Section 3
Creating Medical Home Systems to Support Mental Health Integration

For the integrated early childhood mental health model to work, you need systems and resources in place within the medical home that help keep services organized. This includes systems for communication between providers, documentation and records of family progress, and standards for planning home visits. Keeping track of services is critical to success, but it's important to consider where and how you will document things like caregiver mental health. Plus, you'll want to get parents involved in the leadership of services, so this section includes information on recruiting and shaping parent voice. Finally, perfecting this model is always a work in progress, so there are tips for doing quality improvement analysis to continuously make your services the best they can be.

Table of Contents

Objectives	Quick Links

1) Enhancing Provider Communication

Objectives	Quick Links
➢ Identify the Core Team's Role in Improving Communication Between Primary Care and Behavioral Health Providers	• Intro: Enhancing Provider Communication
➢ Identify Strategies the Core Team Can Implement to Enhance Communication Between the Family Partner, Clinician and Other Medical Home Providers	• Strategies to Facilitate FP-Clinician Communication with Other Medical Home Providers

2) Family Partner Documentation in Medical Records

Objectives	Quick Links
➢ Identify Strategies for Supporting FPs to Effectively and Succinctly Document the Services they Provide Families	• Intro: Family Partner Documentation in Medical Records • Tip Sheet: Supporting FP Documentation in the Medical Home
➢ Develop A Standard for Family Partner Documentation in Your Medical Home Using Examples from a Demonstration Site	• Developing Our Standard for Family Partner Documentation, MYCHILD QI • Sample: Standard for Family Partner Progress Notes

3) Building Medical Home Systems for Home and Community Visits

Objectives	Quick Links
➢ Recognize the Value and Challenges of Home Visiting as a Service Strategy and Discuss Characteristics to Consider When Determining Whether Home Visits Are the Right Fit	• Intro: Building Medical Home Systems for Home and Community Visits • Table and Checklist: Is Home Visiting the Right Strategy?
➢ Identify Medical Home Processes that Must Be Developed for the Family Partner and Clinician to Conduct Home Visits	• Checklist: Preparing A Health Practice for Home Visiting

Objectives	Quick Links

4) Integrating Caregiver-Child Mental Health Services

- Recognize the Interdependence of Caregiver Wellness and Children's Social and Emotional Development

- Identify the Pediatric Medical Home as a Key Opportunity to Screen Caregivers and Select Specific Screening Tools Your Medical Home Will Use

- List Strategies to Effectively Connect Caregivers to Adult Mental Health Services

- Discuss the Trade-Offs Between Caregiver Privacy and Family-Centered Care-Coordination, and Identify Strategies for Documenting Caregiver Mental Health

Quick Links:

- [Intro: Integrating Child-Caregiver Mental Health Services]

- [Screening Tools for Caregiver Depression and Stress]

- [Tips for Connecting Caregivers to Mental Health Services]

- [The Challenge of Documenting Caregiver Mental Health in Pediatrics]

5) Parent Voice in Shaping Medical Home Services/Systems

- Identify Strategies for Bringing Parent Voice to Healthcare Services and Systems Improvement, Recognizing the Advantages and Challenges of Each Strategy

- Identify any Current or Previous Strategies Employed by Your Medical Home to Engage Parents in Improvement; Discuss Lessons Learned from these Efforts

Quick Links:

- [Intro: Parent Voice in Shaping Medical Home Services/Systems]
- [Strategies for Bringing Parent Voice to Systems Improvement]

- [Core Team Worksheet: What's Your Health Practice's Experience with Parent Feedback]
- [Tips for Creating a Patient Survey]
  - [Sample Family Experience Survey, LAUNCH QI]
  - [Sample Family Experience Survey, MYCHILD QI]

Objectives

- ➤ Recognize Parent Representatives as Key Assets in Meaningfully Informing Medical Home Systems and Discuss the Potential Roles Parent Leaders Can Play in Your Medical Home

- ➤ Brainstorm Feasible Strategies Your Core Team Could Implement to Partner with Parents on Improvement Using Examples from Demonstration Sites (Surveys, Parent Council Materials)

Quick Links

- VIDEO: Parent Representatives as Colleagues in Systems Change
  - COMING SOON
- Assembling Parent Leadership Groups and Fostering Parent-Professional Partnerships
  - Challenges of Parent Leadership
  - Employing Parent Leaders
  - Parent Council Recruitment Process and Selection Criteria
  - Parent Council Roles and Responsibilities

- Parent Council Materials, MA Partnership for ECMH
  - Parent Council Recruitment Flyer
  - BPHC's Parent Council Handbook
- Parent Leadership Series Curriculum Outline
  - Example Curriculum Activity: Developing Your Personal Story
  - Example Letter: Preparing Parents to Participate in Multi-disciplinary Meetings
- Leadership Opportunities for Parent Representatives

6) Engaging in Quality Improvement Efforts

- ➤ Recognize the Utility of a Structured QI Process to Guide Service Improvement Efforts

- ➤ Engage in a Continuous Quality Improvement Process as a Core Team Using Guidance Provided by MA Partnership for ECMH and TA Resources

- Intro: Engaging in Quality Improvement Efforts
- QI Process Snapshot

- Examples of QI Goals and Projects from Demonstration Sites
- MYCHILD-LAUNCH Learning Collaborative QI Process
- Quality Improvement Worksheets for the Core Team
  - Worksheet 1: Setting a QI Goal
  - Deliver: Doing the Change
  - Worksheet 2: Assessing the Status of Your Goal
  - Worksheet 3: Pursuing the Current Goal and Re-strategizing

- ➤ Raise Awareness of Your Quality Improvement Project Throughout Your Medical Home and Spread Successful Changes Across Primary Care/Behavioral Health Departments

- Raise Awareness of Your QI Project and Seek Feedback

For a complete list of the URLs mentioned in this section, view the Glossary of Links.

1) Enhancing Provider Communication

Clear communication between medical home providers is pivotal to providing integrated, comprehensive care. When providers have a shared understanding of a family's strengths, needs and goals, you can provide consistent, continuous support to families with a unified approach.

Defining expectations of how and when providers will communicate is important for the success of the Family Partner (FP)/Mental Health Clinician (MHC) model. Clear expectations for provider communication will both ensure timely coordination of services for families, and also reduce the sentiment often felt by consultation services in medical homes—the feeling of "burdening" primary care providers (PCPs) with patient updates regarding mental health and family support services. Relationships are the heart of effective communication systems: When providers know and trust each other, they are more likely to optimize resources for families as to provide the best array of multidisciplinary support.

Given its multidisciplinary nature, the Core Team is well-positioned to propose communication systems that both meet the needs of diverse providers and ensure clear, consistent communication with families. You can serve as a bridge between primary care and behavioral health providers, thus facilitating relationships among these traditionally siloed service departments.

Demonstration sites note two core aspects of effective communication systems: spatial proximity among providers and electronic medical records (EMR). These components, along with several others, will be explored as strategies to enhance communication between multidisciplinary providers in the medical home, with particular focus on Family Partner-Clinician communication with primary care and behavioral health providers.

STRATEGIES TO FACILITATE FAMILY PARTNER-CLINICIAN COMMUNICATION WITH OTHER MEDICAL HOME PROVIDERS

#1

Share Documentation Systems:

The medical record is a great vehicle for provider communication. The Family Partner and Mental Health Clinician must have full access to the medical record system that primary care providers and behavioral health providers use in the health practice to effectively communicate. Specifically, the FP and MHC should be able to read the notes of other medical home providers as well as document their patient encounters in appropriate templates accessible to other medical home providers.

For health practices with electronic medical records, the EMR can be used to facilitate referrals to the FP and MHC, share the comprehensive care plan, flag a provider regarding new concerns for families mutually followed, and communicate the transition plans when families are closing services with the FP-MHC dyad. Demonstration sites consistently report the EMR as a key element of their routine communication with PCPs.

Also, on the front of the medical record, designate "FP-MHC services" (or the name of your new services), so that all providers who open the child's chart can easily identify the FP and MHC as supports in care decisions. A front-page display will reduce errors in coordinating care or duplicative efforts for families receiving FP-MHC services. It will also trigger a reminder for primary care staff (medical assistants, receptionists) to notify the FP or MHC when a family is present for well visits, enabling collaborative primary care visits.

#2

Make the FP and MHC Easily Accessible:

The Family Partner and Mental Health Clinician should be regularly accessible to primary care providers for consultation and referrals. Demonstration sites have tried various strategies to facilitate this accessibility.

Pagers, Cell Phones: Practices can have a FP or MHC consult pager that PCPs can access to facilitate "warm handoffs" or immediate consultation for a family during a well visit or urgent care visit. Similarly, a work cell phone for the FP-MHC dyad can facilitate real-time consultation with PCPs when families are present, especially as some medical homes use texting as a means of less interruptive communication.

#3

Designated Primary Care Hours: The Family Partner and Mental Health Clinician can both designate 4-8 hours a week (1-2 clinical sessions) to be physically present in a primary care clinic room or provider room. Committing to such regular times builds provider trust, facilitates warm handoffs, and enables the Primary Care Provider and MHC/FP to jointly see families who have questions regarding social, emotional, or behavioral health. During these hours, the FP and MHC may also provide resource linkages to other medical home or community services for families with developmental or mental health support. If space allows, the FP or MHC may also complete the engagement and assessment visits with families who have a higher level of social and emotional health needs.

Team Huddles: The FP/MHC can join a "team huddle" at the beginning of the primary care sessions they attend; these huddles may consist of PCP, nurse, medical assistant and receptionist. During these huddles, the team reviews a list of patients scheduled for the day, identifying patients that may have specific medical screening or treatment needs, as well as identifying families that may require support services from the FP or MHC. This can help prepare the whole team to efficiently connect families with needed medical and social/emotional supports during well visits.

#4

Proximity Matters. Share Space:

Physical proximity matters: If the FP and MHC share a space, they will better coordinate services; if the FP/MHC are visible in primary care, their services will be better utilized by primary care providers.

Family Partner-Clinician Space: It is recommended that the FP and MHC share a common administrative space to facilitate continuous communication regarding families enrolled in their joint services. This shared space may also serve as a meeting place with families depending on the set up; ideally, the FP and MHC would have an additional space that is designed for engaging families in social-emotional health (play space, interactive space), but it is clear that all health practices face space constraints.

Proximity to PCPs: The closer the FP and MHC are to the primary care providers, the more PCPs will access their services. True integration in primary care means the FP and MHC are based in the primary care setting for administrative work and family encounters. Having the FP-MHC dyad share an office that abuts the PCP's work space facilitates integrated care.

Proximity to Behavioral Health: Demonstration site also recognize that the closer they are based to behavioral health providers, the more likely they are to coordinate behavioral health services across family members. Given that

caregivers and siblings of the child referred to the FP/MHC may also require mental health supports, having a close relationship with behavioral health providers enables the FP and/or MHC to facilitate family-centered care that bridges adult and child mental health services. These relationships are especially critical for young children where the health of the caregiver and child are inseparable. For more systems considerations regarding caregiver-child health integration, see the section titled *Integrating Child-Caregiver Mental Health Services.*

#5 Set Clear Communication Systems:

The Family Partner-Mental Health Clinician dyad and Primary Care Provider should together define expectations for communication. Identifying reasonable expectations ahead of time will remove the sentiment often felt by consultation services in medical homes—the feeling of "burdening" the PCPs who are known to be very busy. Given an understanding of both the value of integrated care and the time pressures PCPs face, the PCP Champion should facilitate discussion on communication systems with PCPs.

Three questions should be addressed:

1) When is it important for the FP/MHC and PCP to communicate about any particular family?
2) What's the best way to communicate this information?
3) How fast should communication occur?

There are two clear times when communication between the FP/MHC and PCP is critical.

Handoffs in Care: There are two key service steps that require "handoffs" between the FP/MHC and the PCP—referrals and transition. Communication between the FP/MHC and PCP should at least occur in detail at these points, to ensure that families experience seamless transitions in and out of services.

Urgent Concerns: When either the FP/MHC or the PCP identifies an urgent concern with a family, they should communicate this with the partnering providers as to jointly 'step up' supports to this family.

It is also important to define timelines for communication, both between providers and also between provider and family. For example, how quickly are the FP/MHC expected to contact families after a PCP makes a referral? Within how many days after the FP/MHC send a PCP a transition plan should the PCP review and acknowledge? Setting upfront expectations, which may later change, gives the team a starting place for reliable communicating with PCPs.

#6

Share Schedules:

One clear way to demonstrate a team approach with families is having joint provider visits. The most realistic opportunity to do so is primary care well child visits which occur frequently in the first three years of life. For collaborative visits to work, the Family Partner and Mental Health Clinician need to be aware of the scheduled primary care visits for families they follow and also be available to be in primary care during the visit. Having access to primary care providers' schedules enables this logistically, but it still requires that the FP or MHC to look through the visits for PCPs regularly, which takes up valuable time.

Demonstration sites vary in their approach to this. One demonstration site designated "LAUNCH family" on the electronic medical record of patients enrolled and then had an administrative assistant look through PCPs schedules every 2-3 weeks and make lists of LAUNCH families with scheduled visits with PCPs. The most effective way would be an EMR system that generates lists of upcoming well child checks for the FP and MHC. This means having an electronically-applied label of "FP/MHC service" to EMR charts of participating families, and a corresponding IT program which allows the FP and MHC to automatically receive weekly schedules for their patients' primary care visits. However is feasible in your medical home, the FP and MHC need streamlined access to the schedules of PCPs to provide collaborative care in the clinic.

#7

Commit to Regular Meetings:

All providers have packed schedules and balance competing demands; however, investing in regular provider meetings can be mutually beneficial. The communication that results will be reliable and ultimately time-effective in coordinating care by reducing emails and EMR messages.

Family Case Review with PCPs: The opportunity for the FP-MHC dyad and PCP to discuss the care of specific families is important. It enables providers to brainstorm new or more intensive supports for families experiencing complex psychosocial stressors or mental health needs. This dialogue may also offer providers a support system when they feel stressed about caring for a particular family in crisis. Most health practices have set Pediatrics meetings which offer opportunities to discuss specific concerns regarding patients. The FP and MHC should be part of these meetings with designated time to discuss families facing complex stressors. In addition, this regular meeting time allows the MHC and FP and PCPs to facilitate effective handoffs in care during the referral and transition phases.

#8 Post Reminders in Clinics:

Since primary care providers are balancing multiple service demands, it is important to have visual cues in clinic rooms that keep the Family Partner/Mental Health Clinician services on the minds of medical home providers. Post reminder posters to trigger providers' memory about the valuable new FP/MHC services, especially in the start-up phase. Ensure the contact information of the FP and MHC are easily available in all clinic rooms and don't require PCPs to be dependent on a phone directory to access contact info.

#9 Plan Joint Professional Development Opportunities:

Identifying shared professional development interests among the Core Team, pediatric staff providers and behavioral health providers can facilitate mutual learning, shared perspective and motivation to collaborate. The FP or MHC may lead a brief training on a topic related to childhood social and emotional health.

Alternatively, the Core Team as a whole may recruit guest speakers from the community with an expertise not otherwise represented in the medical home. Hosting professional development opportunities requires the Core Team Administrator to advocate for designated time on medical home or departmental meetings agendas.

#10 Seek Joint Parent Advisors:

Consumer voice and leadership is becoming a well-recognized component of the pediatric medical home. This model greatly values the voice of parents as partners in healthcare service and system improvements. Rather than separately seeking this input of parent representatives, providers collaborate to build 1 group of parent advisors in the pediatric medical home. Doing so aligns the agendas of multiple medical home providers while facilitating communication regarding joint systems improvement.

