SDOH SCREENING TOOLS FOR PUBLIC HOUSING RESIDENTS

LEARNING COLLABORATIVE

Implementing a Screening Process with Whole Families in Mind

May 18, 2021

National Center for Health in Public Housing

National Center for Health in Public Housing

The National Center for Health in Public Housing (NCHPH), a project of North American Management, is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09734, a National Training and Technical Assistance Cooperative Agreement (NCA) for $2,006,400 and is 100% financed by this grant. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

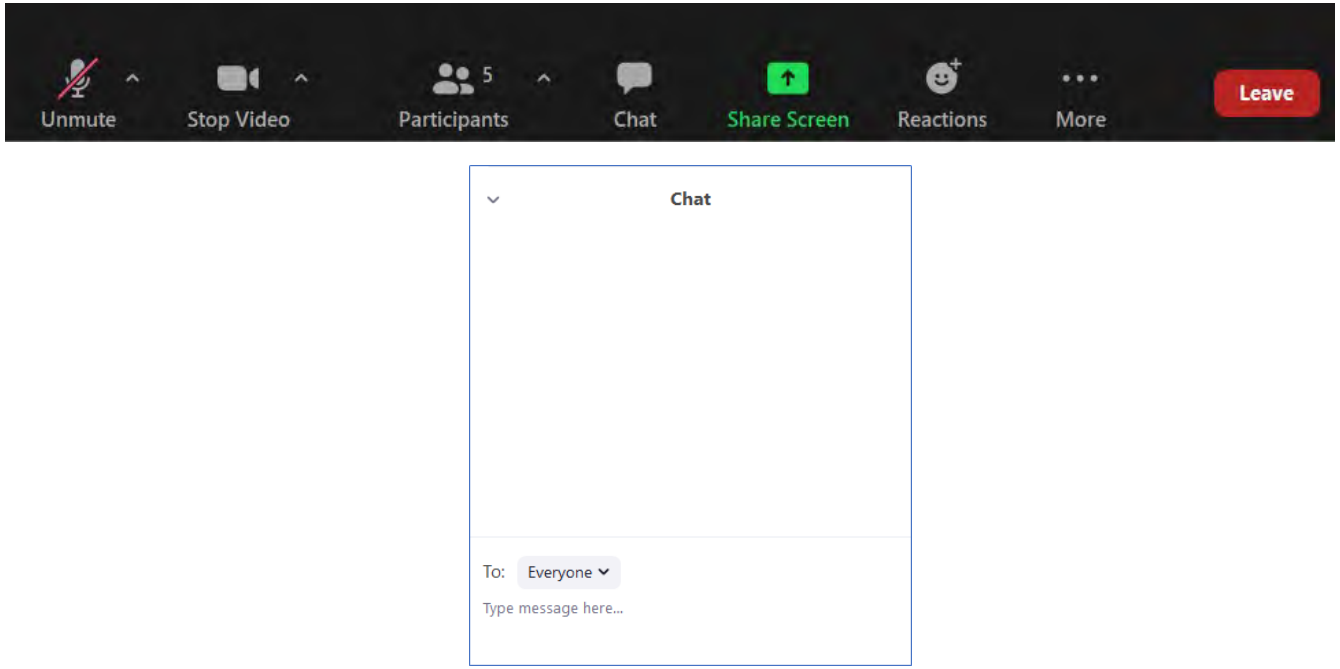
Housekeeping

- All participants muted upon entry
- Cameras on (if possible)
- Engage in chat
- Raise hand if you would like to unmute
- Meeting is being recorded
- Slides and recording link will be sent via email and posted to Moodle within a week after session

Icebreakers

In the Chat

- Name and role
- Health center name
- City and State



Moodle

- Materials related to LC will be available through this platform
- Visit Moodle.nchph.org select “Screening SDOH for Public Housing Residents”
- Create account
- Detailed instructions on how to access materials included in our “Welcome Packet”

Moderator and Facilitators

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Guest Speaker

Dr. Christina Bethell

Professor, Bloomberg School of Public Health

Department of Population, Family and Reproductive Health

Director, Child and Adolescent Health Measurement Initiative

Johns Hopkins University

Agenda

- Review of previous session
- Session 3 overview
- Case Study
- Guest Speaker- Dr. Christina Bethell
- Q&A
- Wrap up

NCHPH
National Center for Health in Public Housing

Criteria for Choosing a Standardized Screener

- Domains
- Length of assessment
- Reading level
- Languages available
- Cost
- Integration into EHRs
- Flexibility
- Resources needed to implement screening tool
- Rating or ranking

What is PRAPARE?

A national standardized patient risk assessment protocol built into the EHR designed to engage patients in assessing and addressing social determinants of health.

www.nachc.org/prapare

PRAPARE

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SDOH Data Collection: Five Rights Framework

PRAPARE

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Session 3: Guiding Questions

1. How can trust be built between patients and providers when addressing patient risks?
2. It is important to integrate social needs data into the delivery of health care, but how?
3. Can screening tools be helpful in the assessment of quality of care? How?

