk, Read, Play) and Massachusetts (CSEFEL).

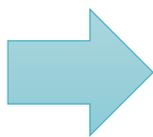
### **Important Notes**

- In choosing which materials to use in your medical home, consider using a committee to review handouts and choose which best match the culture of the medical home.
- Parents should be involved in this decision-making, because they will have a key perspective on the acceptability of the materials to other parents.

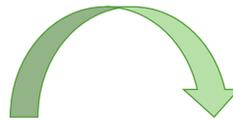
## MEDICAL HOME POSTERS AND FLASHCARDS ON ECMH

The MA Partnership for ECMH developed a series of promotion materials aimed at building awareness of social and emotional health in the medical home. The messages were developed through collaborations with city and state administrators, physicians, parents, mental health clinicians and communications experts.

These messages aim to remind medical home providers the importance of asking families about their child's social and emotional development as well as prompt parents to voice their questions and concerns regarding development to medical home providers. The materials are free and accessible online as well as distributed as "Parent Toolkits" to demonstration sites.



**Click here to view a sample poster from Martha Eliot Health Center on baby expression cues.**



### Tips for Using Flashcards in the Medical Home

#### Reasons to Use Flashcards:

- Use the flashcards to assist in meeting the EHR Incentive Program Stage 2 Objective: Identify patient-specific education resources and provide those resources to the patient.
- Flashcards can also be used following the mandated behavioral health screenings (e.g. PEDS or Pediatric Symptom Checklist) to generate further discussion with families.

#### Opportunities to Engage Parents with Flashcards:

- Place flashcards on registration desk so caretakers can see them when they arrive.
- Invite caretakers to take a look at them as they wait in the waiting room.
- Place flashcards in exam rooms for caretakers to see.
- Ask Medical Assistance to keep the flashcards and then share them with caretakers as they escort them to the exam room.

### Accessing the Posters and Flashcards

Download materials from the [MA Partnership for ECMH website](#)<sup>29</sup>. Go to *Family and Friends* and click on "Social and Emotional Toolkit for Parents." See "Toolkit for Families" (Flashcards) and "Campaign Posters." (Flashcards are in English and Spanish, and soon to be Vietnamese and Portuguese.)

- Each pediatric clinic operates based on the operational and clinical needs of their organization and thus must determine which of these methods would work best for them. The Core Team should take the time to think about how these flashcards and posters may be integrated into their medical home flow.

## SOCIAL-EMOTIONAL DEVELOPMENT: UNDERSTANDING FEELINGS

Help your child understand their feelings by making sense of them and by using words to describe emotions.

Teaching children the words for emotions is important because, over time, it gives children the ability to talk about their feelings instead of acting them out.

**Happy**



**Angry**



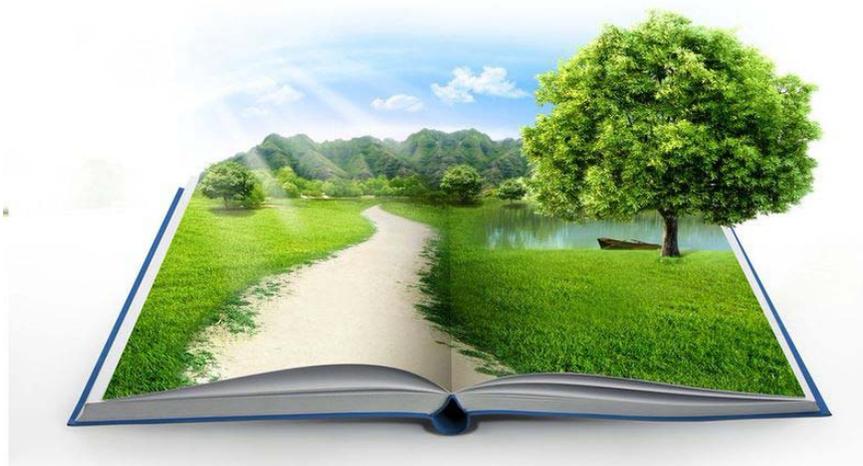
**Surprised**



**Sad**



## FAMILY EDUCATION ON EARLY CHILDHOOD SOCIAL AND EMOTIONAL DEVELOPMENT



The following websites provide high-quality information on early childhood social and emotional development, specifically with free, reproducible parent information.