Given their background and role, the FP can be particularly helpful in engaging parents as colleagues in medical home service and systems improvement. For more about parent leadership in informing services, see the section *Parent Voice in Shaping Medical Home Services/Systems*.
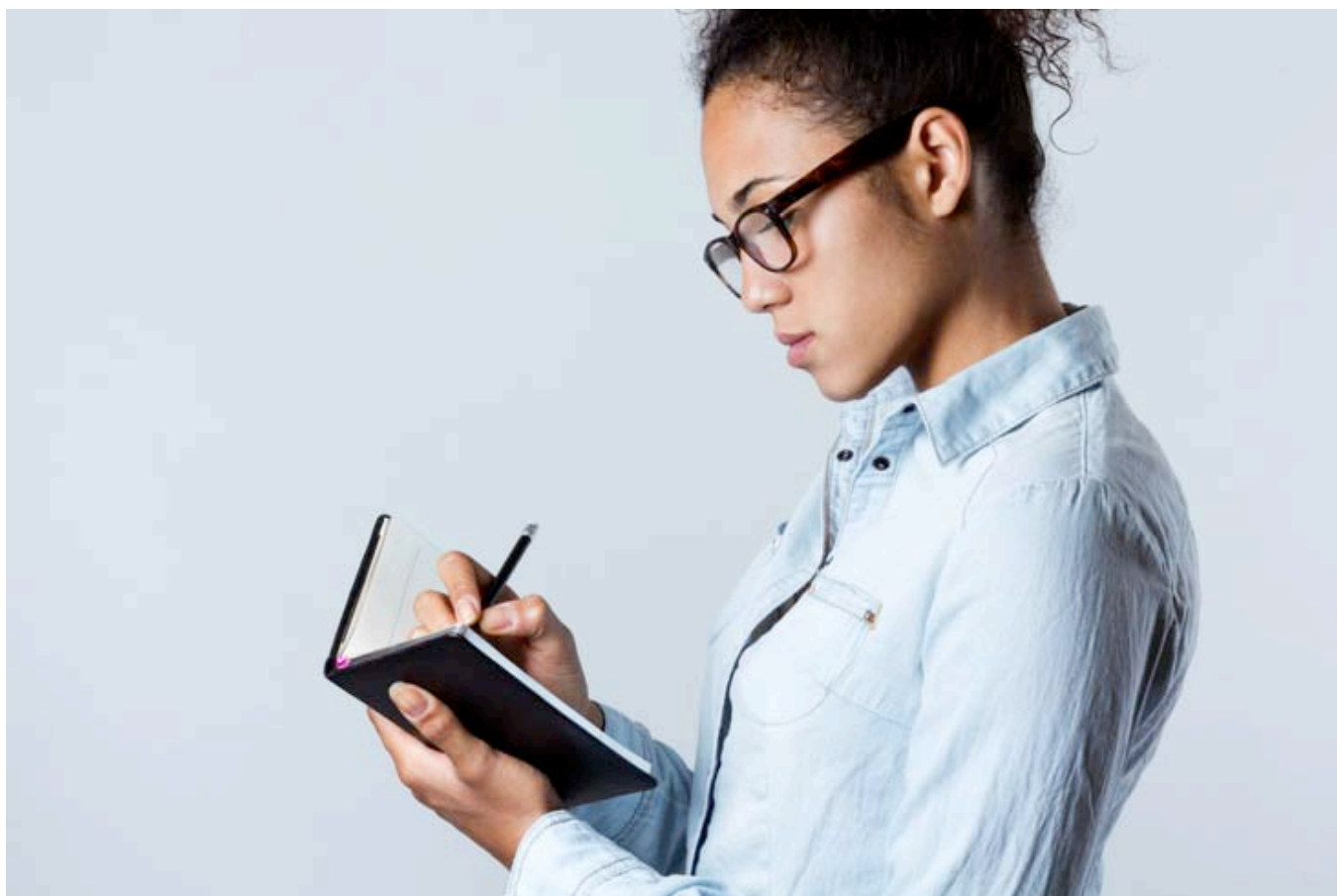
2) Family Partner Documentation in Medical Records

The adopting health practice needs to pay particular attention to supporting Family Partners in documenting visits with families. You should design a medical record template that captures the expertise and work of this unique role. Many FPs also need training on how to concisely document their work with families, because this may be the first time they are asked to do so.

The Family Partner's supervisor should review notes with the FP and provide feedback and coaching as needed to ensure notes meet health practice standards, reflect an outcomes-based approach to supporting families, and are useful for coordinating care with primary care providers.

SUPPORTING FAMILY PARTNERS IN DOCUMENTING WORK WITH FAMILIES
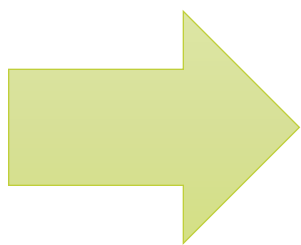
Ask About Experience: Family Partners enter with varying backgrounds and familiarity with healthcare documentation. For some FPs, this may be the first time they have to formally document their work with families. Ask if the FP has had to write a note summarizing their work with families to open the discussion and understand the starting point. Also, keep in mind the cultural and linguistic background of the FP.

The Family Partner should be reflective of the cultural background of families in the medical home; this may mean the first language of the FP is not English. Recognize that a FP may be quite skilled in documenting their work in another language, but face challenges in doing so in English. Make sure to differentiate this linguistic challenge from challenges around understanding the purpose or content of notes.
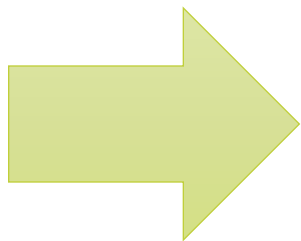
Define <u>Your</u> Health Practice's Standard for Family Partner Documentation: There is no state or national standard template for Family Partners; however, in Massachusetts, both our demonstration sites as well as agencies providing Children's Behavioral Health Initiative Services have experience developing their own standards for FP documentation, also guided by requirements from Managed Care Entities. It's important that your medical home clearly define expectations for FP notes.

While sample key ingredients for Family Partner documentation are provided, it may be helpful to consider the following three questions in forming your health practice's standard:

1) What are the key services the FP will provide within your medical home? *Create a list.*

1) Does your health practice have a way for FP services to be reimbursed through insurance? (*Depends on FP background and your health practice's contracts with Medicaid/private insurance; see* Sustainability *section*)

1) What existing templates does your health practice use that could be modified for FP? (*Community resource specialists, case managers, outreach coordinators, etc.*)
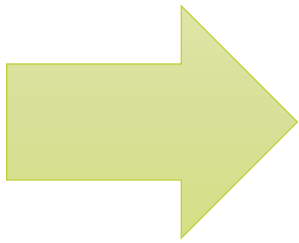
Provide Training on Documentation Content: Use the health practice's developed standard to train FPs on how to document the content of their visits with families. New clinicians receive automatic training on the electronic medical record system or paper record system, including where to find charts and how to access charts, but clinicians are assumed to know what to write in patient's notes.

This assumption cannot be applied to FPs, as the background experience of this professional role varies. So be prepared to train FPs on what to write in notes to succinctly and effectively communicate the goal-oriented work done with families. Provide FPs with examples of notes that meet the standard of the health practice and effectively summarize the encounter with a family. Some questions that may arise include: What type of information goes in a note? How are notes organized? Are there things I should not write in patient charts?
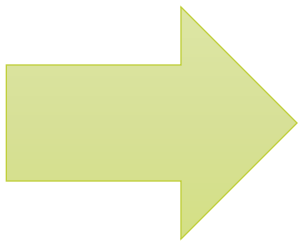
Make Chart Reviews Part of Supervision: Use medical record charts as a tool for coaching on documentation. Provide examples of documentation that reflects the goal for FP notes as defined by your Core Team. FP notes will vary across medical home sites depending on the target population, the focus across a spectrum of promotion, prevention, and intervention services, and the potential for third-party reimbursement. Be clear in your expectations for notes. Review a couple of the FP's charts during supervision to provide feedback on content and ensure all essential components are present. Chart reviewing may help the FP and supervisor both better understand the role of the FP and the value of services provided.

DEVELOPING OUR STANDARD FOR FAMILY PARTNER DOCUMENTATION

Boston Healthcare for the Homeless Program (BHCHP)
Rachel Harrington-Levey, PhD., Clinician – October 2012

Improvement Goal

To create and implement a standard for MYCHILD Family Partner documentation that meets the requirements of the "Family Support and Training" Medicaid specs, as to position us for future billing. To have 90% of Family Partner notes meet these documentation standards by October 1, 2012.

Rationale

Family Partner billing can increase revenue to support sustainability of MYCHILD services. Since Community Service Agencies (CSAs) currently receive reimbursement for FP services, we will align our FP documentation with CSAs to prepare our site for potential billing opportunities.

Strategic Approach

1) Researched Current FP Billing Practices:

➢ "Family Support and Training" services are billed by Community Service Agencies via MassHealth

➢ Gathered information about Medicaid standards for Family Support and Training; information limited in detail

➢ Discussed opportunity to contract with a CSA

2) Consulted Local Partners for FP Charting Specifications:

Mass Behavioral Health Partnership

Discussions suggested documentation standards:

• Access to the CANS and family treatment/Care Plan

• Progress reports should have current goal, progress toward goal and next steps

• Document a discharge plan, signed by all parties

• Discharge plans should have the reasons for discharge, ongoing strategies and resource supports

• Give the plan to parents/caregivers within 5 days

• If caregiver terminates care without notice then FP must document "every effort to contact the person"

Children's Behavioral Health Initiative (CBHI)

See attached CBHI Guidelines.

The Home for Little Wanderers CSA

Informal discussion with CSA director about components of their documentation templates; consistent with above.

3) Identified a FP Documentation Standard for BHCHP

➢ Feasible standard that both promotes "good" practice in cross-provider communication and aligns with billing standards

4) Implemented Family Partner Chart Reviews with Checklist

5) Implemented Family Partner Feedback Sessions to Facilitate Progress toward Standard

Data Analysis

Prior to beginning our current Quality Improvement goal 0 % of notes met Medicaid specifications for Family Support and Training service. As a result, with the useful information that we collected from our community partners who already bill, we were able to identify elements needed for documentation.

Required Elements for Progress Notes:

1. Type of service provided
2. Length of service
3. Care Plan goal addressed
4. Progress towards goal

To assist in implementing the new documentation standards, the clinician performed 10 Family Partner chart reviews per month. Below shows the progress throughout the first 5 months (March 2012 – July 2012). Based on chart review results, Family Partners received feedback.
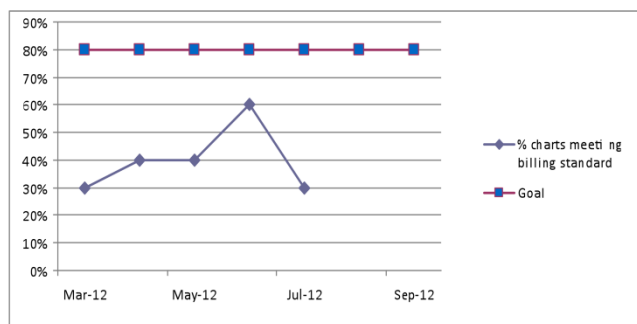
A New Opportunity Led to a New Approach:

➢ Health Care for the Homeless contracted with Massachusetts Behavioral Health Partnership (MBHP) for Community Supports Program (CSP): This is an alternative reimbursement plan for our FP that aligns with our new CSP infrastructure.

➢ Shifted our goal to have 90% of progress reports align with CSP documentation standards by Oct 2013

➢ CSP documentation standard includes certification by MBHP as a CSP provider and progress notes which contain required elements

Outcomes

During the first several months of chart review, FP success at documenting progress reports in alignment with CSA standards steadily increased, reaching a high of 60% in June 2012. It appears that the process of conducting monthly chart reviews and providing feedback related to our goal was helpful in making progress in the desired direction.

This trend reversed in July 2012, which was during the time that we became aware of an alternate possibility for billing for FP services and began to shift our focus. We believe that this was because of our program's lack of clarity about whether to continue with our initial goal, or to develop a new goal of re-working our documentation to meet CSP billing standards.

Now that we have explored both opportunities for reimbursement we have decided to shift our goals focus as to documentation alignment with CSP specifications. For this reason our next steps will be to obtain MBHP certification for family partners, receive training on CSP documentation requirements and initiate a similar chart review process to track our progress toward our new goal.

Conclusion

This project was helpful to our program in developing a system for creating and monitoring appropriate Family Partner documentation. We believe that this same process will allow us to implement documentation practices that are consistent with CSP billing standards over the next 12 months.

Lessons Learned

✧ Chart review with feedback to Family Partner appears to be an effective strategy for moving toward goal.

✧ One challenge that arose for the FP was confusion about how to document progress reports for services provided to prior to the creation of the family's care plan; engagement can take several weeks. Because the family had not yet specified goals, our team was unclear about what information should be included in these notes. From consultation with community partners, we decided that progress reports should define the goal addressed as "engagement."

✧ It is essential for the FP to have easy access to a list of Care Plan goals for each family, so that he/she can refer to them during family meetings and while documenting. Currently, Care Plans are kept in a scanned medical records file that is not easy to access when providing outreach visits to families or during the note writing process. We have been talking with program staff at Boston Public Health Commission about a brief Care Plan summary that can be used for this purpose.

Sample 1: Standard for Family Partner Progress Notes

1) Type of service provided:

    ❑ Crisis monitoring   ❑ Documentation
    ❑ Collateral contact   ❑ Member outreach
    ❑ Care planning team meeting   ❑ Member transportation
    ❑ Face-to-face contact with child   ❑ Telephone support for child and
       and caregiver   caregiver

2) State which Care Plan goal was addressed *(Reminder: If Care Plan has not yet been developed, goal addressed is "engagement"):*

3) Brief statement of progress toward Care Plan goal, including any significant barriers or challenges faced:

4) Next steps for caregiver and Family Partner:

5) Duration of services (in 15 minute increments):

Place an "X" in each box for notes that are in alignment with chart review standards and an "O" in the box next to notes which do not meet standards.

Note #	October	November	December	January	February	March
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
Monthly Total						

Note #	April	May	June	July	August	September
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
Monthly Total						

3) Building Medical Home Systems for Home and Community Visits

Home visits are a useful strategy for increasing the accessibility of mental health services for all families. **It is important for medical homes to both consider home visits as a service strategy and also anticipate the potential challenges that home visiting presents.**

All demonstration sites developed systems for the Family Partner and Mental Health Clinician to provide family support and clinical care services in caregivers' homes and local community settings. Home visits can be particularly helpful for reaching families who cannot easily come to the medical home; for example, families with limited transportation, atypical work schedules, special healthcare needs or multiple young children. Home visits also add depth to the relationships between families and caregivers by fostering a greater understanding of a family's daily experience in the natural environment.

At the same time, home visits are not the right fit for all families or providers. Families may feel uncomfortable allowing visitors to see their home and cultural practices. Families experiencing poverty may fear the personal judgment of a home visitor, making it hard to build a trusting relationship.

Similarly, providers may experience discomfort in adjusting to home environments, negotiating relationships between multiple family members present, dealing with distractions such as TV and observing the cultural practices of a family. Providers may feel limited in the types of service they can provide or access during home visits, as they may not have their full range of supplies and resources. Providers are likely to have limited access to interpreter services available in clinic, thus limiting home visits with families whose primary language is not English. In addition, providers may have safety concerns with home visiting in various neighborhoods.

Despite these challenges, home visits can both reduce the burden families experience in accessing services, strengthen the relationship between providers and families, and contribute to the growing trust of a community in the local health practice. For this model, health practices must understand the systems and structures that need to be in place to support the FP and MHC in home visits.

Health practices vary in their existing systems, comfort, and experience with home visiting. Enabling staff to conduct home visits does require special consideration regarding provider availability, scheduling, resource availability, provider training, transportation needs, safety concerns, malpractice insurance coverage and third-party reimbursement.

This section will support a health practice in discussing the benefits and challenges to home visits for families in their medical home. Tools will help identify caregivers who may benefit most from home visits, provide training and support to providers in leading home visits, and develop medical home systems that enable safe, effective home visits. They will help your team provide feedback and coaching as needed to ensure notes meet health practice standards, reflect an outcomes-based approach to supporting families, and are useful for coordinating care with primary care providers.

IS HOME VISITING THE RIGHT STRATEGY?

The question "Is home visiting the right match for this family?" was frequently discussed by Family Partners and Clinicians in service planning.

Before offering home visits to a family, there are a number of questions the Core Team should consider regarding the family, provider and medical home. The following grid is designed to support a provider in determining if home visiting is the best strategy for the caregiver-provider pair.

These questions assume that:

✓ A family understands what a home visit is and is interested in this service
✓ The provider is trained and comfortable with home visiting practices

View the chart below.