Implementing a Screening Process with Whole Families in Mind

- Learning Objectives
  - Identify ways to build trust between patients and providers when identifying and addressing social risks.
  - Describe practical ways to integrate data from screening tools and guides with clinical summary reports to prepare for inpatient visits.
  - Discuss practical methods to measure and assess quality of care based on input from screening tools.

Polling Question:

- What pediatric screening tools are you currently using? (Check all that apply.)
  - Ages and Stages Questionnaire (ASQ-3 or ASQ-SE-2)
  - Parents' Evaluation of Developmental Status (PEDS)
  - Survey of Wellbeing of Young Children (any component)
  - Modified Checklist for Autism in Toddlers (MCHAT)
  - Patient Health Questionnaire or EPDS (PHQ-2 or PHQ-9)
  - Accountable Health Communities (AHC) HRSN Screening Tool
  - Health Leads Screening Tool
  - PEARLS- Pediatric ACEs Screening and Related Life-events Screener
  - A Safe Environment for Every Kid (SEEK) Questionnaire
  - Well Child Care, Evaluation, Communities Resources, Advocacy, Referral, Education Survey Instrument (WE CARE)

SAMPLE PATIENT FOR EARLY CHILDHOOD AND FAMILY PREVENTIVE CARE

Case: Rocio is a 17-year-old who is pregnant and has a 1-year-old child. She has come in for her child's 12-month well child visit. As she has reported, she is having difficulty with her pregnancy and very afraid for her health and seems to be lacking support.

Implications for SDOH screening: How can the screening of the social determinants of health help reduce her risk of adverse pregnancy as well as support her well-being?

SCIENCE AND EPIDEMIOLOGY OF CHILD DEVELOPMENT AND MATERNAL HEALTH:

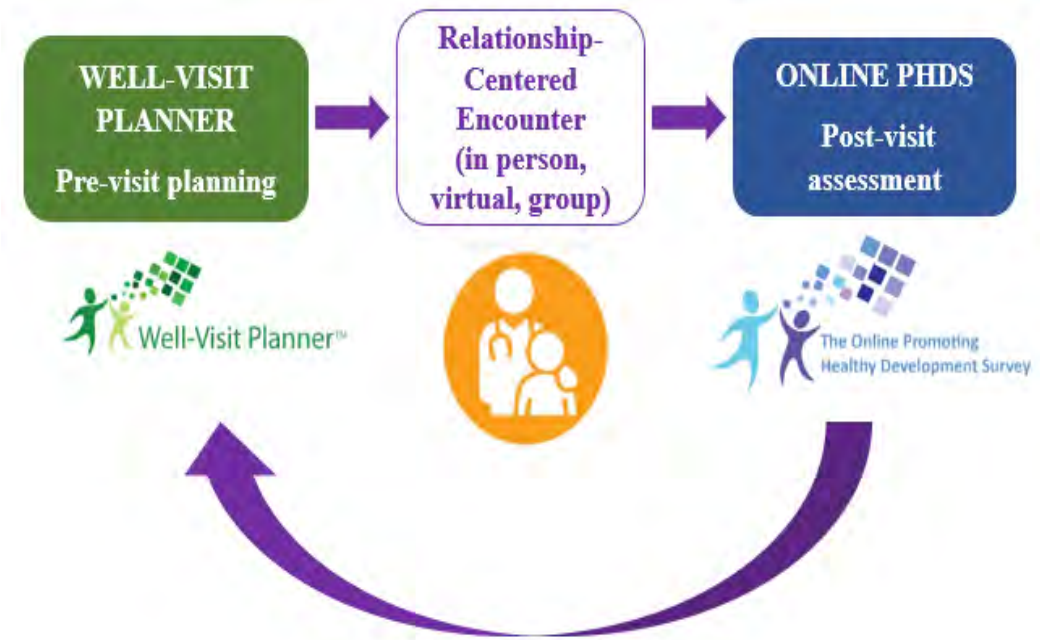
- ***Fact***: Over 60% of young children have mothers who do not have excellent or very good health and nearly 30% of mothers report lacking emotional support. This often prevents healthy attachment, which impact child brain development and early and lifelong health and well-being of children and families.
- ***Implications for SDOH screening***: What does this mean for screening the social determinants of health?

Guest Speaker

Creating a Cycle of Engagement to Promote Child and Family Well Being: Implementing a Screening and Care Process with the Whole Family in Mind

Christina Bethell, PhD, MPH, MBA

Professor, Johns Hopkins Bloomberg School of Public Health
Director, Child and Adolescent Health Measurement Initiative



CAHMI
The Child & Adolescent Health Measurement Initiative

JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

WHO WE ARE

The Child and Adolescent Health Measurement Initiative (CAHMI) is a national initiative that strives to promote early and lifelong health for children, families, and communities using family-centered measurement, data, and engagement tools with a particular focus on factors that make flourishing possible.