While the literacy levels of handouts may not be the best match for all families, the materials can provide a basis in educating staff and families in medical homes about the importance of early childhood. Talk, Read, Play and Center on the Social and Emotional Foundations of Early Learning have been key partners for the MA Partnership for Early Childhood Mental Health and are widely used by demonstration sites.

1.

### Talk, Read, Play

Family Materials: [TalkReadPlay.com](http://TalkReadPlay.com)<sup>30</sup>

**Organization Statement:** "Talk, Read & Play is an informational campaign to support families with children ages birth to five. It aims to raise awareness about the importance of the early years to school readiness. The campaign is a product of Countdown to Kindergarten, in collaboration with [Thrive in 5](#)<sup>31</sup>."

**Resources:** The website provides parents with information and resources on developmental milestones, parenting tips, school readiness activities, as well as programs that offer early intervention services, childcare, and recreational activities for your child from birth through age five. Parent education materials are available for free in multiple languages online.

2.

## Center on the Social and Emotional Foundations for Early Learning

Family Materials: [CSEFEL Resources for Families](#)<sup>32</sup>

**Organization Statement:** “The Center on the Social and Emotional Foundations for Early Learning is a five-year project designed to strengthen the capacity of Head Start and child care programs to improve the social and emotional outcomes of young children.”

**Resources:** CSEFEL training and technical assistance materials reflect evidence-based practices for promoting children’s social and emotional development and preventing challenging behaviors. Resources include educational materials and activities for early childhood educators and parents. In addition, there are formal training curriculums that can be implemented with training from the technical assistance center. Demonstration sites have used the CSEFEL Infant-Toddler modules to run parent groups within medical homes. See the training and supervision information in section 1 of this toolkit for more on implementing CSEFEL curriculums with groups of families.

3.

## Zero to Three

Family Materials: [Free Parent Brochures and Guides](#)<sup>33</sup>

**Organization Statement:** “Zero to Three is a national nonprofit organization that provides parents, professionals and policymakers the knowledge and the know-how to nurture early development. Our mission is to ensure that all babies and toddlers have a strong start in life.”

**Materials:** Zero to Three has a breadth of information on early childhood development and social and emotional health inclusive of family education materials, scientific research and journal publication, training and professional development initiatives, and a national training institute.



## BUILDING STAFF AWARENESS OF ECMH PRINCIPLES AND PRACTICES

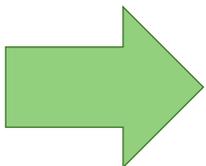
One approach to build capacity on early childhood mental health (ECMH) in the medical home is improving staff awareness of ECMH principles and practices. This strategy of providing brief, awareness-building trainings allows for key messages to be broadly disseminated to all staff within the medical home, not just clinical providers.

These one-time trainings differ from the more intensive, longitudinal trainings on ECMH that the Family Partner and Clinician need to provide specialized direct services to families on ECMH (see the training information in section 1, *Building A Core Team*). In fact, these awareness-building trainings or educational sessions can be lead by the Core Team to facilitate dialogue within the medical home on ECMH.

Family Partners and Mental Health Clinicians, at times in partnership with other ECMH experts, led a variety of discussions and presentations at demonstration sites to build awareness of ECMH. While FPs and Clinicians may have many informal opportunities to share ECMH principles with primary care providers, exposing non-clinical medical home staff to ECMH principles is just as important and may take more deliberate planning. Building capacity of all medical home staff on ECMH increases the likelihood that families with young children will experience compassionate, family-centered care from the moment they enter the health practice.



To demonstrate unique approaches to building staff capacity on ECMH, one quality improvement project from a demonstration site will be highlighted—focusing on training “front line” staff on responding to families with post-traumatic symptoms.



**Click here to view the PDF “Trauma in Our Patients, What Does it Mean for Us?”**

## IMPROVING STAFF RESPONSE TO FAMILIES WITH POST-TRAUMATIC SYMPTOMS

QI Project: Joseph Smith Community Health Center  
Anna Cable, LCSW (EMCH Clinician) – June 2013

### Improvement Goal

To improve the capacity of “front line” staff to understand and respond to patients with post-traumatic symptoms.

### Rationale

The “front line” staff serve as the first contact for all patients, including MYCHILD patients. They answer the phone, check in patients, and register patients for health insurance. Improving the staff’s knowledge about trauma and how to respond to affected patients will improve our patients’ quality of care. It will also improve patients’ comfort in accessing medical homes in times of mental health crises or need.