Table 1: Determining if Home Visiting is the Right Fit

	Family Factors	Provider Factors	Health Practice Factors
Transportation	Does the family have reliable transportation to the health practice? How far away does the family live?	How long is the provider's travel time to reach the patient's home? Can the provider travel this distance?	Is there additional transportation support the health practice can offer the family (taxi vouchers, public transportation cards) to enable a visit in a health practice or mid-point community location?
Special Needs	Are there specific medical, family, or social/emotional health needs that limit the family's ability to access the health practice or leave the home?	Does the provider have any medical or social/emotional health needs that limit travel?	Are there other health practice supports that can reduce the burden on the family to access the clinic? (e.g. on-site childcare)
Language	What is the caregiver's primary language?	Does either the Family Partner or Mental Health Clinician speak the primary language?	Does the health practice have interpreters accessible by cell phone? Does health practice give the provider a cell phone for home visits?
Scheduling	Does the family have difficulty accessing health practice services during regular business hours?	Does the provider have schedule flexibility to complete home visits after regular business hours?	Does the medical home have a policy to accommodate this flexibility through compensated time?
Safety	Are there safety concerns in the home that will limit the caregiver from openly discussing their social and emotional health needs?	Does the provider feel safe entering the home of this family?	Does the health practice have additional safety measures to support this specific home visit?

Table 2: Preparing a Health Practice for Home Visits

To conduct home visits, a health practice must have clear systems and protocols that ensure that home visits are safe, supported, and held to the standards of on-site services. Below are systems considerations to discuss prior to launching home visits.

System Component	Description	Status
License and Insurance Coverage to Provide Clinical Services at Home	Requires that the health practice have the behavioral health licensing and malpractice insurance coverage to allow employed clinicians to provide clinical service in a home and community setting.	
Flexible Scheduling	Requires flexibility in scheduling patients, including increased time slot allocation to accommodate travel. This works best when the Family Partner and Clinician can directly manage their own appointment scheduling, especially if visits are occurring when clinic is closed.	
Safety Protocols	Must have a clear safety protocol that defines procedures by which the Clinician and/or FP assess risk of visit, communicates schedule with supervisor, confirms safety after home visit, and accesses local police or other resources as needed, such as the Department of Children and Families.	
Crisis Protocols	Must have clear crisis protocols that support Clinician and FP in responding to crisis situations, such as disclosure of suicidality, homicidality or severe mental illness. These protocols should clearly define who to notify regarding crisis management.	
Cell Phones for Home Visits	Available cell phones for providers to take with them during home visits to enable emergency communication as necessary. Phone numbers programmed into cell phone to access health center administration, behavioral health on-call provider, local crisis resources and local police.	
Travel Reimbursement Policy for Mileage	Written policy regarding provider reimbursement for public transportation or car commuting as used for home visits.	

Sample: Home Visiting Policy

Joseph Smith Community Health Center

Below is an example of a home visiting policy developed by a Joseph Community Health Center, a MYCHILD demonstration site. This policy was developed such that the MYCHILD Clinician could provide in-home clinical services.

Category: Clinical: Mental Health

Subject: Mental Health In Home Treatment

Site: Off Site

Distribution: All clinical staff

Effective Date: September 2012

Revision Date(s):

Policy:
- The Mental Health Clinician assesses need and appropriateness for in-home therapy.
- In-home therapy may be provided where the patient is naturally located, including but not limited to , the home (including foster homes), schools, childcare centers, respite settings and other community settings.
- The Mental Health Clinician (e.g. LICSW, psychologist, supervised social work or psychology intern) provides services that include case consultation, individual, group, couple and family therapy in the patient's home or location other than the health center.
- The Mental Health Clinician consults with other members of the health care team as appropriate to provide comprehensive services.
- The Mental Health Clinician documents the progress of the patient towards treatment goals and any changes made to the treatment plan and whether a translator was used during the sessions.
- The determination for in-home therapy should be made when barriers to access prevent a patient from engaging mental health services.

Procedure*:

   1) All initial intakes are conducted onsite at either clinic or school locations. Once intake is complete and patient is known to Mental Health Clinician, determination can be made whether in-home therapy is appropriate. Determination should be based on the following:

✓ Barriers to accessing health center location prevent patient from engaging in ongoing mental health services.

✓ Safety has been assessed by following Offsite Safety Policy.

✓ Consent has been obtained from the patient or patient's caregiver.

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2) Treatment is provided to patients, based upon the assessment and diagnosis, in the home or other mutually agreed upon location other than the health center. The mode of treatment (e.g. individual therapy, family therapy) is determined by the Mental Health Clinician.

3) Treatment plans and goals are discussed with the patient as are progress towards accomplishment of the goals.

4) The Mental Health Clinician consults with other providers (such as the psychiatrist or primary care provider) as necessary to provide comprehensive services. If medication is recommended by the psychiatrist or Primary Care Provider, all policies as they relate to medications/prescriptions are followed.

5) The Mental Health Clinician documents in the medical record all treatment provided including telephone consultation, progress towards accomplishing the treatment goals, barriers or impediments affecting the accomplishment and any revisions to the treatment plan. The clinician also notes when a translator has been used during any portion of the care provided (e.g. intake, assessment, goal discussion).

6) Recommendations of providers who are consulted are incorporated into the plan as appropriate.

Director of Counseling: _____   **Date:** _____

Executive Director Approval: _____   **Date:** _____

Established Home Visiting Programs

If your health practice doesn't have the systems to support home visiting, consider partnerships with established home visiting programs to provide enhanced social/emotional interventions in conjunction with their existing models. Many of these programs are approved home visiting models that meet the evidence-based criteria of the Maternal, Infant, Early Childhood Visiting Program through the Health Resources and Services Administration.

These home visiting programs help parents of children from birth to age 5 tap the resources and develop the skills they need to raise children who are physically, socially and emotionally healthy and ready to learn. The following list provides examples of established home visiting programs.

Home Visiting Programs in Massachusetts:

➢ Healthy Baby, Healthy Child[1]: Boston Public Health Commission

➢ Visiting Moms[2]: Jewish Family and Children Service

➢ Massachusetts Home Visiting Initiative[3]: Department of Public Health

Home Visiting Programs Nationally:

➢ Healthy Families[4]: Children's Trust

➢ Early Head Start[5]: Home Based Programs

➢ Parents as Teachers[6]

➢ Healthy Steps[7]

➢ Parent Child Home Program[8]: Department of Early Education and Care

Early Childhood Mental Health Integration Toolkit: Boston Public Health Commission, 2014   25

4) Integrating Caregiver-Child Mental Health Services

The health of a caregiver and child are uniquely intertwined, especially for young children. At times, caregivers may experience stress or illness that impacts their relationships and their child's social and emotional health. Medical homes must support families during these times, addressing the needs of the caregiver-child dyad as well as the caregiver herself.

Medical homes must explore the impact of each caregiver's health on her family without assumption or judgment, as stress impacts every family differently. Caregivers may fear being labeled a "bad parent" because they experience stress or illness, and thus not ask for help. It is important that pediatric providers ask caregivers about the stressors they face and practices for self-care. All caregivers need to be cared for, especially when experiencing high levels of stress or mental health concerns.

Discussing mental health with the caregiver

The pediatric medical home may be the first open door a caregiver experiences to discuss her own mental health. It is important that pediatric medical homes can respond to the mental health needs of caregiver by offering a breadth of resources spanning promotion through intervention services. Medical homes must consider the delicate balance of respecting caregiver confidentiality in the pediatric setting while still optimizing care coordination to integrate caregiver and child supports.

Health practices must create systems that link children to services that are informed by their caregiver's mental health, but that also still respect boundaries that a caregiver may prefer in maintaining her own health information distinct from that of her child's, especially for written documentation. Caregivers may worry that information recorded about their health in their child's record may later be seen by the child herself or another legal guardian.

This section explores strategies to support child-caregiver integration in the pediatric home while still respecting caregiver boundaries regarding confidentiality. This includes using screening tools in pediatric visits that assess caregiver mental health, responding to caregivers with compassionate options for support services, and discussing options for documenting caregiver's health in the pediatric medical home.

SCREENING TOOLS FOR CAREGIVER DEPRESSION AND STRESS

It is important to screen caregivers for mental health concerns and significant stressors, both of which can significantly impact the quality of the parent-child relationship and subsequently the child's social and emotional health.

The postpartum period remains a particularly critical period for caregiver screening as 10-15% of women experience post-partum depression. Based on preliminary data from the Pregnancy Risk Assessment Monitoring System (PRAMS) on 2007 births in Massachusetts, 13% of women reported symptoms consistent with postpartum depression, but only 23% of those women sought professional help.[A] Emerging data regarding paternal depression suggest postpartum depression affects 10% of men and is relatively higher in the 3- to 6-month postpartum period.[B]

Evidence suggests that children of severely depressed mothers are at risk of social and emotional health challenges, including insecure attachments to caregivers, difficulty with self control, internalizing and externalizing problems, challenging social interactions, and ultimately mental health disorders.[C] Aside from depression, it is important to understand the broader stressors caregivers face, as the medical home can offer strategies to mitigate the impact of this stress on the family.

Demonstration sites implemented caregiver screening for depression and stressors as an essential part of the service delivery model. Most sites used the Patient Health Questionnaire-9 (PHQ-9) and Parenting Stress Index (PSI) as initial tools to screen for depression and caregiver stress, and then used these tools to triage needs and guide caregiver referrals. Using these tools, the Family Partner and Mental Health Clinician identified caregivers who could benefit from a spectrum of resources, from caregiver support groups to individualized behavioral health therapy. These tools are also particularly helpful in informing the "Caregiver Resources and Needs" section of the CANS (Child and Adolescent Need and Strengths assessment), the universal decision-support tool that is required for providers of children's mental health services in Massachusetts.

More information about the PHQ-9 and the PSI is provided below, as well as links to websites that detail metrics and tool validity.

_____

[A] Center for Disease Control (CDC). Pregnancy Risk Assessment Monitoring System (PRAMS) and Postpartum Depression. In: Department of Health and Human Services, Massachusetts Department of Public Health; 2007.

[B] James F. Paulson, PhD; Sharnail D. Bazemore, MS*JAMA.* 2010;303(19):1961-1969. doi:10.1001/jama.2010.605. Prenatal and Postpartum Depression in Fathers and Its Association With Maternal Depression: A metaanalysis

[C] Center on the Developing Child at Harvard University (2009). *Maternal Depression Can Undermine the Development of Young Children: Working Paper No. 8.* http://www.developingchild.harvard.edu

Tools for Caregiver Screening
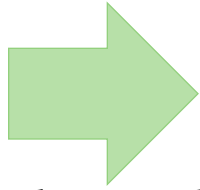
Patient Health Questionnaire-9: This is a self-administered nine item depression scale that can assist clinicians with diagnosing depression and monitoring treatment response. Each question is directly based on the diagnostic criteria for major depressive disorder. The tool can also help providers track a patient's depression severity and specific symptoms if administered over multiple points. The tool has been translated into over 50 languages, which can be accessed for free online. The PHQ Screeners website[9] offers both brief screening tools, such as the GAD-7 (screens for anxiety) as well as other forms of the PHQ, including the PHQ-2 ultra-brief screener. Also view the PHQ instructions here[10].
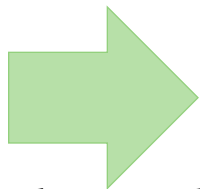
Parent Stress Index: The Parent Stress Index[11] explores the magnitude of stress in the parent-child system. The questionnaire assesses three major domains of stress: child characteristics, parent characteristics, and situational/demographic life stress that can impact the behaviors of the caregiver and child. There is also a version of this tool for older children and their caregivers, titled "Stress Index for Parenting Adolescents."

These websites were used to inform the following grid regarding use of the PHQ-9 and PSI:

Tool	Type	Age Range	Time	Qualifications for Administering	Access
PHQ-9	Screening tool for depression	Adolescents, Adults	5 minutes	Self administered, or provider-administered. No degrees required.	Free. Many languages (validated in English).
Parenting Stress Index	Evaluates magnitude of stress in parent-child relationship	For caregiver of child 3 months to 12 years old	20 minutes (long version) OR 10 minutes (short version)	Provider administered. *Masters degree OR Bachelors degree in related field and "license/certification from an agency/organization that requires training/experience in assessment"*	$210 for introductory kit, $75 for instruction manual. About 15 languages.
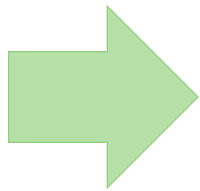
Postpartum Depression Tools: See Massachusetts Department of Public Health postpartum depression resources[12].

Also, learn about what Massachusetts is doing to help moms with postpartum depression. See this link with resources for providers and families[13].
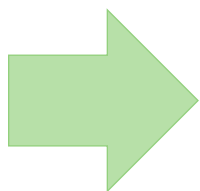
Caregiver Health and Stressors: See American Academy of Pediatrics "Mental Health Screening and Assessment Tools for Primary Care" section titled "Screening for Environmental Risk Factors[14]."

Tips for Connecting Caregivers to Mental Health Services

Pediatric providers recognize that caregiver's mental health matters, but connecting caregivers to support and behavioral health resources remains challenging and time consuming. Caregivers and health practices face many barriers in the process, including burdensome intake processes, long waitlists for services, shortages of bilingual providers, and limitations in insurance coverage.

Below are tips or strategies demonstration sites have tried to more effectively connect caregivers to behavioral health services.

1. **View the Pediatric Visit as An Open Door for the Caregiver:** Caregivers prioritize their child's health over their own. The pediatric visit may be the only opportunity to connect caregivers with services to address their own mental health needs. Challenge pediatricians to ask caregivers about their mental health through both open-ended questions and with formal screening tools. Pediatricians will ask caregivers these questions if they feel prepared to respond, so ensure Pediatricians can call upon the Family Partner and Mental Health Clinician when a caregiver needs resource connection.

2. **Emphasize the Importance of Self-Care:** Caregivers often overlook the importance of self-care. Emphasize that caregivers' well-being matters for the whole family. Caregiver stress reduction supports the whole family in healthy relationships and development. Help the caregivers' partner or social supports understand this too.

3. **Optimize Your Internal Behavioral Health Resources:** Many health practices with pediatric services also have adult behavioral health providers within the agency; however, often there is limited coordination between caregiver and child behavioral health services. Invest in relationship-building with onsite adult behavioral health providers so that connecting caregivers to services is both streamlined and reliable. Develop an ongoing system for communicating with adult providers (i.e. medical record notes, periodic case reviews) so that child and caregiver services are aligned and referrals for community support or basic resources are not duplicative.

4. **Facilitate Warm Handoffs:** Caregivers hesitate to engage in mental health services for many reasons, including community stigma and social isolation. Support caregiver engagement by "warm handoffs" to adult providers. Introduce the caregiver to the behavioral health office prior to the appointment by contact with the behavioral health provider, a medical assistant or office staff. Help the caregiver feel known by at least one person in the practice prior to the appointment.

5. **Provide Caregivers with Clear Expectations of Intake Process:** Know the provider and practice you are referring a caregiver to, so you can provide expectations. Visit the practice before referring patients. Help prepare the caregiver for their first visit, describing the reception environment, forms to complete, typical intake process, and nature of the provider themselves. This expectation may help caregivers cope with any aspect of the process that feels uncomfortable or burdensome.

6. **Involve the Adult Primary Care Provider:** Sometimes caregivers will have to wait several weeks for an appointment with a behavioral health provider. In the meantime, reconnect the caregiver with their adult PCP for additional support and perhaps initial treatment. The caregiver may not view their PCP as a resource for their mental health; however, increasingly, adult PCPs are managing mental health concerns in the primary care office, at least until a behavioral health appointment is available. If a caregiver doesn't have a PCP, now is a good time to connect them with a provider as well.

7. **Connect Mom to Community Resources While on Wait Lists:** Examples include PCP, support groups, exercise club. Given known waitlists for behavioral health services, connect mom to social supports while waiting for a provider. Help the caregiver to identify natural supports they can call upon—family, friends, religious organizations, cultural organizations. Consider connections to mom's groups, home visiting programs, cultural organizations and events.

8. **Accompany Caregivers to First Appointment:** The first appointment with a new provider can be the hardest to keep, as there's no provider-patient relationship yet. The Family Partner can accompany the caregiver to her first behavioral health appointment to support engagement in the service. The presence of the FP, even if just in the waiting room, also validates the importance of the behavioral health or self-care service for the caregiver.

9. **Seek Providers with Language Capacity:** More than any medical specialty, behavioral health services are most engaging when a provider speaks the primary language of a patient. The direct communication can facilitate trust and understanding between caregivers and providers, reduce caregiver hesitation to discuss cultural practices, and save time for both the patient and provider. Invest time in relationship-building with providers that have the language capacity to meet your patients' needs. Contact these providers and discuss how your practices can best work together to address the social and emotional health needs of the community.