Data in Action | Measurement in Action | Engagement in Action | Flourishing in Action

WHAT IS CAHMI?

OUR MISSION: CAHMI seeks to address what we need to know about children, families and communities, how to measure it, and how that data can be used to improve outcomes through advancing change in policy and practice.

OUR VALUES: CAHMI believes all children, families and communities deserve equitable, safe, stable environments, and through actionable data, transformational partnerships, and transformative goals, that can be a reality for all.

Ask a Question | Request a Dataset | Stay Connected | What can we help you find?

Data Resource Center for Child & Adolescent Health
A project of the Child and Adolescent Health Measurement Initiative

CAHMI The Child & Adolescent Health Measurement Initiative

Learn About the NSCH | Explore the Data | Spread the Word | About Us

National Survey of Children's Health Interactive Data Query

Video Tour of the Interactive Data Query

2018-2019 (two years combined)

Nationwide

Note: For the most reliable estimates, use the two-year combined data (e.g. 2018-2019).

Continue

Archived Data Query for NSCH and NS-CSHCN (prior to 2016)

How to Use the DRC Website

The DRC advances the use of the National Survey of Children's Health, led by HRSA MCHB. Find more resources here:

- About the DRC
- DRC Video Overview
- DRC Frequently Asked Questions
- Data available in the online data query
- Request NSCH datasets
- Download NSCH codebooks

For Title V

The DRC focuses on data and resources for Title V programs and partners. For over 75 years, the HRSA Maternal and Child Health Bureau (MCHB) has funded the Title V program to ensure the health of the nation's mothers, women, children and youth.

- Link to Ways to Compare Data Across States on the DRC Website
- Link to HRSA MCHB Title V Information System
- Link to Get Help

Compare Data Across States

Highlights and Updates


Combined 2018-2019 NSCH downloadable data sets and codebooks are now available on the DRC


Single year 2019 NSCH estimates, downloadable data sets, and codebooks will be available through the DRC in late


Estimates from the combined 2018-2019 National Survey of Children's Health available on the DRC Interactive

@childhealthdata

Data Resource Center
@childhealthdata
66.5% of children and adolescents meet all 3 flourishing measures according to the #NSCH18-19. Learn more at bit.ly/3eaj8ax. NSCH funded and directed by @HRSAgov.

Current Search Criteria

Survey: 2018-2019 National Survey of Children's Health
Starting Point: Child and Family Health Measures
State/Region: Nationwide (quick edit)
Topic: Family Health and Activities
Question: Indicator 6.26: Food insufficiency
Sub Group: Adverse childhood experiences

Edit Search Criteria

Select a State or Region to Compare

Adverse childhood experiences

Change Question, Topic or Survey

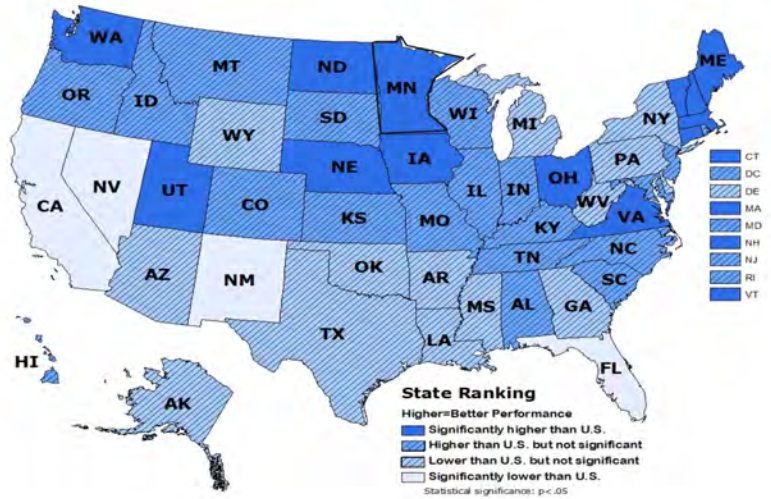
Indicator 6.26: Which of these statements best describes your household's ability to afford the food you need during the past 12 months?