### Strategic Approach

#### 1) Defined goals of training

- Former health benefits staff and then Family Partner Myleisy Navarro identified a need for staff to have the tools to empathize with “difficult” patients – often those affected by traumatic events.
- In light of numerous “Dr. Snows” (emergency code used to assist in escalated patient encounters), JMSCHC Executive Director expressed interest in a training to improve staff comfort in de-escalating patients.

- Anna Cable and Maria Celli, BH Dept Head, met with current front-line supervisors, who requested a focus on concrete ideas for in-the-moment interventions, and resources and supports for staff.

#### 2) Designed training to meet identified needs.

- We designed the training in collaboration with JMSCHC intern Kristin Rajala, PsyD, who had conducted a similar training for nursing staff several months prior.

#### 3) Conducted training.

- Training conducted during the March Department meeting, in which health benefits, front desk and switchboard staff were present.
- All staff completed a pre-test before the training.
- Amarilis Guzman, Family Partner, administered post-tests to staff on a voluntary basis in June.



### Challenges in Implementing Strategic Approach

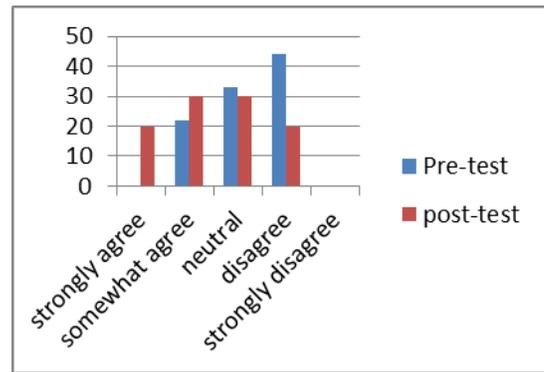
- Due to limited opportunities to present to staff, our training was designed to make the most of one session.
- 45-minute time limitation meant reduced opportunity for discussion, questions and integration.
- Front line staff works with patients in a range of ways: over the phone or in-person; brief and repeated; lengthy and one-shot. Thus, the training needed to accommodate a range of learning needs.

### Data Analysis

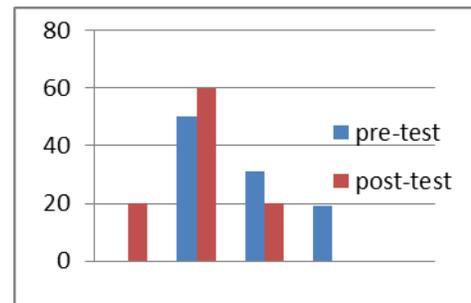
To determine whether the training was an effective medium for educating front-line staff, we administered a pre-test during the training and a follow-up post-test three months later. We hoped the gap between pre- and post-test would provide an accurate read on the efficacy of one-shot trainings. The surveys were identical.

Staff rated their level of comfort with various interventions and self-care strategies on Likert scales; in addition, two multiple choice questions measured staff’s understanding of very basic trauma concepts.

After the training, staff showed a greater level of comfort in using a variety of interventions to respond to escalated clients. In particular, staff members were more likely to agree that they could respond empathically to a patient who was escalated.



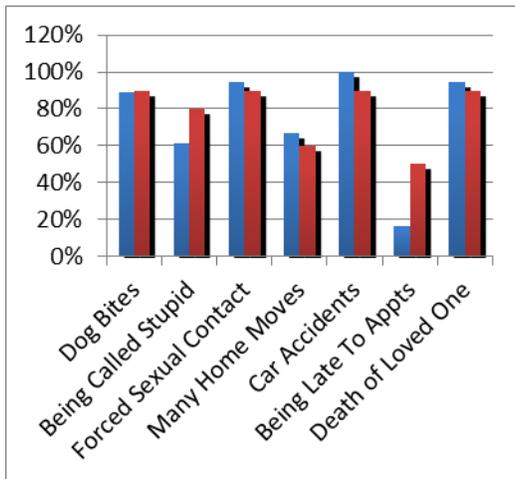
Staff were also more likely to agree that they would feel comfortable allowing the patient to vent.



Most notably of all, staff reported far greater confidence in “containing” and “regulating” their own emotions in challenging situations. 36% of staff reported strongly agree in the post-test, rather than 17%, and 63% versus 56% responded affirmatively overall.