10. **Employ Parent Ambassadors:** Develop a group of parent ambassadors who have participated in behavioral health or self-care interventions. These may be the most effective members to support caregivers in engaging in behavioral health services. Using their experience and with support of the Core Team, they can provide direct support to caregivers contemplating behavioral health services, moving forward their readiness to engage. Ambassadors can also have a broader voice in promoting "mom's mental health" throughout the health practice through education and outreach events. See the *Parent Voice in Shaping Medical Home Services/Systems* section.

11. **Add "Caregiver Provider Liaison" to Your Core Team:** While the Core Team offers a multidisciplinary approach, it is important to find other "champions" within the medical home to co-lead initiatives related to mental health. It's through the addition of new champions that momentum in the medical home grows and integration of child-caregiver services develops. Seek an adult behavioral health provider to join your Core Team. This provider can help connect caregivers to self-care and behavioral health resources in Pediatrics, as well as propose systems for family-centered mental health services.

12. **Discuss Systems Barriers to Caregiver Engagement:** Many caregivers will be referred to behavioral health services and not follow through on intakes or appointments. Non-adherence to appointments is multifactorial and complex, but we must ask the question: "What aspects of our healthcare practice make it hard for parents to keep appointments?" Ask caregivers and listen. Share feedback with behavioral health providers to better understand the barriers caregivers face in accessing mental health services, and strive to change processes to improve caregiver engagement. A quality improvement framework may help structure this discussion across multi-disciplinary teams (see *Engaging in Quality Improvement Efforts*).

THE CHALLENGE OF DOCUMENTING CAREGIVER MENTAL HEALTH IN PEDIATRICS

Demonstration sites faced a common question with supporting caregiver's health:

"Where do we document information about a caregiver's health and well-being?"

Below is a summary of the challenge demonstration sites faced in documenting caregiver's mental health, options brainstormed for managing documentation, and pros and cons identified for each option. As there is no right answer on how to document mom's health information in child-parent interventions, the following questions and charts are meant to support the Core Team in discussing this topic within their health practice, not provide one solution to this challenge.

The Challenge

While the identified patient in MYCHILD and LAUNCH remains the young child, the child's relationships and environment are critical in understanding social and emotional development. Information regarding caregiver health and stressors are essential to ask about; however, due to lack of access to caregiver's medical records, it remains unclear where to document the sensitive information shared.

While many Pediatricians document brief information about mom's health and social supports in the "social history" section of notes, the Family Partner and Mental Health Clinician inquire about caregiver mental health with much more detail and with formalized screening tools, thus raising additional questions about where and how to document mom's sensitive health information.

Some providers have concerns about documenting information regarding mom's mental health in the child's record in case the child's record is seen by another guardian or by the child themself in later years. Practices in documenting caregiver's information vary across the health practices and there appears to be no standard practice.

The Question

WHERE DO WE DOCUMENT INFORMATION ABOUT MOM'S HEALTH AND WELL-BEING?

1. What should health practices do with screening tools used in Pediatrics that focus on mom's health (PHQ-9) or stressors experienced by mom (PSI)? The following is sensitive information:

- Depression Screens
- Parenting Stress Index
- Stories and Experiences Shared

2. Where should I put the Screen/Assessment of mom?
- In child's record
- Shred the document
- Give tool to caregiver
- In mom's record (with consent)
- Other?

3. What do I write in the child's chart about mom's Screen/Assessment?
- Nothing.
- Vague statement (e.g. "screening tools administered and anticipatory guidance provided")
- Name and outcome of screen/assessment tool (e.g. "screen administered and scored")
- Other?

Massachusetts Context
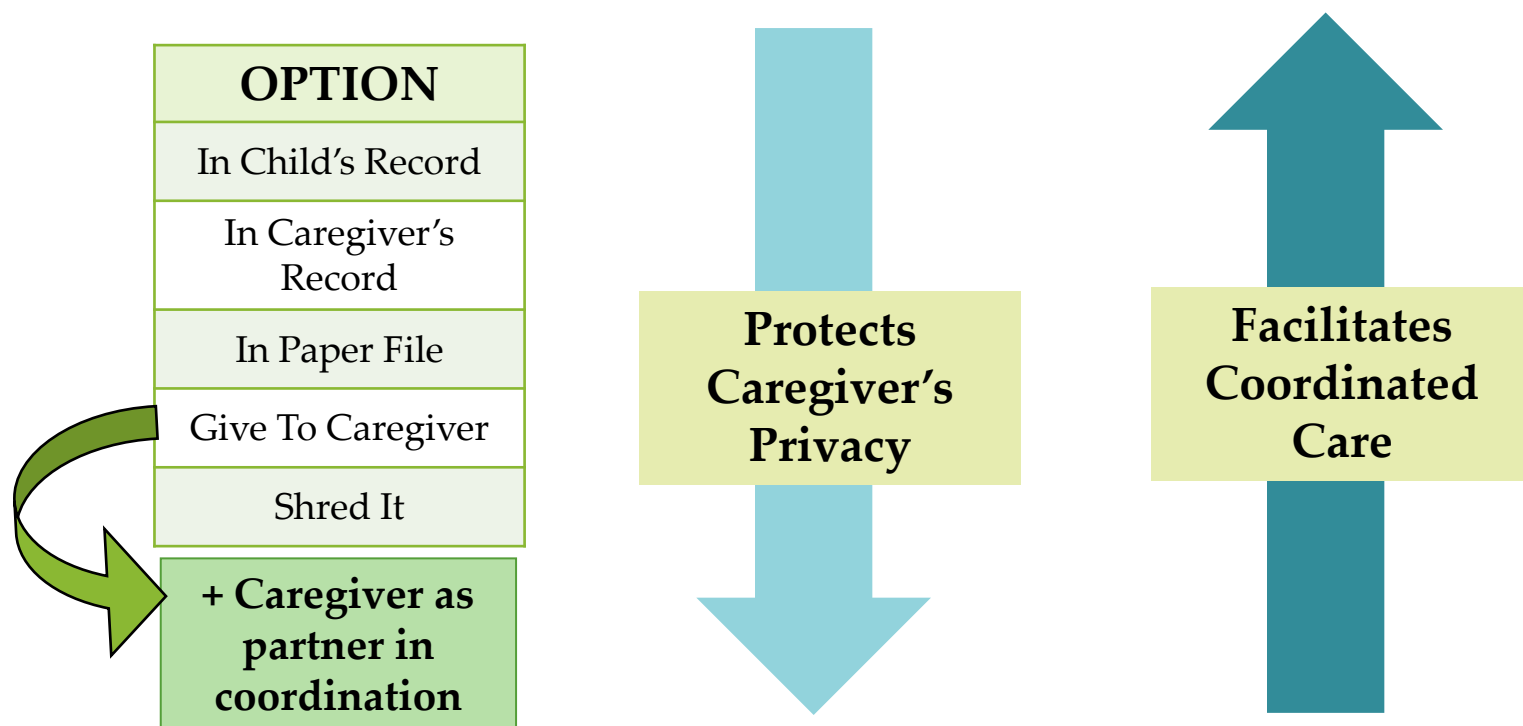
2010 Act Relative to Post Partum Depression (PPD)
-Promotes screening for PPD
-Commission on PPD to advise Dept. of Public Health on best practices
-Recommendations for data reporting on numbers screened

MCAAP Children's Mental Health Task Force
-Has recommended use of parental depression screen for CBHI as an alternative to behavioral health screen for children under 6 months

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Considering the Documentation Options

OPTION
In Child's Record
In Caregiver's Record
In Paper File
Give To Caregiver
Shred It

+ Caregiver as partner in coordination

Protects Caregiver's Privacy

Facilitates Coordinated Care

OPTION	PROS	CONS
In Child's Record	Supports team-based, coordinated pediatric care	Caregiver's health information accessible if chart subpoenaed
In Caregiver Record	Supports integrated adult and pediatric services for parent-child dyad	Information may be seen by many staff in cross-system communication
In Paper File	Allows information to continuously inform LAUNCH/MYCHILD care	Shadow files discouraged in practices with electronic medical record
Give To Caregiver	Enables caregivers to bring info to their provider; Treats caregivers as partners	Onus on caregiver to seek their own help
Shred It	Protects mom's health information if chart subpoenaed	Loss of critical information regarding mom's well-being

Storage Method

Health Center #1:
- Screening tools in paper files
- Details in child's chart depend on level of concern

Health Center #2:
- Screening tools in paper files
- Detailed results entered in child's chart
- Direct access to caregiver's chart
  - Writes note directly in caregivers chart if high level concern

Why the Differences?

1) Different EMR systems
- Scanning?
- Access to adult charts?
- Paper charts allowed?

2) Uncertainty on best practice
- Input from site administration
- Legal implications

Practice Discussion on Documentation – YCC, Jan. 2013

Things heard and discussed:

- Immigration status

- Consent forms

- Caregiver rights

- Caregiver input on this issue

- The line between child health and family stress/caregiver mental health

New perspectives:

Question: When these records are subpoenaed, is identifying information redacted as it is in other state agencies?

Suggestion: Outreach to the Attorney General's office.

Discussion point: This is a struggle (in MA) because we are ahead of the curve in clinical care delivery. The medical home and family-centered care models force this issue. HIPPA laws weren't written to consider these issues.

Suggestion: Look to family practice providers for ideas.

Question: Is there anything to learn from the Massachusetts Child Psychiatry Access Project model for women in the perinatal period?

Table: How to Document Caregiver's Information

Use this chart to help determine what you should do with documentation and the pros and cons of each option.

Option	Pros	Cons
Shred the Screen/Assessment	If child's chart examined in legal case, mom's private information not present in the chart.	-Critical information that impacts treatment plans is not documented -If provider turns over (or forgets information), then the information completely lost -Does not facilitate integrated care with pediatrician -Provider liability if crisis occurs?
Give Screen/Assessment Tool to Caregiver	-Enables caregiver to share written information with their own providers -Supports caregivers building skills in care-management and being partners in their own care	-Puts onus on caregiver, who has needs identified in the tool, to seek their own help -Paper copies easy to lose and it's unlikely caregiver has appointment with own provider immediately -Stigma makes it hard for a caregiver to use the document with another provider -May compromise confidentiality if someone sees paper copy in caregiver's home
Send to Mom's Own Provider and Flag Provider (with consent?)	-Could facilitate communication and coordination of mom and child's providers in treatment plans that are essentially inter-related -Reduces redundancy in screenings (e.g. PHQ-9) that might be done at caregiver's visit with own provider -Protects mom's health information from being seen in child's record, if legal case arises (e.g. custody issue) -Promotes partnership with caregiver by asking for consent to share with their own provider	-May not be feasible at all practices where electronic medical record systems differ between adult and child -Could be additional administrative burden to scan -If system fails, then paper copy with mom's information is lost

Option	Pros	Cons
Keep in Locked Paper Chart (i.e. shadow folder)	-Screen accessible for review with caregiver at follow up -Screen accessible to MYCHILD or LAUNCH provider as needed -If provider turns over, screen could be accessible to new provider	-Limits Pediatrician's ability to follow up with mom on screen, given no access to paper chart -Paper charts get lost -Paper charts are being phased out by health centers as privacy not as secure as electronic medical record; shadow folder not allowed in some centers
Scan Into Child's Record (with consent?)	-Information fully pertinent to the wellbeing of the child; and thus better informs the care of the child in MYCHILD or LAUNCH -Valuable information that could benefit the family from the Pediatrician knowing, and thus promotes continuous, integrated care -Gives mom the choice, given its her private information (if consent!)	-If mom says no, then information potentially lost -If record pulled for legal case, mom's health information is readily available

5) Parent Voice in Shaping Medical Home Services/Systems

Parent partnership in healthcare decision-making is an important principle of the pediatric medical home. Beyond individual care, health practices are also recognizing the value of parents, healthcare consumers, as partners in improving healthcare systems for all families. There are many strategies to engage parents in systems improvement and the approaches vary in terms of time commitment and depth of family input.

Traditionally, health practices have used patient experience and satisfaction surveys to elicit consumer feedback. While this can still be an effective way to seek feedback for improvement, medical homes are piloting new strategies to bring consumers to the discussions tables with health practice leaders. Consumers playing this role as employed leaders in decision-making have had many titles, including patient leaders, parent representatives, and parent ambassadors. Parent representatives can more meaningfully facilitate provider-patient partnerships, enabling in-depth discussions and collaborative decision-making for common improvement goals.

Having consumer voice present for systems discussions increases the chances that decisions will reflect principles of family-centered care. At the same time, having parent representatives as colleagues in systems discussions may be a significant adjustment for both the parent and providers, and thus requires more intensive planning as a strategy for bringing family voice to systems change.

The following section identifies strategies for using family voice to shape pediatric medical home systems on social and emotional health. Multiple strategies will be described, each with examples of materials developed by demonstration sites.

However, particular emphasis will be placed on identifying, training, and employing parent representatives to inform pediatric systems, as a Parent Council was the primary strategy used by the MA Partnership for Early Childhood Mental Health (ECMH) to bring family voice to systems improvement at medical home and public health levels. Parent Council materials from the MA Partnership for ECMH will be provided as well as links to organizations with expertise on parent partnership on healthcare improvement, such as the National Initiative for Children's Health Quality (NICHQ).

STRATEGIES FOR BRINGING PARENT VOICE TO SYSTEMS IMPROVEMENT

The following strategies were used by demonstration sites to improve mental health systems in pediatric practices. Consider the following options in the context of your medical home to determine feasible, effective strategies.

Strategy	Implementation	Family Considerations	Challenges Experienced
Family Experience Surveys	Brief series of questions administered to families after an encounter with the healthcare systems. May be in via paper copy, phone call, or email.	**Literacy Level**: Will a written survey be accessible to your whole population? **Anonymity**: How will families trust that their responses are anonymous? (especially if phone call survey). Who will conduct the phone surveys? **Primary Language**: How will you administer the survey to non-English speaking families? **Phones/Email**: How many of the families you serve have consistent phone service? How many have access to email?	**Getting responses:** Many healthcare practices, including MYCHILD-LAUNCH demonstration sites, have tried this approach but had limited success in achieving goal survey completion. **No Opportunity For Discussion:** Families may identify key problems in surveys, but they are not present for discussions to co-develop solutions and may never know if their input mattered.
Suggestion Boxes	Anonymous, brief written feedback that can be collected in the health practice.	**Literacy Level**: Will families be able to write responses that fully express their feedback? **Primary Language**: How will you support families to write suggestions in their native language?	**Low Response Rates:** Often times suggestion boxes are underutilized and contain little information regarding specific systems **Limited Follow-up:** No ability to discuss the suggestion with the responder for clarity or to demonstrate the change made in response

Strategy	Implementation	Family Considerations	Challenges Experienced
Focus Groups and Key Informant Interviews	Group opportunity for families to share opinions and ideas on the services received or systems experienced; allows for participants to build develop ideas in the context of peers. Individual opportunity for families to share opinions and ideas on the services received or systems experienced; allows for more in-depth feedback than an individual survey.	*Accessibility is the main consideration. Requires administrative time arranging logistics (space, food, childcare, etc.) to support family recruitment and adequate preparation time to ensure questions are understandable and accessible to all families.* **Timing:** What time of the day is most convenient for families to participate in a group discussion? Where is a convenient community location for this meeting? **Recruitment:** How will families find out about the focus group? **Language Capacity:** How will the focus group be accessible to families whose primary language is not English? **Logistical Support:** Will families receive support with food, transportation, and/or childcare? **Emotional Support:** What happens if a family discloses an urgent or crisis-level concern during the focus group? Who will follow up?	**Time Intensive:** Planning and leading focus group takes a lot of planning. Adequate time must be dedicated to preparing questions and arranging logistics to support family participation. There needs to be a designated lead organizer. **Facilitation:** Focus groups require a facilitator who has training and experience in leading. The health practice may need external support in running this group. **Accessibility:** For families facing multiple stressors, it may be difficult to commit to a focus group. **Cost:** To provide the supports needed for all families to access the group, funds must be dedicate to the focus group to cover transportation, food and childcare.