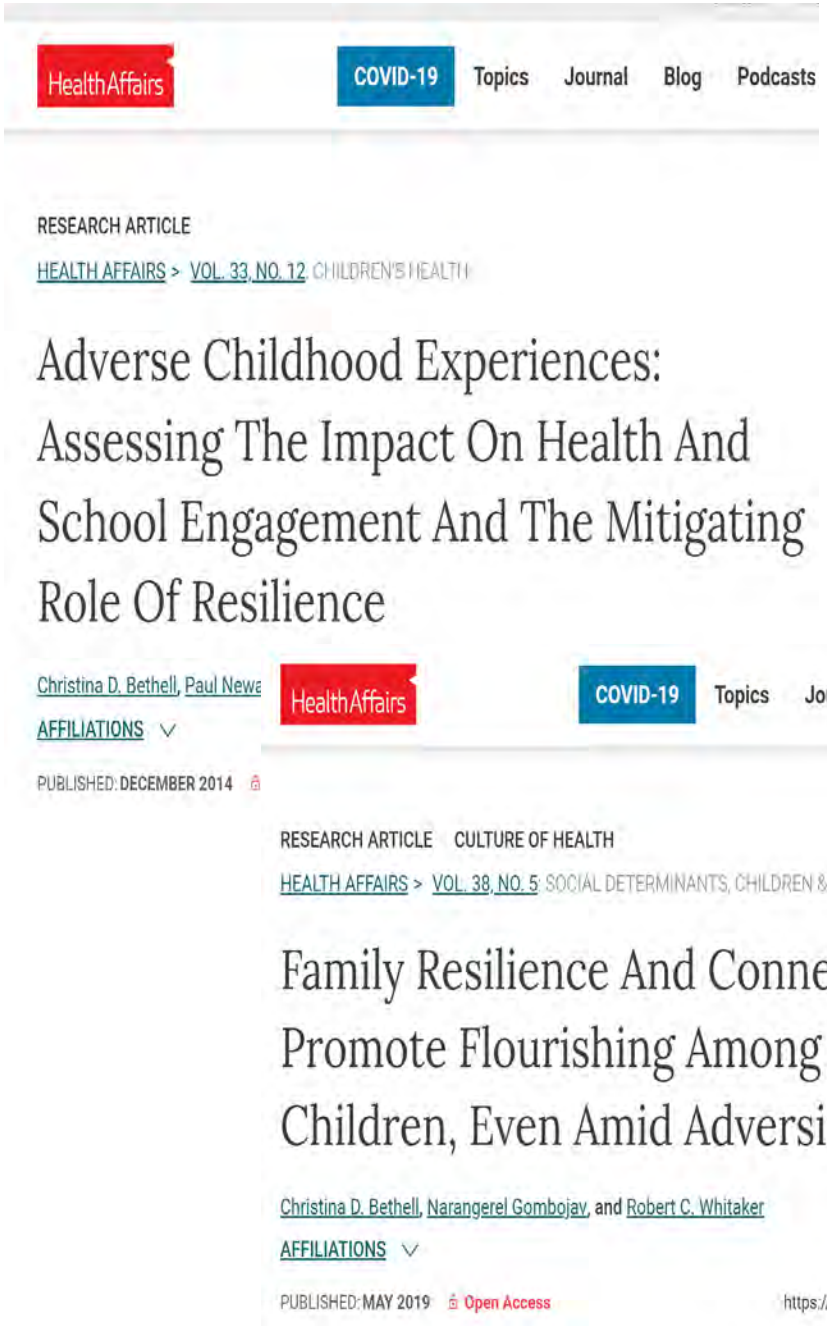
		We could always afford to eat good nutritious meals	We could always afford enough to eat but not always the kinds of food we should eat	Sometimes we could not afford enough to eat	Often we could not afford enough to eat	Total %
No adverse childhood experiences	%	81.0	18.0	0.9	0.1	100.0
	C.I.	80.1 - 81.9	17.1 - 19.0	0.7 - 1.1	0.0 - 0.2	
	Sample Count	30,713	5,307	175	17	
	Pop. Est.	34,798,518	7,750,133	379,902	29,015	
	%	56.7	35.6	6.5	1.2	100.0

Title V National Performance Measure #11: Percent of children without special health care needs, ages 0 through 17, who have a medical home

2017-2018 National Survey of Children's Health (2 years combined)

Nationwide: 49.4% of children met indicator
Range Across States: 42.4% to 62.3%





HealthAffairs COVID-19 Topics Journal Blog Podcasts

RESEARCH ARTICLE

HEALTH AFFAIRS > VOL. 33, NO. 12: CHILDREN'S HEALTH

Adverse Childhood Experiences: Assessing The Impact On Health And School Engagement And The Mitigating Role Of Resilience