Pre- and post-test questions designed to measure staff’s understanding of trauma as a concept showed less clear results. The following graph shows staff’s responses in the affirmative about whether various events can cause trauma.

## Objective 3: Identify Strategies to Build Staff Awareness



As the graph shows, respondents' answers stayed consistent for the most part, but respondents were also more likely to provide a false positive (e.g. to answer that "being late to multiple appointments" was traumatizing.)

This result reflects staff's written responses to the open-ended measure "Trauma means/is: \_\_\_\_." Staff responses tended to be extremely general, such as "an experience that leaves a negative lasting effect on a person," or even "event or events that affects someone's emotions."

### Outcomes

Our one-time training did provide staff with a greater sense of confidence with various interventions to use with challenging clients. It also left staff feeling marginally more comfortable with self-care strategies, especially with "containing" and "regulating" their own emotions. Staff members did not, however, appear leave the training with a greater sense of understanding of trauma in a clinical sense.

### Conclusion

We consider this goal a success. Front line staff left the training with a greater sense of confidence. From our clinical experience, we know that a feeling of confidence and competence can be invaluable in sustaining workers and communicating safety to vulnerable patients. Thus, we hope that this sense of confidence will result in improved experiences for patients.

Though we have no current plans to provide follow-up training to front line staff, results across both pre- and post-test indicate that a majority of staff members would be interested in trainings on self-care tips. We will keep this in mind for the future. We will also keep these lessons in mind for our ongoing consultations to the Community Outreach and Medical Departments in motivational interviewing, which will continue in September.

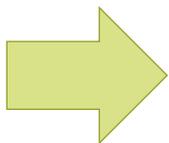
### Lessons Learned

- One-time trainings should be targeted and specific. There may not be enough time to effectively provide information and teach interventions.
- Pre-screening of trainee targets, or more extensive conversation with their supervisors, may be necessary to determine trainees baseline level of expertise.

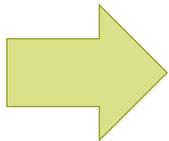
## EDUCATING PEDIATRIC TRAINEES ON ECMH IN THE MEDICAL HOME

Just as it is important to educate non-medical staff on the significance of early childhood mental health, it is critical to bring that same awareness to pediatric medicine trainees. These staff play a key role in integrating mental health into young children's pediatric care, so they need to be aware of how ECMH can fold into their own clinical sessions with the family and patient.

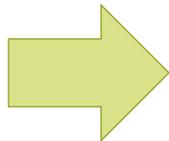
The following materials provide links to PDF documents that will help educate pediatric trainees on ECMH.



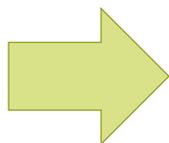
**Resident Introductory Training**



**Resident Pre-Test**



**Micro-Training: Local Resources and Referrals**



**Micro-Training: Working with and Understanding Challenging Parents**



# Worksheet: Brainstorming Capacity-Building Activities in Your Medical Home

**Refresh:** What has your Core Team already done to build knowledge and awareness of early childhood mental health in your medical home? Make a List.

Activity	Audience

**Brainstorm:** What types of activities could your team do to further build knowledge of early childhood mental health within your medical home? **\*Star the activities that seem feasible for your team.**

Activity/Resource	Audience

**Support:** What support, materials or training do you need to do the activities above?

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**Partnerships:** What partnerships within the medical home or community can help you obtain the support, materials or training you need to do the activities above?

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### Early Childhood Community Partners

Below is a list of early childhood specific resources to consider as potential partners to improving capacity of your medical home on early childhood mental health. In addition to building partnerships with other healthcare providers, the Core Team should seek partnerships with experts from other sectors, as these professionals can both broaden perspective on early childhood development and also strengthen linkages to the community. With such collaborations, families will experience consistent, coordinated messaging on the importance of early childhood social and emotional health in the multiple settings they naturally encounter.