Strategy	Implementation	Family Considerations	Challenges Experienced
Designated Parent Representatives	Consumers of services who are trained to advise on healthcare services and systems and are compensated for their time. These representatives are colleagues to health care providers and administrators in shaping systems.	*Parent readiness to be in a leadership role is a key consideration. This requires close consideration of parent recruitment and training to support participation in systems improvement.* **Parent Readiness**: How will you identify parents who have experienced services and are now ready to take on leadership roles? **Training**: How will you train parents on leadership skills to effectively influence systems? **Representation:** How will you ensure that parent leaders are representative of the community served, including immigrant populations? Need for interpreters?	**Very Time Intensive:** Recruiting and preparing parent representatives to be leaders in the medical home takes a large time commitment, especially if you strive for parent leaders who directly experienced the services you are aiming to improve. This takes a designated Core Team lead and carved out time for planning and preparation. **May Require External Expertise:** If your health practice doesn't have experience with fostering parent leadership, then external expertise may be needed to inform. Technical assistance resources are available for this, though some will require additional funds depending on the collaborating organization. **Requires Additional Provider Time:** This approach also requires provider preparation to effectively integrate parent reps into decision making processes.

Worksheet 1: Experience with Parent Feedback

This worksheet will help you answer the question: What is your medical home's experience with parent feedback? Use this exercise to take stock of how you already incorporate parent voice and how you can do so in the future.

1. **What strategies has your health practice already used to bring parent voice to improvement efforts?**

List each strategy and describe the context of its use.

_____
_____
_____
_____

Example: The practice previously designed a survey that families completed after their medical appointments that was aimed at understanding wait times (how long patients had to wait to at different points in their medical visits).

2. **What specific questions did your practice aim to answer by using each strategy?**

What systems or service were you trying to better understand or improve?

_____
_____
_____
_____

Example: The practice was trying to better understand patients' experience in waiting for providers, since families were clearly frustrated with wait times. We wanted to know the average time patients waited to check-in with the receptionists, to see medical assistants, to see physicians, and to receive vaccinations (by nurses) at the end of the visit. We were trying to collect data to determine where in the process the wait-time was longest so we could focus on developing new protocols to reduce the overall time patients wait for multiple providers.

3. **Who was the "lead person" in implementing this strategy at the health practice?**

What additional supports, technical assistance, partnerships, or funding resources were needed to implement this strategy?

What expertise did the lead person offer in implementing this strategy?

_____
_____
_____
_____

Example: There was a nurse manager who led this implementation of the survey. She had experience from her previous jobs in writing surveys that were simple and well understood by families. She could also translate this survey into Spanish as a native speaker.

4. **What was the parent response rate to the strategy?**

Did parents actually respond to the strategy?

Was parent response representative of the patient population or population accessing that specific service or system? Whose voice is missing from the feedback obtained?

_____
_____
_____

Example: We had about 25% of families seen in pediatric visits complete the survey at the end of the visit over a 3-month period. All responses were in English; however, we know that 18% of our pediatric population have caregivers whose primary language is Spanish.

5. **Meaningful Use: How informative was the parent response in answering the questions proposed?**

Was the feedback elicited detailed enough to inform systems?

Were responders able to engage in ongoing dialogue with providers to clarify feedback or discuss solutions? Did parent voice actually influence a systems or service decision?

_____
_____
_____

Example: The objective feedback about wait-time for different provider roles was helpful. We identified that wait-time for vaccinations after the completion of the physician-patient encounter as the longest time patients waited, or at least perceived to wait. We asked an administrator if we could reduce this time by altering the schedule of nurses on, especially during peak clinic afternoon hours. We wondered if there were ways to improve patient experience overall during the wait times—like having more educational or interactive materials available in the rooms for parents and children. We wanted to engage parents in a discussion on this follow up question, but did not do so.

6. **What are the Core Team members' skills that can be used to facilitate parent engagement in systems improvement?**

(Consider the whole medical home, but in particular the Core Team members as they will likely be the initial lead on parent engagement efforts in improving children's mental health services in primary care at your practice.)

Has anyone lead focus groups before? Does anyone have experience writing surveys? Analyzing surveys? Does anyone have experience training parent leaders?

_____
_____
_____

Example: Our Family Partner has participated in various parent leadership trainings through local community organizations; she can advise us on which leadership curriculums would be most useful in content to train parent representatives. Our Administrator knows the IT person in the medical home who has the most experience in designing surveys and electronically recording data.

TIPS FOR CREATING A PATIENT SURVEY
Bowdoin Street Health Center, MYCHILD QI

The following tip sheet was created by Bowdoin Street Health Center's MYCHILD team as part of a quality improvement process to better understand family's reasons for disengagement. It provides tips for writing family surveys. Following this, please see sample surveys from demonstration sites.

Identify your Target Audience: Current patients? Past patients? A sub-group of patients whose perceptions and opinions you would like to learn more about?

Write the Survey Questions*:* Think of how to frame your questions into a few general categories. Common categories include questions regarding accessibility, quality, and how patients feel treated.

- Frame your questions as statements and use a Likert scale to categorize answers. Use an even number of categories on the Likert scale to "force" patients to answer in either a positive or negative manner.
- Use language that is easy to understand. Share your survey questions and format with other staff members or patients to assure that the intent of the questions is being portrayed.
- Think about whether you want the survey to be completely anonymous. You could ask patients to write in some identifying information (e.g. age of the child by category), while still keeping the survey anonymous.

Distribution*:* Decide whether you are going to give surveys directly to patients, mail the surveys, or have a staff member call the family and complete the survey by phone. You will want to decrease as many barriers to completing the survey as possible. For example, if you mail the survey, include a return envelope that is pre-addressed and stamped.
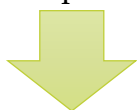
Results*:* Identify how you will track your results. Use your initial round of results to give you information about success of the survey questions, distribution, etc.

Sample 1: Family Experience Survey

Boston Medical Center, LAUNCH QI

You were referred to Project LAUNCH by your pediatrician for support around your child's behavior and development. We are asking you to provide some **CONFIDENTIAL FEEDBACK** about your experience with the referral and service delivery so we can improve our services. Please answer these questions and mail this back in the enclosed stamped envelope.

Thank you for your participation! ☺

① Were you aware that your Pediatrician referred you to Project LAUNCH?
❑ Yes
❑ No

② Did your provider explain to you what Project LAUNCH was and what services we provide?
❑ Yes
❑ No

③ During your visit with the Pediatrician did you express concerns about:
❑ Your child's behavior
❑ Your child's school performance
❑ Your child's development (speech, walking, playing or other skills)
❑ Your child's eating, sleeping or toileting issues
❑ Other issues:_____

④ Were you interested in services around these issues at the time of your visit?
❑ Yes
❑ No

⑤ Did your provider explain that the LAUNCH team would call you to schedule an intake?
❑ Yes
❑ No

⑥ Did we meet you the day of your visit with the Pediatrician?
❑ Yes
❑ No

And did it make a difference in your decision to enroll in services?
❑ Yes
❑ No

⑦ If you did not schedule an intake with us, which were the main reasons that led you to decide against receiving services? Select as many as apply.

❑ Did not agree with the pediatrician's referral

❑ Not interested in support

❑ Other stressors in my life at this point (homelessness, unemployment, personal issues, etc.)

❑ Did not receive your voicemails and letters

❑ Received voicemails and letters, but was unable to call back to schedule intake

If you **HAVE RECEIVED SERVICES** from Project LAUNCH, if possible please provide brief responses to the following questions:

When we met with you we might have asked you to fill out some questionnaires. Was that a burden for you?

_____

_____

When you call/email one of the Project LAUNCH staff, what are the main reasons you do so?

_____

_____

_____

What are the things you most value in our services? What are the things we could improve?

_____

_____

_____

If you could tell another parent why you enjoy this service, what would you say?

_____

_____

_____

Anyone that received or did not receive services, that wishes to provide more feedback, please do so here:

_____

_____

_____

_____

THANK YOU FOR YOUR PARTICIPATION! ☺

Sample 2: Family Experience Survey

Bowdoin Street Health Center (BSHC)QI

		Strongly Agree	Agree	Disagree	Strongly Disagree
1)	I felt that MYCHILD home visits were helpful.	4	3	2	1
2)	I felt that MYCHILD office visits were helpful.	4	3	2	1
3)	I felt that weekly visits were helpful.	4	3	2	1
4)	I understood how the MYCHILD team could help me.	4	3	2	1
5)	Treatment and information were provided to me in a language and way that I could easily understand.	4	3	2	1
6)	MYCHILD helped me learn some skills to help me and my family.	4	3	2	1
7)	I felt pressure from staff at BSHC to join the MYCHILD program.	4	3	2	1
8)	I felt that the MYCHILD team understood and respected me.	4	3	2	1
9)	I felt that my family needed help at the time of our referral to MYCHILD.	4	3	2	1
10)	Overall, I felt satisfied with the MYCHILD program at Bowdoin Street Health Center.	4	3	2	1

Please feel free to provide any other comments about the care you received through the MYCHILD program:

ASSEMBLING PARENT LEADERSHIP GROUPS AND FOSTERING PARENT-PROFESSIONAL PARTNERSHIPS

One strategy for bringing parent voice to healthcare systems is employing parent representatives or creating a Parent Council. Parents leaders can play a multitude of roles in improving healthcare systems and services, often bridging the gap between patient perspective on what matters for families and provider perspective on what families need. There are many opportunities for parent leaders to influence healthcare services and systems.

For example, parent leaders can provide structured feedback on the usefulness of services or the accessibility of written materials from a consumer perspective. They can participate in a quality improvement process, often proposing feasible changes that have a big impact on family engagement in and satisfaction with services. Over time, parent leaders can be incorporated into health management teams or boards who have decision-making power regarding medical home systems.

Parent leaders can also serve as ambassadors to other parents, thus spreading valuable health education or resource information among consumers in the medical home and in the community more broadly.

Challenges of Parent Leadership

While the possibilities for parent leadership on medical home systems are vast, there are several challenges that health practices face in integrating parent leaders into the existing management structures at their practice. These challenges may be more pronounced when engaging parents facing the stressors commonly experienced by the patient population as a whole.

Logistical challenges may include:

• compensating parents for their hours of work
• arranging for language interpreters
• supporting parent participation with transportation and childcare

Perhaps more importantly, no matter how much parents and providers want this type of partnership to thrive, interpersonal challenges arise as well. Here are some examples:

• Parents and providers may both feel self-conscious about their opinions in the presence of the other, like they may "offend" other participants.
• Parents and providers may both feel "blamed" by the other for problems in services, without recognizing the positive intent of each other.
• Cultural expectations around participation and behavior in formal meetings might differ, leading to providers or parents feeling inappropriate or unappreciated.

To ease these challenges, ample preparation and reflection must be done with parents and providers prior to starting the work. Here are two ways to do so:

1) Parents, especially if new to management roles, may benefit from additional training leadership training to understand the format and culture of traditional management meetings as well as develop the self-efficacy to effectively voice opinions.
2) Providers may benefit from reflection on how to incorporate family voice in to meetings and how to breakdown traditional medical hierarchies to foster equal participation.

Dedicating a small amount of time for preparation can be powerful in bringing together providers and parents in successful partnerships for system improvement.

Employing Parent Leaders

In MYCHILD and LAUNCH, employing parent leaders was a primary strategy for ensuring parent voice influenced new medical home services, community-based promotion efforts, and state-wide stakeholder discussion regarding policy.

The Lead Family Partner, an administrative role held at the Boston Public Health Commission, became the point person in supporting parents as colleagues in decision-making. The Lead FP provided technical assistance on fostering parent-provider partnerships to demonstration sites while also creating a cross-site Parent Council to inform every level of the grant. "Parents with a Purpose," the MYCHILD-LAUNCH Parent Council, soon became the go-to team for parent feedback and discussions on MYCHILD and LAUNCH services. It also became a launching point, because the council provided training that then enabled parents to participate as colleagues in a wide variety of city and state councils on children's mental health services.

The experience creating, supporting, and learning from Parents with a Purpose lends to many insights on the powerful impact of parent leaders in shaping systems as well as the challenges that can arise in parent-provider partnerships. Of note, this specific Parent Council had a dual purpose of training parents to be leaders while also integrating parent leaders into decision-making forums to shape and improve healthcare systems. Other Parent Councils may focus entirely on giving a voice to parent leaders who may already have significant training and skills that enables them to be colleagues within the medical home.

Materials in this section can inform your approach to fostering parent leadership in systems improvement, whether your practice pursues individual parent leaders or a full parent council. The tools include:

- General guidance on forming a Family Advisory Council and fostering parent-provider partnerships, through formal handbooks and toolkits from the National Initiative for Children's Healthcare Quality.

- Parents with a Purpose example materials of how to recruit parents, structure a council, train parent leaders, and creatively integrate parents into leadership forums as colleagues.

Many of these materials were developed and written by the Parents with a Purpose council, thus reflecting their culture and experience in defining their role as a group.

Parent Council Recruitment Process and Selection Criteria

(MA Partnership on ECMH)

The following brief information on recruitment process and selection criteria were written by the MYCHILD-LAUNCH Parent Council.

Process for Identification:

Family Partners and Clinicians can refer a family to represent their center and serve on the parent council. Each site should aim to identify two people.

Guidelines For Parent Selection:

The parent should have experience participating in either MYCHILD or LAUNCH services as a caregiver. The best candidates:

✓Actively engage in the MYCHILD or LAUNCH program and demonstrates the ability to overcome challenges

✓Show interest in discussing issues and concerns parents face in raising young children

✓Want to improve services for families facing stress or mental health challenges

✓Show willingness to serve on LAUNCH or MYCHILD workgroups and will be able to serve if selected

✓Have an interest in and want to learn more about community partnerships, the medical home

✓Are willing to abide by the guidelines of the parent council (see the following handbook)
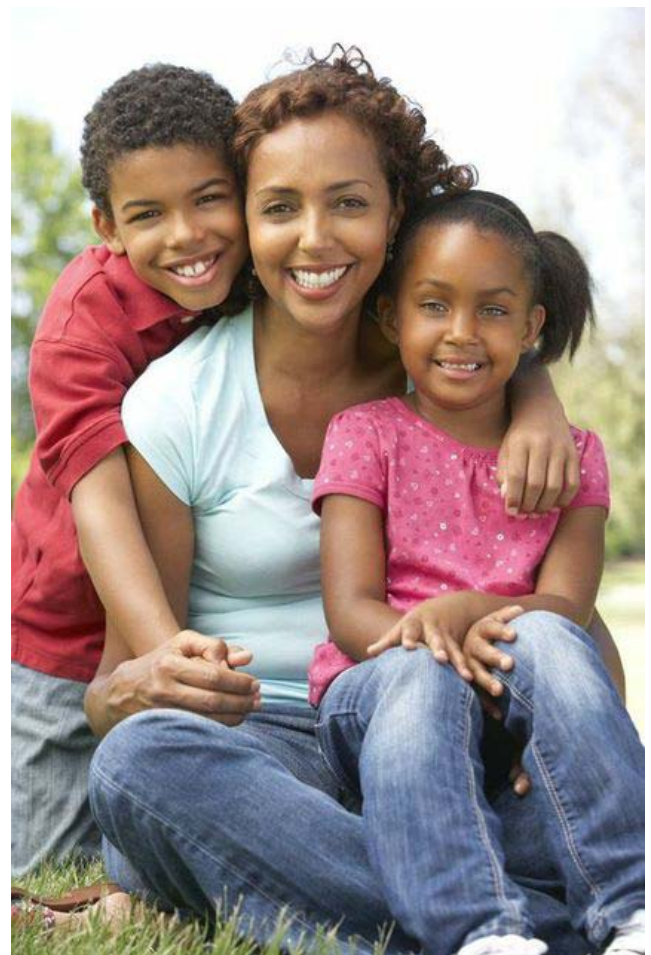
Parent Council Roles and Responsibilities

*Providers can use the following points to explain the role of the Parent Council to potential members:***

First…

Participate in monthly leadership workshop and prepare to be colleagues in improving programs and services

Then…

- Improve healthcare services and collaborations between community programs and healthcare services for young children and their families by sharing with intention lived experiences.
- Identify family friendly activities and events to support social and emotional wellness.
- Share experiences with intention to increase the awareness of the importance of social and emotional wellness for families.

***Use the flyer sample on the following page to recruit parents for the Parent Council.*

Sample 1: Parent Council Recruitment Flyer

Project LAUNCH and MYCHILD

Parent Council

Parent Representatives

The Parent Council is a group of parents, with different abilities, experiences and backgrounds working together to improve young children's wellness.

Do you think the Pediatrician's office is a place parents should go to get support raising happy, healthy children?

Have you ever thought you had an idea that could make childhood in Boston better?