Christina D. Bethell, Paul Newa

AFFILIATIONS

PUBLISHED: DECEMBER 2014

HealthAffairs COVID-19 Topics Journal Blog

RESEARCH ARTICLE CULTURE OF HEALTH

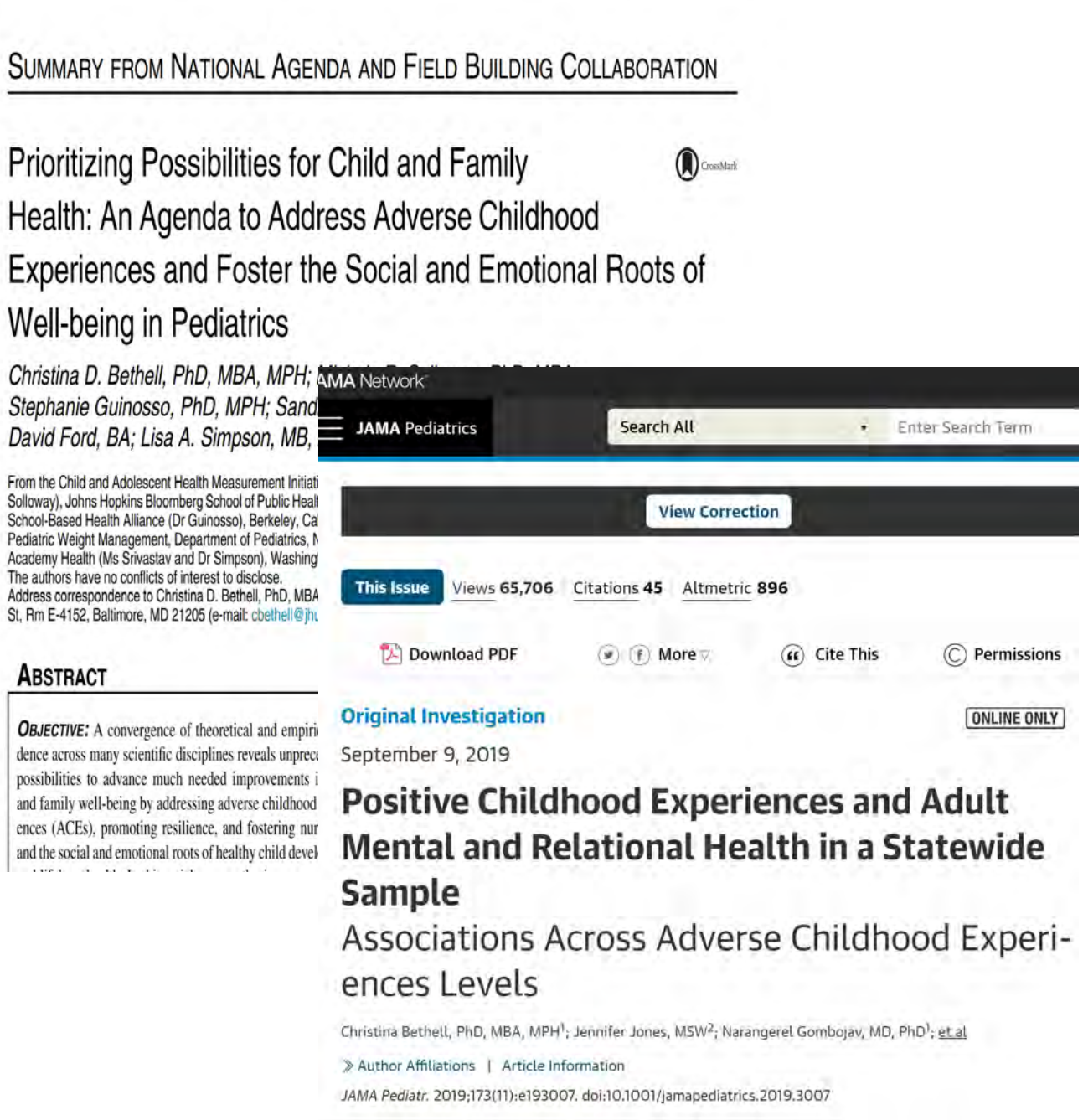
HEALTH AFFAIRS > VOL. 38, NO. 5: SOCIAL DETERMINANTS, CHILDREN & MORE

Family Resilience And Connection Promote Flourishing Among US Children, Even Amid Adversity

Christina D. Bethell, Narangerel Gombojav, and Robert C. Whitaker

AFFILIATIONS

PUBLISHED: MAY 2019 Open Access https://doi.org/10.1377/h



SUMMARY FROM NATIONAL AGENDA AND FIELD BUILDING COLLABORATION

Prioritizing Possibilities for Child and Family Health: An Agenda to Address Adverse Childhood Experiences and Foster the Social and Emotional Roots of Well-being in Pediatrics

Christina D. Bethell, PhD, MBA, MPH; Stephanie Guinosso, PhD, MPH; Sand David Ford, BA; Lisa A. Simpson, MB,

From the Child and Adolescent Health Measurement Initiati Solloway), Johns Hopkins Bloomberg School of Public Healt School-Based Health Alliance (Dr Guinosso), Berkeley, Ca Pediatric Weight Management, Department of Pediatrics, N Academy Health (Ms Srivastav and Dr Simpson), Washing The authors have no conflicts of interest to disclose. Address correspondence to Christina D. Bethell, PhD, MBA St, Rm E-4152, Baltimore, MD 21205 (e-mail: cbethell@jhu