#### External Resources Guides



[Talk, Read, Play](#)<sup>34</sup> (Boston)



[Connected Beginnings](#)<sup>35</sup> (Massachusetts)

#### Massachusetts Key Resources



[Early Intervention](#)<sup>36</sup>

Contact by phone: 617-624-5070

Statewide Department of Public Health initiative

- Provides those who qualify with services to develop healthy mental and emotional behaviors
- Program provides family-centered services for children at risk and in need:
  - ✓ Children who are not developing typically for their age
  - ✓ Children who have a physical, emotional, or [cognitive](#)<sup>37</sup> condition that may cause [developmental delays](#)<sup>38</sup>
  - ✓ Children who are at risk of developmental delays because of biological or environmental factors
  - ✓ Children must be between birth and age 3 to qualify



[Head Start](#)<sup>39</sup>

Early childhood education program

Citywide initiative that serves low income families

- Program serves families living in Boston who meet federal low-income guidelines, receive public assistance or other benefits
- Purpose is to help develop children's social and learning skills by:
  - ✓ High Quality Education
  - ✓ Individualized Curriculum
  - ✓ Family Case Management
  - ✓ Disability Services and Support
  - ✓ Mental Health Services for Children and Families
  - ✓ Meal Plans
  - ✓ Health Screenings (Including Dental, Vision and Hearing)

## Objective 3: Identify Strategies to Build Staff Awareness

### Early Head Start<sup>40</sup>

Program that serves pregnant women, infants, and toddlers up to 3 years of age

- Program serves families living in Boston who meet federal low-income guidelines, receive public assistance or other benefits
- Services are meant to prepare children for school and teach new parents skills necessary to be caregivers:
  - ✓ High Quality Education
  - ✓ Individualized Curriculum
  - ✓ Family Education and Case Management
  - ✓ Disability Services
  - ✓ Mental Health Services for Children and Families
  - ✓ Meal Plans
  - ✓ Health Screenings (Including Dental, Vision and Hearing)

### Healthy Families Massachusetts<sup>41</sup>

Contact by phone: 1-888-775-4KIDS

Program provides free parenting education and home visits for young first-time parents

- There are no income limits for parents
- Home visitors teach parenting skills and help new parents find health care, day care, transportation, and other necessary services
- Parents who qualify must:
  - ✓ Be age 20 or younger
  - ✓ Be a first-time parent
  - ✓ Have a child no older than age 1
- Parents can receive services until their child turns 3 years old

### Early Childhood Resource Centers<sup>42</sup>

Initiative started and funded by Massachusetts Department of Early Education and Care

- Program offers a variety of resources that anyone interested in the care and education of young children can borrow for free
- Available materials include:
  - ✓ Books for caregivers
  - ✓ Children's books
  - ✓ Curriculum kits
  - ✓ Puppets
  - ✓ DVDs and videos
- Five centers are located at children's sections of the public libraries throughout Massachusetts in Cambridge, Falmouth, Haverhill, Norfolk, and Springfield

# Glossary of Links

A complete list of the online links to Web and PDF resources found in this section of the toolkit.

Foot note #	Subsection Title	Link Title	URL
1	Promotion, Prevention and Intervention Strategies and Services Examples from Demonstration Sites	CSEFEL website	<a href="http://csefel.vanderbilt.edu/">http://csefel.vanderbilt.edu/</a>
2		Family Nurturing Center	<a href="http://www.nurturingparenting.com/">http://www.nurturingparenting.com/</a>
3		Sample infant, toddler, preschooler session	<a href="http://nurturingparenting.com/images/cmsfiles/np2cim16-2lesson12.pdf">http://nurturingparenting.com/images/cmsfiles/np2cim16-2lesson12.pdf</a>
4		Sample parent session	<a href="http://nurturingparenting.com/images/cmsfiles/np2gim16lesson5.pdf">http://nurturingparenting.com/images/cmsfiles/np2gim16lesson5.pdf</a>
5		Full PBS Tutorial here	<a href="http://www.challengingbehavior.org/expl ore/pbs/process.htm">http://www.challengingbehavior.org/expl ore/pbs/process.htm</a>
6		Building a Behavior Support Team	<a href="http://www.challengingbehavior.org/expl ore/pbs/step1.htm">http://www.challengingbehavior.org/expl ore/pbs/step1.htm</a>
7		Person-Centered Planning	<a href="http://www.challengingbehavior.org/expl ore/pbs/step2.htm">http://www.challengingbehavior.org/expl ore/pbs/step2.htm</a>
8		Functional, Behavioral Assessment	<a href="http://www.challengingbehavior.org/expl ore/pbs/step3.htm">http://www.challengingbehavior.org/expl ore/pbs/step3.htm</a>
9		Hypothesis Development	<a href="http://www.challengingbehavior.org/expl ore/pbs/step4.htm">http://www.challengingbehavior.org/expl ore/pbs/step4.htm</a>
10		Behavioral Support Plan Development	<a href="http://www.challengingbehavior.org/expl ore/pbs/step5.htm">http://www.challengingbehavior.org/expl ore/pbs/step5.htm</a>
11		Monitoring Outcomes	<a href="http://www.challengingbehavior.org/expl ore/pbs/step6.htm">http://www.challengingbehavior.org/expl ore/pbs/step6.htm</a>
12	Project LAUNCH Digital Stories	View video here	<a href="https://www.youtube.com/watch?v=I8wCsdSRcVM&amp;feature=youtu.be">https://www.youtube.com/watch?v=I8wCsdSRcVM&amp;feature=youtu.be</a>
13	CANS Tool for Intake	User Guides, Tool Forms and Race/Ethnicity Implementation Data	<a href="http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/child-and-adolescent-needs-and-strengths-cans/clinical-guidance-on-the-cans.html">http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/child-and-adolescent-needs-and-strengths-cans/clinical-guidance-on-the-cans.html</a>