Is a child's mental health and wellness as important to you as physical health?

Are you a parent or guardian interested in using your voice of experience to improve child wellness in Boston?

Details to consider:

➢ Meetings will be held during the day for two hours every month.

➢ The date, time and location will be decided based on the availability of council members.

➢ Parent representatives receive a $35 gift card/stipend to cover transportation and for attending meeting.

➢ Childcare and translation will be provided upon request.

If you answered yes to any one of these questions, <u>please consider contributing your ideas and opinions</u> to the Project LAUNCH and MYCHILD Parent Council as a Parent Representative for your site.

Organized by Boston's Public Health Commission

Sample 2: BPHC's Parent Council Handbook

The following text is from the Boston Public Health Commission's (BPHC) Project LAUNCH and MYCHILD Parent Council Handbook, which provides guidelines for developing and running a parents' council. We have included the Foreword to provide insight into the handbook's content and goals.

BOSTON PUBLIC HEALTH COMMISSION

Project LAUNCH & MYCHILD Parent Council Handbook

© Boston Public Health Commission
1010 Massachusetts Avenue
Boston, Ma 02118
Phone 617.534.2018 • Fax 857.288.2332
Website: ecmhmatters.org

Contents

FOREWORD

Massachusetts Young Children's Health Interventions for Learning and Development

MYCHILD is a SAMHSA-funded *System of Care (CCMHS)* initiative that integrates early childhood mental health in pediatric medical homes. The project is a collaboration of families, health centers, and child serving agencies led by the MA Executive Office of Health and Human Services and Boston Public Health Commission in partnership with 3 pediatric medical homes & Health Care for the Homeless. MYCHILD aims to identify young children (birth- 1st grade) with significant behavioral and emotional needs and provide them with individualized, coordinated and comprehensive services. MYCHILD also aims to build the capacity of pediatric medical homes and community-based organizations to support young children with social and emotional needs through consultation and training.

Linking Actions Unmet Needs in Children's Health

In Massachusetts, Project LAUNCH is a collaborative effort led by the Department of Public Health. The Boston Public Health Commission oversees local LAUNCH efforts to improve systems of care for Boston children. The project is collaboration of families, health centers, and child serving agencies. Boston LAUNCH direct services are provided for children ages 0-8 and their parents at two community health centers and the pediatric primary care clinic at Boston Medical Center. These services focus on strengthening families' understanding of early childhood development and specifically supporting their children's social and emotional development.

BPHC Parent Council Mission Statement

The Project LAUNCH and MYCHILD Parent Council is a place to develop empowerment skills, build-up self-efficacy, explore healthy family growth and develop opportunities that are not dependant on long-term public support. Families maintain healthy interdependence with extended family, friends, spiritual organizations, cultural and community groups, schools, community agencies, and physicians. The council builds awareness of the family's role in public health, and provides a platform for families' voice to be heard and included in the continued development of the ECMH programs. Members have a primary role in the decision making process and an opportunity to make an important contribution to their communities.

BPHC Goals of Parent Council

- Parent Council members will become resources to their fellow members, families, and communities.
- Provide ECMH Team flexible and responsive feedback to emerging service and community issues.
- Build family engagement in all program activities, including planning, governance, and administration.

The council will:

- Positively impact young children and their families, professionals and programs.
- Increase coordination and collaboration among service providers.
- Enhance communication with service providers, engagement, and cultural responsiveness.

Parent Council Statement of Purpose

As participants of the Project LAUNCH and MYCHILD Parent Council, we feel it is a place to gain information about raising children and healthy households through the exchange of knowledge and resources. We share our experiences to empower other families in the community.

We commit to enhance programs and support services for children and families in our communities. We will do this by collaborating with each other and fully participating in the Council by bringing honest information and feedback to help improve health programs, influence policies, and program materials distributed to families.

Goals Composed by Parent Council Members

- To build leadership skills and develop job skills
- To build empowerment
- To share and learn from each other
- To create opportunities to learn and participate in community programs
- To empower members to identify and respond to community needs
- To build parent leaders.

Parent Council Tag Line

Parents with a Purpose: listening, learning, and leading the charge for change

Membership Guideline

ECMH family partners and clinician's can refer a family to represent their center and serve on the parent council. Each site will identify 2 people. Members will take on various roles such as participating in activities, workgroups or serving in a leadership roles.

Guidelines to be considered for selection:

-Actively engages in the program and demonstrates the ability to overcome challenges.

-Willing to be a candidate for workgroups and able to serve if selected.

-Has an interest in community partnerships, medical home, and is a willing learner.

-Willing to abide by the guidelines of the parent council.

Parent Council Members Roles and Responsibilities

-Identify family friendly activities and events to support social and emotional wellness.

-Share experiences with intention to increase the awareness of the importance of social and emotional wellness for families

-Improve services for families facing stress or mental health challenges

-Enhance collaboration among community programs and services for young children and their families by sharing with intention known experiences that may improve services.

-Serve on at least one workgroup related to ECMH programs.

Confidentiality Statement

Creating a safe, secure environment where families feel comfortable sharing personal experiences, ideas and opinions is of utmost importance to the Council. To this end, participants must exercise confidentiality regarding the sharing of personal information. In the case where a participant is not sure whether information shared is confidential, please consult with the Lead Family Partner for guidance.

Parent Council House Rules

In order to create a safe, productive, respectful environment for all participants, the parent council has established the following house rules.

Dress code: All members are expected to represent ECMH in business casual attire and model a standard of professionalism at all events.

Code of Conduct

-Be respectful of others and do not judge.

-Build each other up and do not tear others down.

-Give others opportunity to speak and voice opinions.

-Make a commitment to be present and involved in every meeting. Arrives on time and stay the duration of the meeting.

-Keep personal stories confidential.

-Use nice or neutral language.

-Avoid side conversations and use of cell phone calls.

-Phones should be on vibrating mode during meeting or events.

Transportation

The Early Childhood Mental Health program at BPHC occasionally use the Metro Cab Association, Inc. to provide clients transportation to and from approved program events, meetings, and trainings when needed (as determined by BPHC staff) by the family. There are two voucher payment methods: paper vouchers and electronic vouchers. BPHC staff reserve the right in selection of voucher method. While taxis use is reserved for approved events, BPHC staff reserve the right to limit or deny usage. The council aims to support parents in identifying other transportation options that will enable them to attend.

Expectation for Attendance

The parent council meets every third Wednesday of the month. Members should attend every two-hour meeting of the parent council, unless otherwise noted and shared with the Lead Family Partner. Members are expected to arrive on time, engage in the meeting, and stay for the entire time of the meeting.

Childcare

The ECMH program uses Arbor Staffing Association, Inc. to provide childcare for parent while attending a parent council meeting. Children can range in age from 0 to 8 years. It is ECMH practice to have a minimum of two childcare providers at a parent council meeting when childcare is requested. It is necessary for parent to notify the Lead Family Contact 48-hours prior to the scheduled meeting if it is a need for childcare. When space allows, children will have separate space in the same building of the parent council for childcare.

Food

Balanced meals are provided by Serving Our Selves Caterer (SOS). Parents are responsible in informing the Lead Family Partner, (LFP) of any diet restrictions or allergies, when LFP calls to confirm attendance for monthly meetings. Parents are responsible for preparing food selection and bringing food over to the childcare room for their child(ren) attending childcare at the parent council meeting, workshop or activity.

Stipends

Council members are compensated by gift cards for their unique expertise, time and participation in monthly parent council meetings, workgroup or events. The recognized rate of $35.00 per quarter day will be distributed at the end of the meeting or workgroup. The Lead Family Partner will request that each council member sign a Card Request & Distribution Form, for the purpose of documenting and recording stipends. This policy is implemented to assure respect for family.

Contact Us

Contact Information:
All questions in relation to the structure and practices of the Project LAUNCH and MYCHILD Parent Council should be directed to:
Gloria Weekes

PARENT LEADERSHIP SERIES CURRICULUM
MA Partnership for ECMH and Parent-Professional Advocacy League

This curriculum was used by the learning series to help teach parents about leadership and enacting change.

Module 1
Awareness and Development of Personal Leadership Style

Objectives	Materials
1) Participants will gain an understanding of leadership. 2) Participants will be able to identity leadership styles. 3) Participants will be able to identify their leadership styles.	• Awareness and development of leadership styles • Pre-leadership self-assessment survey • Two interactive activities

Module 2
Parents as Change Agents

Objectives	Materials
1) Participants will gain an understanding of how the family movement began. 2) Participants will be able to deliver their message clearer. 3) Participants will gain an understanding of the six stages of change. 4) Participants will be able to identify the problem and work toward a solution.	• Overview of the family movement • Refining and defining the message • Characteristics and techniques in the stages of change • One interactive activity

Module 3
Council Essentials

Objectives	Materials
1) Participants will gain an understanding of how to work as a team. 2) Participants will gain an understanding of Honesty, Accountability, Respect and Trust. 3) Participants will gain an understanding of what second chances and fresh starts mean.	• Acknowledge of each members contribution • Communication skills quiz • Two interactive activities

Module 4
Communication Skills and Strategies

Objectives	Materials
1) Participants will learn how to communicate effectively using their voice. 2) Participants will learn active listening skills. 3) Participants will learn what strategies are needed for effective communication. 4) Participants will learn what's needed to run a productive meeting. 5) Participants will learn the formatting of a newsletter.	• Interactive exercise • Effective communication strategies • How to run a productive meeting • Starting a parent council newsletter • Three interactive activities

Module 5
Collaboration and Challenges

Objectives	Materials
1) Participants will gain an understanding of collaborating. 2) Participants will gain an understanding of principal of an effective team. 3) Participants will gain an understanding of several strategies of becoming a better negotiator.	• Collaborating exercise • 10 principles of an effective team • One interactive activity

Module 6
Raising Public Awareness around Your Issues of Concern

Objectives	Materials
1) Participants will gain an understanding of what a community is. 2) Participants will be able to express themselves in a written letter.	• Key components of a community • Case study • Two interactive activities

Example Curriculum Activity: Developing Your Personal Story

Parents can use this exercise to prepare their story and develop how their lived experience will contribute to advocacy efforts, speaking engagements, participation in community meetings, etc.

My story is:

The Story of a working mother with a son diagnosed with a mental health condition.

What Lessons Can I share?

- ✓ Need for flexible time
- ✓ Importance of being organized
- ✓ The ability to leave work at work to be fully present at home

Select one lesson to be your message. Then…

Give a specific example in your life that illustrates the lesson learned/your message. Limit yourself to 5 sentences.

I received a call from school principle about my son involvement in a fight.

School wanted to have a immediate meeting with him.

I wanted to be there to advocate on his behalf because his diagnosed condition can contribute to his inability to interact with peers.

I told the school that they are not to meet with him without me.

I was able to leave work and go to the school and speak to the Principal and be a part of the meeting.

Now that you have a story and a message, check to make sure you have the right story using "The CRY Test."

Does it **Connect** the audience to your message?

Is it **Relevant** to the message?

Is it **Yours**, does it add the personal touch?

Example Letter: Preparing Parents to Participate in Multidisciplinary Meetings

Below is an example of a letter sent to select Parent Council members to prepare them for participating in the MYCHILD-LAUNCH Learning Collaborative. It is an example of the preparation that helps before meetings to support parents to be colleagues at multidisciplinary meetings.

When: October 23 and 24, 2012; 9:00am-4:00pm (Continental breakfast and lunch will be served)
Where: Kroc Center, 650 Dudley Street, Dorchester
Who Organizes It? Boston Public Health Commission
Contact: Gloria Weekes (_____#)

We welcome you to participate in our Learning Session:

What Is it?

This is a meeting with health centers that have MYCHILD or LAUNCH services. The purpose is to have health center teams think through ways to improve MYCHILD or LAUNCH services for families. The participants include clinicians, family partners, doctors, parents, and community partners. Parent voices are really important to have in this meeting.

Why Come?

Your opinions matter. You can influence how MYCHILD or LAUNCH serves families in Boston. You will be able to share ideas on how to make MYCHILD or LAUNCH services useful and helpful to families. Also, depending when you come, you will hear about topics such as children's mental health services, changes in housing resources, and changes in health center systems. For specific information on sessions, see the agenda. Please contact Gloria with questions.

What to Expect?

You can expect to sit next to family partners, clinicians, doctors, and management staff. This may include the family partner and clinician you have met through MYCHILD or LAUNCH. You would hear large group presentations and see slides.

Also, you will be asked to join small table discussions on topics such as how to better engage families in MYCHILD or LAUNCH programs. During small group discussions, you will be encouraged to share your opinions, like all participants. You will also be asked to fill out a survey on your experience at this meeting.

LEADERSHIP OPPORTUNITIES FOR PARENT REPRESENTATIVES

During and after participation in training, Parent Council members from MYCHILD and LAUNCH have become colleagues in decision-making on early childhood mental health interventions, both as individuals and as a collective council. Below are examples of the roles and responsibilities the Parent Council members have assumed as leaders in improving systems for children's social and emotional health.

Shaping Medical Home Systems and Services:

1. **Improving Parent Engagement Materials**: The Parent Council has reviewed MYCHILD and LAUNCH materials, including program brochures and family education handouts, to improve the accessibility of service information in demonstration sites.

2. **Participating in Quality Improvement**: The Council served as a focus group to inform the quality improvement efforts of a LAUNCH demonstration site striving to improve family engagement in services. Council members recalled their own experience with referral and assessment processes in LAUNCH and identified factors that most significantly affect whether they would engage with a provider for support on their child's social and emotional health.

3. **Informing the Medical Home Learning Collaborative**: Council members participated in multiple Learning Sessions of the MYCHILD-LAUNCH Learning Collaborative. They specifically advised on the agenda of the fourth learning session, highlighting the need for discussion between providers and families on trauma-informed care; an expert presentation and discussion at the learning session resulted from their guidance.

4. **Informing Evaluation Efforts:** The Council has also reviewed evaluation materials (focus group questions, parent surveys) to ensure that questions are asked in ways families will understand and freely respond. Parent Council members also have the opportunity to serve as parent interviewers for the MYCHILD evaluation, if no longer participating in services.

5. **Focusing Sustainability Efforts**: As the MA Partnership for ECMH explores strategies for sustaining the Family Partner-Clinician dyad model after grant funding, the Parent Council provided key feedback on which services are most critical to sustain from a parent perspective. This input helps precisely identify the MYCHILD-LAUNCH service strategies that parents perceive to have the greatest impact.

Mentoring Peers and Leading the Council:

1. **Mentoring Peers:** The first parents to join the Council now serve as mentors to new council members, providing peer support as new parents participate in leadership trainings.

2. **Representing the Council at National Conferences:** Parent Council members have attended National Conferences led by the Substance Abuse and Mental Health Services Administration and the National Federation for Children with Mental Health Needs. With the support of the Lead Family Partner, these parents participated in workshops aimed at fostering parent leadership in shaping children's mental health services. Parent Council members returned to Boston to present information learned and engage peers in discussion on strategies for family voice in mental health services.

3. **Providing Parent Council Leadership:** The Parent Council informed the development of a new part-time position, the Parent Engagement Specialist, created for early childhood mental health at the Boston Public Health Commission. This specialist will assist program staff to develop parent engagement materials, create a Parent Council newsletter, and provide administrative support in staffing the Parent Council.

The specialist will also be a supportive role in Learning Collaborative activities for participating medical homes, identifying best practices in pediatric healthcare settings, and developing outreach strategies and tools to promote family engagement. This is a key leadership opportunity for a former or current Parent Council member.

Promoting Children's Mental Health Throughout the Community:

1. **Advising on the Social Marketing Campaign**: The Parent Council shaped the social marketing campaign of the MA Partnership for Early Childhood Mental Health, providing feedback on the acceptability of messages from a parent perspective. These materials are now available in medical home demonstration sites, aimed at improving family and provider awareness on the importance of asking about children's social and emotional development in the pediatric medical home.

2. **Building Collaborations with Community Partners:** Given their lived experience and leadership training, Parent Council members are consistently invited by various community partners (ABCD Headstart, Children's Museum Boston) to share experience and opinions on effective strategies supporting children's social and emotional health. These discussions span child-serving agencies outside of medical homes. Once community partners are aware of a parent leadership group, multiple opportunities will arise for parents to inform community-wide systems and serve as ambassadors in strengthening collaborations between the medical home and community agencies.