ABSTRACT

OBJECTIVE: A convergence of theoretical and empiri dence across many scientific disciplines reveals unprec possibilities to advance much needed improvements i and family well-being by addressing adverse childhood ences (ACEs), promoting resilience, and fostering nur and the social and emotional roots of healthy child devel

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Original Investigation ONLINE ONLY

September 9, 2019

Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample

Associations Across Adverse Childhood Experiences Levels

Christina Bethell, PhD, MBA, MPH[1]; Jennifer Jones, MSW[2]; Narangerel Gombojav, MD, PhD[1]; et al

Author Affiliations | Article Information

JAMA Pediatr. 2019;173(11):e193007. doi:10.1001/jamapediatrics.2019.3007

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Bright Futures

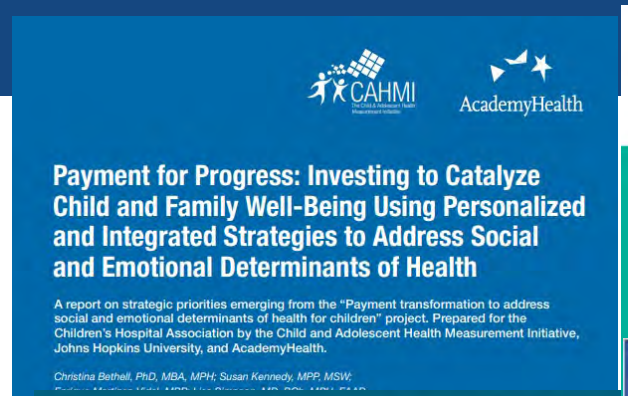
HRSA's Bright Futures Program aims to improve health outcomes for the nation's infants, children, and adolescents by increasing the quality of primary and preventive care through maintenance and dissemination of age-specific, evidence-driven clinical guidelines. HRSA launched the Bright Futures program in 1990 to address a need for unified guidance on how to design the most modern, efficient, and comprehensive pediatric checkup.

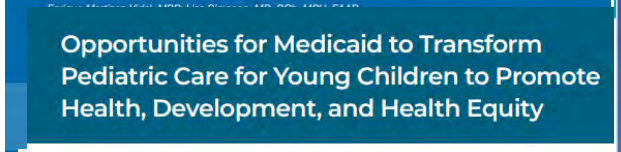
One component of the Bright Futures Guidelines is the Periodicity Schedule, a tool describing which preventive services and screenings should be delivered at each of 32 well visits from prenatal to 21 years of age. On December 28, 2020, HRSA accepted the current version of the Bright Futures Periodicity Schedule for purposes of Section 2713 of the Public Health Service Act (42 U.S.C. § 300gg-13) and 45 CFR Part 147). The Federal Register Notice describes the update. The updated Bright Futures Periodicity Schedule will be made publicly available on the awardee's webpage in March 2021. All non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage must cover the services and screenings listed on the current Bright Futures Periodicity Schedule for plan years (in the individual market, policy years) beginning on or after December 28, 2021.