<b>Foot note #</b>	<b>Subsection Title</b>	<b>Link Title</b>	<b>URL</b>
14	CANS Tool for Intake	Provider Training and Certification for CANS	<a href="https://masscans.ehs.state.ma.us/login.aspx?ReturnUrl=/">https://masscans.ehs.state.ma.us/login.aspx?ReturnUrl=/</a>
15	CANS Tool for Intake	Overview and National Use of the CANS	<a href="http://www.praedfoundation.org/AbouttheCANS.html">http://www.praedfoundation.org/AbouttheCANS.html</a>
16	Childhood Mental Health Screening and Assessment Tools	Mental Health Screening and Assessment Tools Chart	<a href="http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf">http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf</a>
17	Childhood Mental Health Screening and Assessment Tools	Mental Health Screening and Assessment Tools for Children, Literature Review	<a href="http://humanservices.ucdavis.edu/academy/pdf/final2mentalhealthlitreview.pdf">http://humanservices.ucdavis.edu/academy/pdf/final2mentalhealthlitreview.pdf</a>
18	Childhood Mental Health Screening and Assessment Tools	Developmental Screening and Assessment Instruments with an Emphasis on Social and Emotional Development for Young Children Ages Birth through Five	<a href="http://www.nectac.org/~pdfs/pubs/screening.pdf">http://www.nectac.org/~pdfs/pubs/screening.pdf</a>
19	Formulating Early Childhood Diagnoses from Assessments, DC 0-3R	Zero to Three website	<a href="http://www.zerotothree.org/child-development/early-childhood-mental-health/diagnostic-classification-of-mental-health-and-developmental-disorders-of-infancy-and-early-childhood-revised.html">http://www.zerotothree.org/child-development/early-childhood-mental-health/diagnostic-classification-of-mental-health-and-developmental-disorders-of-infancy-and-early-childhood-revised.html</a>
20	Formulating Early Childhood Diagnoses from Assessments, DC 0-3R	Illinois Association for Infant Mental Health	<a href="http://www.ilaimh.org/index.php?option=com_content&amp;view=article&amp;id=37:the-dc-0-3-r-crosswalk-now-available&amp;catid=3:illinois-initiatives&amp;Itemid=10">http://www.ilaimh.org/index.php?option=com_content&amp;view=article&amp;id=37:the-dc-0-3-r-crosswalk-now-available&amp;catid=3:illinois-initiatives&amp;Itemid=10</a>
21	What is a Care Plan?	Wraparound Process	<a href="http://www.nwi.pdx.edu/wraparoundbasics.shtml">http://www.nwi.pdx.edu/wraparoundbasics.shtml</a>
22	Evidence-Based Interventions and Subspecialty Referrals as Care Plan Strategies	Evidence-Based Child and Adolescent Psychosocial Interventions	<a href="http://pediatrics.aappublications.org/content/125/Supplement_3/S128.full.pdf+html?rss=1">http://pediatrics.aappublications.org/content/125/Supplement_3/S128.full.pdf+html?rss=1</a>