Informing State Discussion on Children's Mental Health Services:

1. **Participating in the Young Children's Council (YCC)**: The Young Children's Council is the joint state governance council for the LAUNCH and MYCHILD grants It convenes leaders from state and community agencies, health, mental health and advocacy organizations, and family and youth representatives. The YCC has guided the implementation of the two grants and their sustainability efforts. Parent Council members have presented on the families' experiences with MYCHILD and LAUNCH and participated in discussions with the YCC at least annually.

2. **Bringing Parent Perspective to State Systems:** As the MA Partnership for ECMH is led by both the Massachusetts Executive Office of Health and Human Services and the MA Department of Public Health, the Parent Council has a direct link to state representatives shaping healthcare policies and forums for stakeholder discussions. For example, one Parent Council member is participating in a panel led by the MA Department of Public Health on ECMH in the Context of Health Reform and Payment Reform for the State Mental Health Planning Council. This brings the lived experience of parent to state-wide advocacy for a focus on early childhood in a changing healthcare environment.

Parent Leadership Group Resources

1) National Initiative for Children's Healthcare Quality

➤ Creating a Patient and Family Advisory Council:

A Toolkit for Pediatric Practices[15]

Provides a toolkit that is destined to help pediatric practices create their own Patient and Family Advisory Council. It provides stepwise process guidance on how to engage families the in the design of services and in efforts to improve the overall quality. The toolkit was made in collaboration with the Family-to-Family Health Information Center at the *Federation for Children with Special Needs* and *Mass Family Voices*.

➤ Powerful Partnerships:

A Handbook for Families and Providers Working Together to Improve Care[16]

Provides support for both providers and families on partnering together as colleagues to improve care for children with special needs.

2) Parent Professional Advocacy League

The Parent Professional Advocacy League[17] (PPAL) is a Massachusetts statewide family organization that advocates for improved access to mental health services for children, youth and families. A core part of their mission is to nurture parent leaders as agents in system change. PPAL offers leadership development curriculums for family members, aimed at giving family members the knowledge and skills to participate in leadership roles in their families, teams, communities and state. The curriculum is rooted in the belief that "parent leadership is achieved when parents and professional build effective partnerships, share responsibility and decision making power, and respect each others' unique contribution."

The MA Partnership for Early Childhood Mental Health partnered with PPAL to train parent representatives of the MYCHILD-LAUNCH Parent Council.

6) Engaging in Quality Improvement Efforts

Continuous quality improvement (QI) is an important part of launching any new initiative aimed at improving healthcare services and systems for families in a pediatric medical home. A structured approach to improving service delivery enables the Core Team as a whole to better promote social and emotional health throughout the practice. Furthermore, the QI process helps the Core Team increasingly engage other health practice providers and administrators who might not otherwise be connected to the Family Partner and Mental Health Clinician (IT staff, senior administrators, billing managers), thus advocating for the importance of social and emotional health.

Structured quality improvement may be a new practice for some Core Team members. Thus, building a strong foundation for QI process is an important first step. Collectively using an existing QI approach (e.g. Plan, Do, Study, Act, or PDSA) will lay a foundation that enables all team members to participate equally and use a common QI "language." Carving out time for the QI process is key; you may find it useful to have the process structure part of the monthly Core Team agenda as this helps maintain accountability for improvement.

The tools in this section are from the MYCHILD-LAUNCH Learning Collaborative created to support demonstration sites in practice improvement through the integration of early childhood mental health. Site teams used a "Dream, Discover, Design, and Deliver" ("4Ds") framework, a modified version of the PDSA cycle, to set and strive for their own quality improvement goals. The 4Ds guided sites to dream a goal for improvement, discover system processes related to the goal, design a specific change strategy to achieve the goal, and deliver the change with process measurement to determine efficacy and value of spread. Each site identified a QI Leader who represented their team in monthly conference calls to articulate improvement goals, demonstrate measured results, share tools, seek peer feedback and devise new change strategies.

The Learning Collaborative, specifically the QI process at demonstrations sites, greatly influenced the implementation of both LAUNCH and MYCHILD at multiple sites as well as informed this toolkit. Similarly, the Core Team's QI at any health practice has the potential to broadly influence behavioral health-primary care integration throughout the whole medical home. This potential for broader systems change is another reason to engage in structured QI as a key part of this model.

QI PROCESS SNAPSHOT:
DREAM, DISCOVER, DESIGN, DELIVER

These four steps encourage you to think about each important piece of the quality improvement process. Overall, you are determining your goal and how you'll deliver the changes you plan to make.

Dream

What is a specific challenge you face in MYCHILD or LAUNCH, and what would the project be like if the challenge were removed?

Discover

What processes cause the challenge and what processes are high-yield and feasible to change?

Design

What strategies will you use to make a change? What specific action steps will you do? How will you measure the progress?
State your specific QI aim.

Deliver

This is the action phase. Implement the changes and measure progress. Reflect upon data measured, and summarize lessons learned. Was the change effective in reaching your goal? What changes should be replicated or up-scaled?

Dream | Discover

Deliver | Design
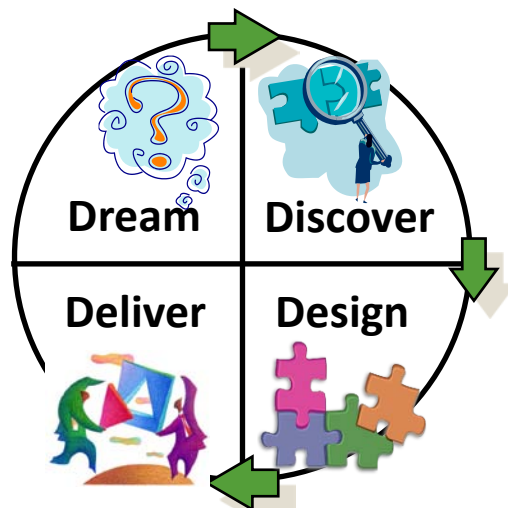
EXAMPLES OF QI GOALS AND PROJECTS
FROM DEMONSTRATION SITES

Before you get started on brainstorming your own quality improvement goals and strategies, take a look at some examples from demonstration sites.

Below are examples of QI goals and improvement strategies that demonstration sites choose to implement through MYCHILD and LAUNCH. These lists and summaries are provided as examples of the breadth of QI projects Core Teams have engaged in to support the social and emotional health of families in the medical home.

Both grant administration and Core Teams experienced a steep learning curve in the process with increasing emphasis on measuring progress. Accordingly, the summaries of the QI projects in years 2012-2014 reflect more in-depth experience in collecting and using data than initial 2011 summaries. We provide both to demonstrate the shared learning across demonstration sites through the LAUNCH-MYCHILD Medical Home Collaborative.

Specific summaries of QI projects are provided throughout this toolkit, because the lessons learned from QI inform many toolkit sections. You will find QI project summaries in sections on *Building A Core Team*, *Delivering Family-Centered Care*, *Promoting Social and Emotional Health Among All Families and Providers*, and *Sustaining the Family Partner and Clinician Model*.

MYCHILD/LAUNCH Quality Improvement Projects Summary May 2011

MYCHILD Sites

1) Bowdoin Street Health Center (BSHC)

Big Picture Theme: Building trust in program among eligible families

Improvement Aim: Reduce time to receiving services (Enrollment, Home Visit) [by 50% in 6 months] by improving patient trust and understanding of program offerings

Measurement (Outcome): Time from referral to enrollment, time from enrollment to home visit, time from referral to team meeting

Measurement (Process): Language (primary), distance from BSHC, material gift, phone calls

Activities to Date: (1) Created log of appointments kept/missed by enrollees and why (stated and provider impression) to figure out why people may not be engaging enough to get to the home visit or team meeting stage. (2) Hired Family Partner with appropriate language skills and cultural awareness. (3) Keeping track of measurement outcomes as above. (4) Keeping track of demographic and process measures to define areas for further improvement.

2) Joseph Smith Community Health Center

Big Picture Theme: Increasing MYCHILD participation by improving provider knowledge of program and facilitating transitions to program

Improvement Aim #1: Increase percentage of referrals who screen in [by 50% in 3 months and 100% in 6 months] by improving provider knowledge of program

Measurement (Outcome): Number of referrals, number of enrolled, why screened out/not enrolled

Measurement (Process): Number of face-to-face meetings with MYCHILD staff and referring providers; number of group outreach activities to referring providers (e.g. lunches), number of educational conferences for referring providers

Improvement Aim #2: Increase conversion rate of screened-in referrals to enrollees by 50% in 6 months

Measurement (Outcome): Number of screened-in referrals, number of enrollees, why not enrolled, demographics

Measurement (Process): Warm vs. cold handoff, focused time to discuss with parent (available child play), private space to discuss with parent

Activities to Date: (1) Created meeting space for providers/families that includes privacy and toys for kids. (2) Posters made by nursing students placed in clinic offices. (3) Held two provider lunches to discuss program, plan more for other providers from nurses to local referring agencies (e.g. Head Start). (4) Referrals increased 100% in one month, 75% of those likely to screen in. (5) Plan community event for family knowledge of program.

3) Health Care for the Homeless

Big Picture Theme: Helping children on the fringe of MYCHILD enrollment benefit from services

Improvement Aim: Increase number of people to whom effective services can be delivered [by 100% in 6 months] by instituting group meetings with parenting curriculum

Measurement (Outcome): Number of children and families reached by Health Care for the Homeless/MYCHILD (enrolled and attend seminars), qualitative reflections on use of program

Measurement (Process): Number of group meetings/attendance, also start to measure status of each child (e.g. screened out, enrolled, graduate) to develop future aims directed at goal of supporting families on MYCHILD fringe.

Activities to Date: (1) Space under investigation; can't use Health Care for the Homeless, looking into Roxbury Community Center. (2) Good lead on AmeriCorps volunteer to spearhead, have a "plan B" as well. (3) Curriculum under development with Family Partner; has strong outline for a 10 week session.

LAUNCH Sites

1) Boston Medical Center

Big Picture Theme: Kindergarten readiness

Improvement Aim: Screen 100% of 3-4 year olds for kindergarten readiness with Ages and Stages. 100% of screened children will have a plan to address school readiness.

Measurement (Outcome): Screened yes/no, whether and what is the readiness plan (e.g. no plan and why, countdown to kindergarten, CORE evaluation)

Activities to Date: (1) Analyzed demographics of patients currently served to determine that a high percentage are in the 3-4 year old age range. (2) Chose Ages and Stages as screening measure.

2) Codman Square Health Center

Big Picture Theme: Customizing quality services based on quantitatively assessed needs

Improvement Aim: To use developmental assessments most effectively to ascertain best engagement strategies. (Utility scores improve 50% in 6 months.)

Measurement (Outcome): "Utility score" of how useful clinician rates their intervention, "utility score" of how useful parent rates their intervention

Measurement (process): Which assessments used, which services utilized

Activities to Date: (1) Clinician learning about range of assessments available. (2) Clinician and Family Partner devising "utility score"

3) Martha Eliot Health Center (MEHC)

Big Picture Theme: Improve MEHC ability to fulfill mission as a medical home (with respect to LAUNCH) by engaging providers in knowledge of early childhood mental health (ECMH) and by focusing on effective transitions for families both to and from the LAUNCH program

Improvement Aim: Improve referral rate and conversion rate (by 50% in next 6 months) by focusing on provider knowledge of ECMH and effective transitions to LAUNCH

<u>Measurement (Outcome)</u>: Percentage referred who screen in recruitment rate, conversion rate, pre-post tests of provider knowledge

<u>Measurement (Process)</u>: Number of meetings/conferences/lunches with providers (plus attendance), number of visual aids created (e.g. video, brochure), number of shadowing episodes, focus group with current families attendance

<u>Activities to Date</u>: (1) Planning focus group with current families to discuss transition best practices. (2) Scheduled one-on-one meetings with each provider to discuss LAUNCH. (3) Received approval for quarterly lunch series with residents and faculty. (4) Plan ECMH-themed months. (5) In process of curriculum planning for lunch meetings and theme months.

LAUNCH-MYCHILD Learning Collaborative Team Improvement Goals

(Oct. 2011-Oct. 2012)

Boston HealthCare for the Homeless Program, MYCHILD

To create and implement a standard for MYCHILD Family Partner (FP) documentation that meets the requirements of the "Family Support and Training" Medicaid specs, as to enable billing for this service. To have 90% of family partner notes meet these documentation standards by October 1, 2012.

Boston Medical Center, LAUNCH

To increase the percentage of LAUNCH patients who receive evidence based therapies (EBTs) within the first 2 months of referral to 75% during August 2011 – August 2012.

Bowdoin Street Health Center, MYCHILD

To increase the overall number of families discharged with a formal transition plan from 23% to 50%.

Codman Square Health Center, LAUNCH

To generate revenue by third party billing for LAUNCH services by exploration of billing under the primary care provider for co-visits of the primary care provider & LAUNCH team, using pediatric codes.

Dorchester House Multi-Service Center, MYCHILD

To increase the percentage of families referred to MYCHILD who engage in at least one visit with a clinician and/or family partner to 40%.

Joseph Smith Community Health Center, MYCHILD

To increase the number of applicants for the vacant family partner position.

Martha Eliot Health Center, LAUNCH

To improve provider understanding and integration of ECMH into patient care by providing micro-trainings and shadowing to 100% of pediatric interns.

MYCHILD-LAUNCH LEARNING COLLABORATIVE QI PROCESS (2012)

What is a Learning Collaborative?

- An approach to support practice change and improvement in medical practices

- Opportunity for health center staff to redesign systems for improved efficiency, family-centered care

- Includes structured cycles of team-based learning sessions and action phases

- Builds collective wisdom from experiences across health centers

- Contributes to a toolkit for replication

Creating the QI Process:

- Modeled off the widely-used PDSA (Plan-Do-Study-Act) Cycle[A]

- Phase terminology geared toward multidisciplinary Pediatric teams, inclusive of parents/consumers

   Plan→ Dream, Discover, Design

   Do, Study, Act → Deliver

[A]Langley G.L. Nolan K.M. Nolan T.W. Norman C.L. Provost L.P (2009) The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd Edition). Jossey Bass, San Francisco.

Learning Sessions
1) Expert content presentations
2) Share lessons learned and barriers faced
3) Define team-specific QI goal

Action Phase ("Deliver")
1) Implement QI goals and measure
2) Monthly TA meetings with QI consultant
3) Monthly cross-site calls for peer feedback
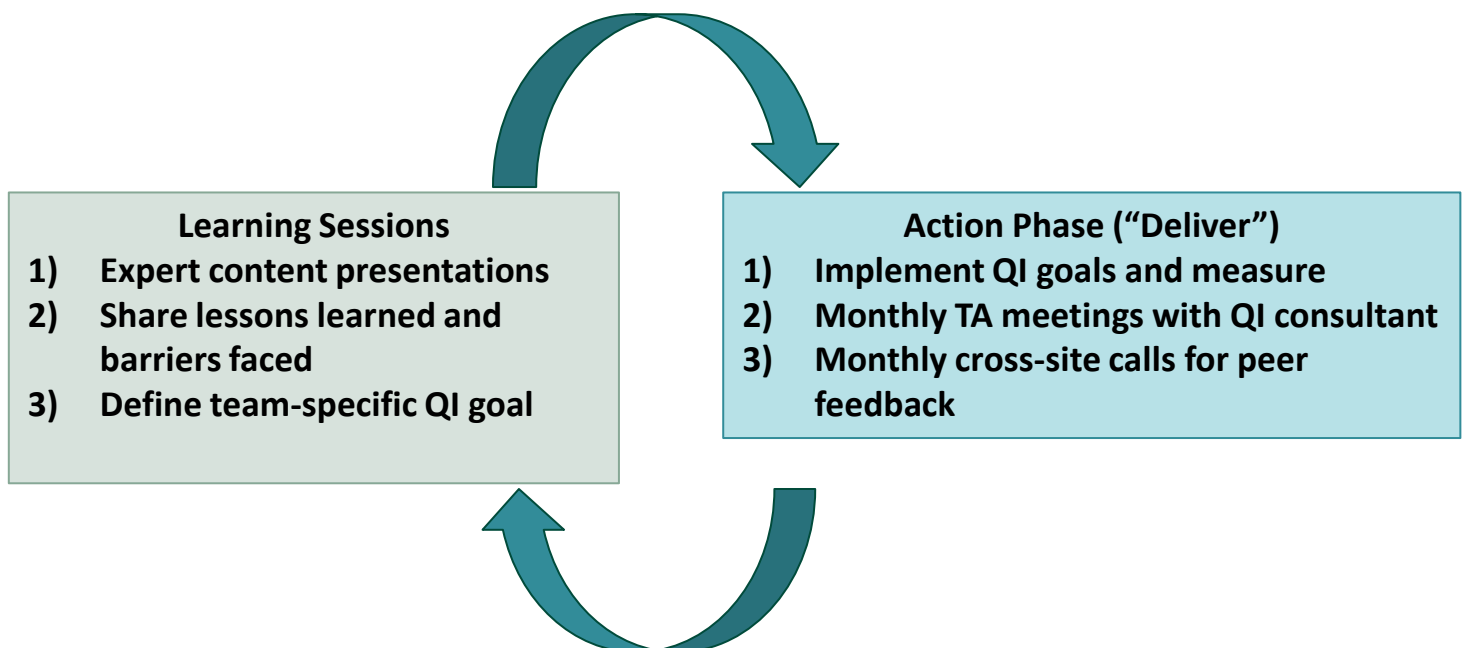
This flow chart shows the progression of steps in the MYCHILD-LAUNCH Learning Collaborative's quality improvement process.