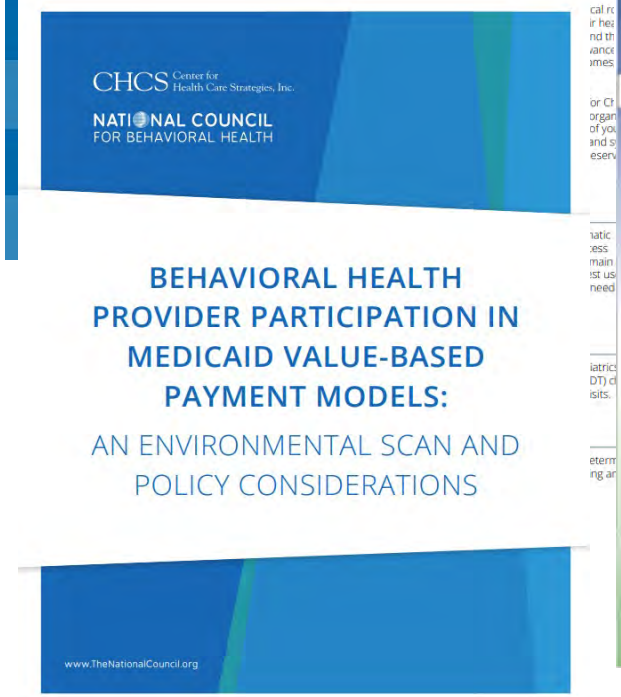
Section 2173 of the PHS Act

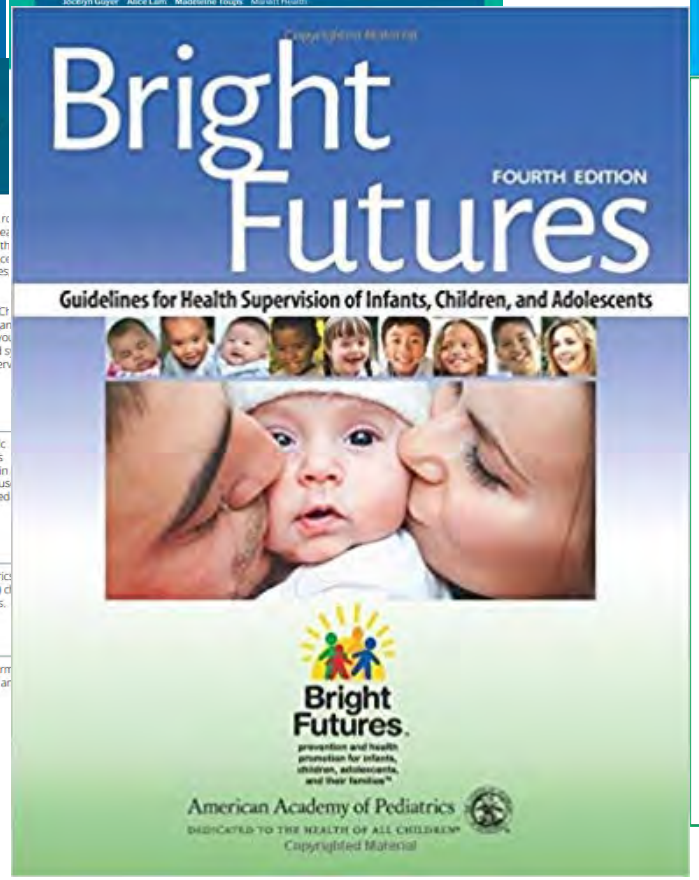
All non-grandfathered group health plans & health insurance issuers offering group or individual health insusrance coverage must cover the services and screenings listed on the current Bright Futures Periodicity Schedule for plan years beginning on or after December 28, 2021

Pediatric Health Services Transformation –Common Recommendations!









Policy, program and research recommendations/opportunities focused on promoting early and life long health of children and families

Well-Child Visits

- Comprehensive well child visits as required under EPSDT.
- Adherence to AAP Bright Futures scope and schedule.
- Screening for physical, developmental, social-emotional-behavioral health, maternal depression and other social determinants of health.
- Anticipatory guidance and parent education, as required in EPSDT and Bright Futures.
- Family engagement, focused on two-generation approaches to ensuring child health
- Other primary care practice augmentations (e.g., Reach Out and Read).

Care Coordination / Case Management

- Individualized, with intensity commensurate with need.
- Routine care coordination for all as part of medical home.
- Intensive care coordination/ case management for those with higher needs identified.
- Structured, family-focused approach to assess and respond to medical and non-medical health-related needs.
- Linkages to community resources, with active identification and engagement of those resources.

Other Services

- Child/family support programs, including those designed to be collocated in primary care (e.g., Healthy Steps, Project DULCE).
- Integrated behavioral health in primary care setting.
- Referrals to and integration with other services such as home visiting, family support, early intervention, early childhood mental health, and other programs.

* InCK Marks Working Paper; Johnson and Bruner and HE & YC papers (2017-2019).