<b>Foot note #</b>	<b>Subsection Title</b>	<b>Link Title</b>	<b>URL</b>
23	Evidence-Based Interventions and Subspecialty Referrals as Care Plan Strategies	References for Evidence Based Programs for Young Children	<a href="http://pediatrics.aappublications.org/content/125/Supplement_3/S155.full.pdf">http://pediatrics.aappublications.org/content/125/Supplement_3/S155.full.pdf</a>
24	Evidence-Based Interventions and Subspecialty Referrals as Care Plan Strategies	Sources of Subspecialty Services for Children with Mental Health Problems and Their Families	<a href="http://pediatrics.aappublications.org/content/125/Supplement_3/S126.full.pdf">http://pediatrics.aappublications.org/content/125/Supplement_3/S126.full.pdf</a>
25	Care Coordination: Definition, Examples and Resources	The Commonwealth Fund, 2009	<a href="http://www.commonwealthfund.org/Publications/Fund-Reports/2009/May/Making-Care-Coordination-a-Critical-Component-of-the-Pediatric-Health-System.aspx">http://www.commonwealthfund.org/Publications/Fund-Reports/2009/May/Making-Care-Coordination-a-Critical-Component-of-the-Pediatric-Health-System.aspx</a>
26	Training and Support for Care Coordination	National Center for Medical Home Implementation	<a href="http://www.medicalhomeinfo.org/how/care_delivery/">http://www.medicalhomeinfo.org/how/care_delivery/</a>
27	Training and Support for Care Coordination	American Academy of Pediatrics	<a href="http://www.aap.org/en-us/professional-resources/practice-support/pages/Care-Coordination-Resources.aspx">http://www.aap.org/en-us/professional-resources/practice-support/pages/Care-Coordination-Resources.aspx</a>
28	Training and Support for Care Coordination	National Wraparound Initiative	<a href="http://www.nwi.pdx.edu/pubsearch.php">http://www.nwi.pdx.edu/pubsearch.php</a>
29	Medical Home Posters and Flashcards on ECMH	MA Partnership for ECMH website	<a href="http://www.ecmhatters.org">http://www.ecmhatters.org</a>
30	Family Education on Childhood Social and Emotional Development	TalkReadPlay.com	<a href="http://www.talkreadplay.com">http://www.talkreadplay.com</a>
31	Family Education on Childhood Social and Emotional Development	Thrive in 5	<a href="http://www.thrivein5boston.org/">http://www.thrivein5boston.org/</a>
32	Family Education on Childhood Social and Emotional Development	CSEFEL Resources for Families	<a href="http://csefel.vanderbilt.edu/resources/family.html">http://csefel.vanderbilt.edu/resources/family.html</a>

<b>Foot note #</b>	<b>Subsection Title</b>	<b>Link Title</b>	<b>URL</b>
33	Family Education on Childhood Social and Emotional Development	Free Parent Brochures and Guides	<a href="http://www.zerotothree.org/about-us/areas-of-expertise/free-parent-brochures-and-guides/">http://www.zerotothree.org/about-us/areas-of-expertise/free-parent-brochures-and-guides/</a>
34	Early Childhood Community Partners	Talk, Read, Play	<a href="http://www.talkreadplay.org/?q=content/resources">http://www.talkreadplay.org/?q=content/resources</a>
35		Connected Beginnings	<a href="http://connectedbeginnings.org/Resources-Issues-Updates/MA">http://connectedbeginnings.org/Resources-Issues-Updates/MA</a>
36		Early Intervention	<a href="http://www.massresources.org/early-intervention.html">http://www.massresources.org/early-intervention.html</a>
37		Cognitive	<a href="http://www.massresources.org/popup.cfm?id_w=317">http://www.massresources.org/popup.cfm?id_w=317</a>
38		developmental delays	<a href="http://www.massresources.org/popup.cfm?id_w=316">http://www.massresources.org/popup.cfm?id_w=316</a>
39		Head Start	<a href="http://bostonabcd.org/head-start-program.aspx">http://bostonabcd.org/head-start-program.aspx</a>
40		Early Head Start	<a href="http://bostonabcd.org/early-head-start.aspx">http://bostonabcd.org/early-head-start.aspx</a>
41		Healthy Families Massachusetts	<a href="http://childrenstrustma.org/our-programs/healthy-families">http://childrenstrustma.org/our-programs/healthy-families</a>
42		Early Childhood Resource Centers	<a href="http://www.mass.gov/edu/birth-grade-12/early-education-and-care/parent-and-family-support/early-childhood-resource-centers.html">http://www.mass.gov/edu/birth-grade-12/early-education-and-care/parent-and-family-support/early-childhood-resource-centers.html</a>