It begins with planning, then moves into an initial learning session. Next, the team followed the 4Ds method, met to implement the goals they planned, and met again to restart the process with new goals.

Planning Group Management Team
- Identified Experts to participate
- Developed framework from PDSA

Learning Session 1
1) Expert Content: Medical Homes
2) Health Center Teams start the cycle

Learning Sessions 2 and 3
1) New Expert Content
2) Repeat Cycle

Action Phase
1) Teams meet to implement QI goals
2) Measures identified to monitor progress

Dream | Discover
Deliver | Design
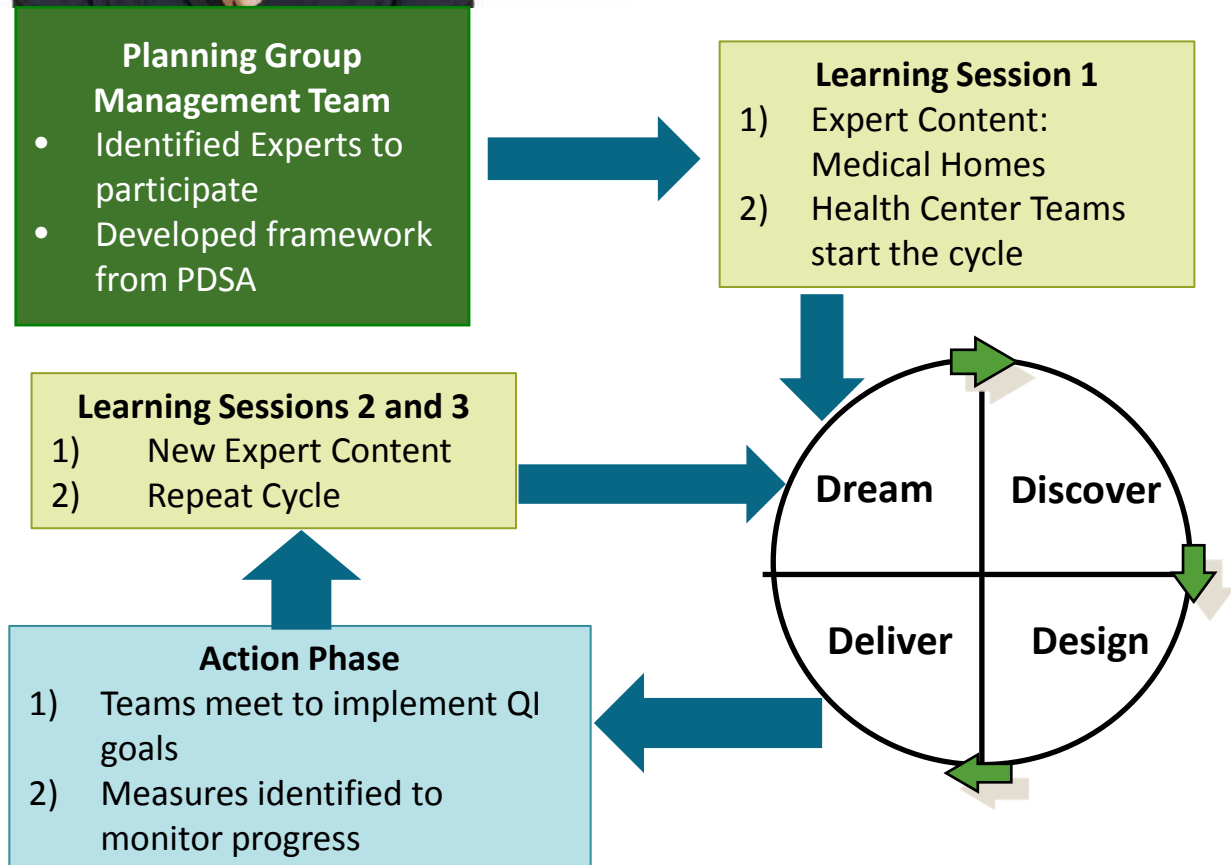
QUALITY IMPROVEMENT WORKSHEETS
FOR THE CORE TEAM

Demonstration sites used the following three handouts to guide their goal setting as a team. These handouts were completed by site Core Teams independently or with guidance at the MYCHILD-LAUNCH Learning Sessions. Technical assistance for completing these worksheets was provided by administrative staff from LAUNCH and MYCHILD.

① The first sheet focused on using the 4Ds to set a specific quality improvement goal and identify a first action step for the deliver phase.

② The second sheet focused on evaluating the status of a current goal to determine if the team should continue efforts toward this goal, or identify a new goal based on priorities and feasibility.

③ The third sheet is to support sites who decide to pursue their current goal after assessing status, but need to re-brainstorm effective change strategies to meet their goal.

Worksheet 1: Setting a QI Goal

<u>DREAM</u>: How would you like MYCHILD or LAUNCH services to look in 6 months at your site?
_____
_____
_____

Describe the Vision for Improvement. (1 sentence)
How would LAUNCH or MYCHILD look if this challenge were removed?
_____
_____

Brainstorm the challenges your team faces in achieving your dream.
Identify *one challenge* you think you can work on that will make the biggest difference with a reasonable amount of effort from your team.
_____
_____
_____
_____

<u>DISCOVER</u> the Barriers:

Describe the current process.
What does your team currently do that made you identify this challenge?
_____
_____
_____
_____
_____

➢ Identify trouble spots and processes that work well. Star processes that work well above, and put an X next to ones that don't.

➢ Where can the trouble spots be changed? Put a box around processes above that can be changed.

Which processes are high yield? (Have an X *and* a box around it.)
_____
_____
_____

What are the underlying causes of these issues? What causes are easy to act on?
_____
_____
_____

Brainstorm the *changes* you can make. *What can be changed in this process to move you toward your vision?*

_____
_____
_____
_____

Circle changes that seem feasible. Start with changes that seem high-impact.

State the change you wish to make as a quality improvement goal**:**
Be as specific as you can.

_____
_____
_____

DESIGN: A Measurement

What are the specific steps that must be taken to do the change you defined above?
1)_____
2) _____
3) _____
4) _____

Brainstorm the *measurements* you could use to monitor progress toward your goal.

_____
_____
_____

For each measure that you thought of, please answer these questions:

    Is it feasible to collect? _____

    Can you measure it every month? _____

    Is the measure important to your team? _____

Select a measurement to which you answered "yes" to all 3 questions.

DELIVER: Next Steps

Who will be your QI leader?_____

Think about the goal, and the measure (s) that you've selected.

What will be your first action step between now and our first monthly QI conference call?

_____
_____

Delivery Phase In-Depth: Doing the Change

Now that you've brainstormed and planned your Dream, Discover, Design and Deliver stages, think about the Delivery step in depth. **What are the steps you need to take to *enact* this change?** (Tips/examples from the MYCHILD-LAUNCH Learning Collaborative.)

Three Keys to Delivery

1) Do the Action Steps to make the change(s)

2) Measure the Change:
- Collect Data at Set Intervals to measure your change

3) Synthesize and Analyze the Data:
- Did your change improve the process?
- Should your change be replicated/scaled up or abandoned?
- What did you learn?

Tips to Remember:

It's a **team project**! Your job as QI leader is to lead the team.

Pick a goal that is **specific:**
- E.g. "increase the percent of families referred that complete the intake process by 20%"
- NOT: "improve family engagement process"
- Focus on a **feasible, measurable change**.

Measurement is KEY.
- Need to know if your team's change worked
- Consider using evaluation data being collected in MYCHILD/LAUNCH for measurement (e.g. demographics of families enrolled)

Communication and Support:

Monthly QI Leaders Conference Goal
- 1 hour call with all QI site leaders, facilitated by QI consultant
- Forum to share measured progress toward goal and strategies implemented across sites
- Facilitates peer feedback and builds collective knowledge

Monthly, Individual Check-Ins with QI Consultant
- 1 hour call with each individual QI leader prior to conference call
- Provides coaching on articulating goal, using measurement, analyzing data, articulating findings, contemplating next steps
- Supports preparation for conference call and learning collaborative

Monthly QI Call Goal:
Purpose: LEARN and IMPROVE. Not impress.

Come ready to summarize your team's work.
Every report out, state your goal first.
Give/get peer feedback.
If you can't attend, sub-in a teammate.

QI Tool Learning Topic (5 mins)
- Presented by QI administrative team leaders
- Examples are related to QI goals: For example. how to do a survey, run charts, pareto charts, fishbone diagram, etc.

QI Site Check Ins (8 mins per site)
- Restate/clarify your goal
- Review what team is measuring/tracking
- Describe action steps planned/completed
- Obtain feedback from the group

Worksheet 2: Assess the Status of Your Goal

1) What has been your current Quality Improvement goal?
_____
_____
_____

2) What is the status of this goal?
Completed? In-Progress? Stopped working on it?
_____
_____

3) What Next?
Is it time to move on to a new goal? *OR* **Will you continue on the current goal?**

To answer this question, consider the following:
  Did you achieve your goal? _____

  If you didn't achieve your goal, why not?

   Does your goal still address a priority challenge for your team?
   _____
   _____
   __
   Is there a new strategy or approach you would like to try to achieve this goal?
   _____
   _____
   __
   Would your team like to identify a new
   goal?_____
   _____
   _____

If you are choosing a new QI Goal, see *Setting a QI Goal* worksheet.

If you are choosing to pursue your current QI goal, see *Pursuing Your Current Goal and Re-strategizing* worksheet.

Worksheet 3: Pursuing Your Current Goal and Re-strategizing

DREAM: How would you like MYCHILD or LAUNCH services to look in 6 months at your site?

_____
_____
_____

How does your QI goal move you toward this dream?

_____
_____
_____

DESIGN:

List the current strategies or interventions you are trying to reach your goal.

_____
_____
_____
_____
_____

Based on your experience:
Circle strategies that seem <u>effective</u> in moving toward the goal.
Cross our strategies that are <u>ineffective</u> or not feasible to do.

Brainstorm additional strategies you can use to achieve your goal.
Which of these strategies are feasible to try? Which of the feasible strategies will make the biggest difference?

_____
_____
_____
_____
_____

Are there additional strategies you will try in order to achieve your goal?

_____
_____

DESIGN: Measurements

What measurements are you using to determine progress toward your goal?

_____
_____
_____

For each measure you are using, please answer these questions:

Measure	Is it feasible to collect?	Can you measure it every month?	Is it important to your team?

Use these questions above as a criteria for measurement. What measurements are you collecting that meet this criteria?

_____
_____
_____

 If not, what else could you measure that meets this criteria?

_____
_____
_____

DELIVER: Next Steps

Who will be your QI leader moving forward? _____

What will be your **first action step** between now and our first monthly QI conference call?

_____
_____

Raise Awareness of Your QI Project and Seek Feedback

Once you begin working on a QI project, take every opportunity possible within the medical home to discuss your goal, seek feedback, provide updates on status and recruit help. Consider presenting at any staff meeting possible, especially Pediatrics, Behavioral Health, and Senior Administrator meetings. Below is the format demonstration sites used when presenting updates on their QI projects within their medical homes and across demonstration sites.

GOAL: State your team's QI goal (be specific).

MEASUREMENT: What is your team measuring or tracking to monitor progress? How are you collecting this data?

ACTION: What strategies or action steps has your team done since starting the project or since the last update?

FEEDBACK and BUY-IN: Propose a question to the group regarding an obstacle or challenge faced in your QI project. Seek feedback from the team. Discussion matters for buy-in.

OR
How can this group health practice staff help your team accomplish your goal?

FOLLOW UP: After the meeting, follow up individually with any staff who were vocal in discussion. Acknowledge their contribution and see if there's any further steps they can take to move your project forward.

HEALTHCARE QI GUIDANCE

Below are descriptions of organizations specializing in healthcare quality improvement. Both offer free guidance resources on their websites as well as examples of QI projects from various practices.

National Initiative for Children's HealthCare Quality (NICHQ)

Organization Statement: "NICHQ is an independent, nonprofit organization working for more than a decade to improve children's health."'

Resources: NICHQ produces Medical Home tools for pediatric practices, informed by Learning Collaboratives. The organization provides tools, trainings and examples of QI projects that are free and accessible online. NICHQ also has multiple toolkits online (hearing loss, epilepsy, cultural competency, parent engagement in councils, infant prematurity).

Institute for Healthcare Improvement

Organization Statement: "The Institute for Healthcare Improvement (IHI), an independent not-for-profit organization based in Cambridge, Massachusetts, is a leading innovator, convener, partner, and driver of results in health and health care improvement worldwide."

Resources: The website contains free trainings, tools, and case studies on improvement in a variety of healthcare settings. One particular focus area is partnering with a patients and families in improvement.

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	Established Home Visiting Programs	Healthy Baby, Healthy Child	http://www.bphc.org/whatwedo/childrens-health/healthy-baby-healthy-child/Pages/Healthy-Baby-Healthy-Child.aspx
2	Established Home Visiting Programs	Visiting Moms	http://www.jfcsboston.org/OurServices/ParentsChildren/CenterforEarlyRelationshipSupport/HealthyFamilies/tabid/416/Default.aspx
3	Established Home Visiting Programs	Massachusetts Home Visiting Initiative	http://www.mass.gov/eohhs/gov/departments/dph/programs/family-health/home-visiting/the-massachusetts-home-visiting-initiative.html
4	Established Home Visiting Programs	Healthy Families	http://childrenstrustma.org/our-programs/healthy-families
5	Established Home Visiting Programs	Early Head Start	http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/poi/home-based
6	Established Home Visiting Programs	Parents as Teachers	http://www.parentsasteachers.org/
7	Established Home Visiting Programs	Healthy Steps	http://healthysteps.org/about/healthy-steps-services/
8	Established Home Visiting Programs	Parent Child Home Program	http://www.parent-child.org/our-program/find-a-pchp-near-you/
9	Tools for Caregiver Screening	The PHQ Screeners website	http://www.phqscreeners.com/overview.aspx?Screener=02_PHQ-9
10	Tools for Caregiver Screening	View the PHQ instructions here	http://www.phqscreeners.com/instructions/instructions.pdf
11	Tools for Caregiver Screening	Parent Stress Index	http://www4.parinc.com/Products/Product.aspx?ProductID=PSI-4#Items

Foot note #	Subsection Title	Link Title	URL
12	Tools for Caregiver Screening	Postpartum depression resources	http://www.mass.gov/eohhs/docs/dph/com-health/postpartum-depression/screening-tool-grid.pdf
13	Tools for Caregiver Screening	This link with resources for providers and families	http://www.mass.gov/eohhs/gov/departments/dph/programs/family-health/postpartum-depression/
14	Tools for Caregiver Screening	Screening for Environmental Risk Factors	http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf
15	Parent Leadership Group Resources	A Toolkit for Pediatric Practices	http://www.nichq.org/resources/PFAC-toolkit-landingpage.html
16	Parent Leadership Group Resources	A Handbook for Families and Providers Working Together to Improve Care	http://www.nichq.org/how%20we%20improve/resources/powerful%20partnerships
17	Parent Leadership Group Resources	Parent Professional Advocacy League	http://ppal.net/training/parent-leadership
18	Healthcare QI Guidance	National Initiative for Children's Healthcare Quality	http://www.nichq.org
19	Healthcare QI Guidance	Institute for Healthcare Improvement	http://www.ihi.org/about/Pages/default.aspx