The Opportunity

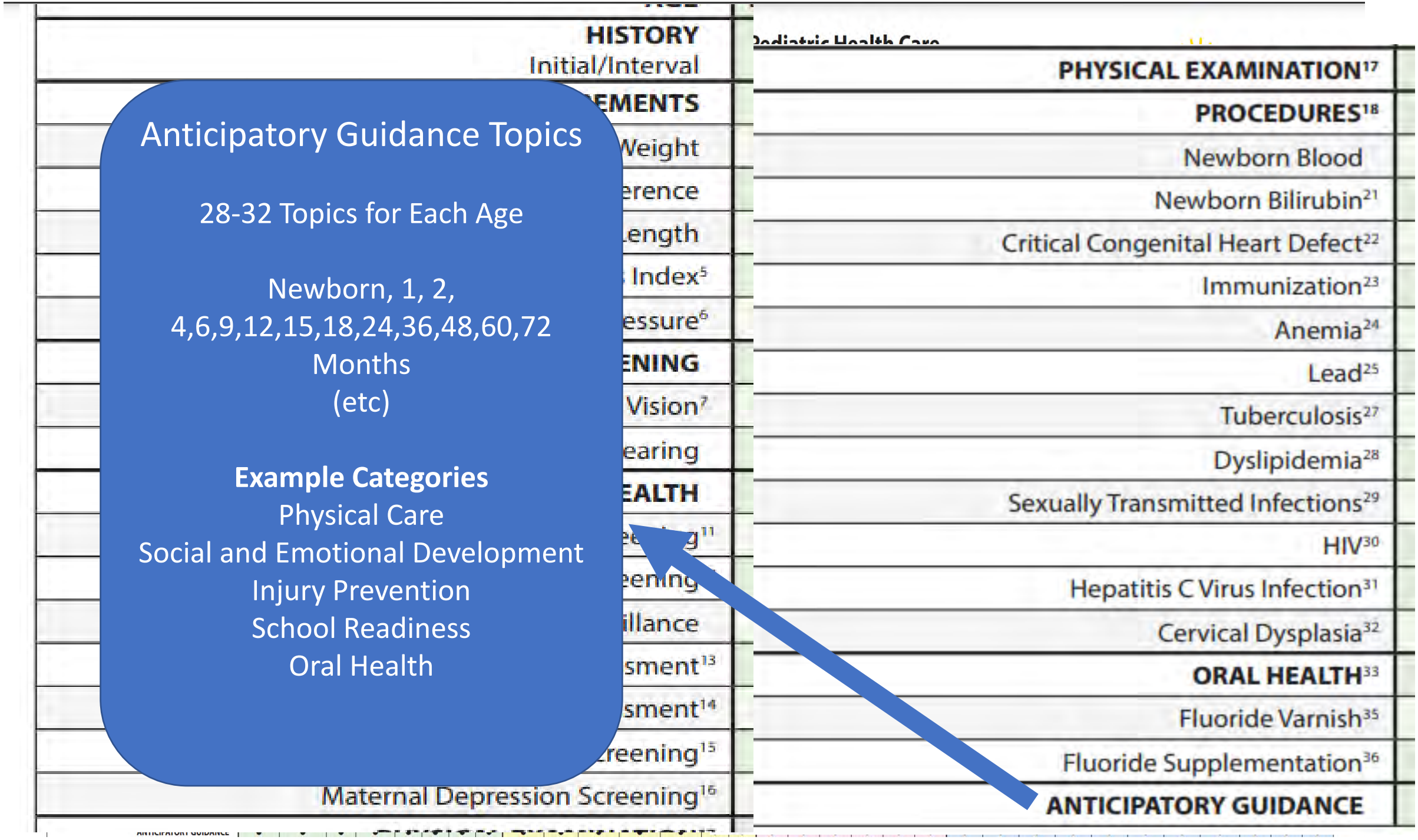
Tremendous opportunities are presented by the large gaps in child flourishing, school readiness and engagement, family resilience, parent-child connection, protective family routines and habits.

Research on evidence based opportunities to close gaps give hope!

9 in 10 children do not receive all of a minimal core set of preventive and developmental services

After decades of work, only 30% of children receive developmental screening; follow up is rare. SDOH screening and FU is much lower.

30-50% of the 65 million per year recommended visits for children age 0-5 do not take place.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Maternal Depression Screening16
Anticipatory Guidance Topics
28-32 Topics for Each Age
Newborn, 1, 2,
4,6,9,12,15,18,24,36,48,60,72
Months
(etc)
Example Categories
Physical Care
Social and Emotional Development
Injury Prevention
School Readiness
Oral Health
PHYSICAL EXAMINATION17
PROCEDURES18
Newborn Blood
Newborn Bilirubin21
Critical Congenital Heart Defect22
Immunization23
Anemia24
Lead25
Tuberculosis27
Dyslipidemia28
Sexually Transmitted Infections29
HIV30
Hepatitis C Virus Infection31
Cervical Dysplasia32
ORAL HEALTH33
Fluoride Varnish35
Fluoride Supplementation36
ANTICIPATORY GUIDANCE

DO WE REALLY NEED TO KNOW ALL OF THIS?

Summary of ten overlapping domains of social determinants of health included across eight prominent measures of SDOH
Housing Instability: homelessness, unsafe housing quality, inability to pay mortgage/rent, eviction
Food Insecurity: limited or uncertain access to adequate & nutritious food
Financial Strain: Unemployment, difficulty paying bills, medication, healthcare underuse due to cost, struggle with basic needs
Discrimination: racism, stigmatization, hostility and unemployment
Social Isolation & Supports: lack of family and/or friend networks, minimal community contacts, social engagement

Addiction: alcohol, tobacco and substance use/addiction
Exposure to Violence: intimate partner violence, community violence
Stress: daily, chronic stress in any aspect of life (work, school, home, etc.)
Parent Personal Well-Being: maternal/caregiver well-being; caregiver tobacco, alcohol and/or drug use/addiction
Parent Relationship Well-Being: ability to provide safe, stable, nurturing relationships; bonding and attachment; knowledge of parenting and development; relationship security, stability

	Integrated Child Risk Index Check mark indicate if each domain contains an item that reflects (R) or contributes to *(C)* each item in the AHC HRSN.		
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool from the Centers for Medicare & Medicaid Services (CMS)[64]	Medical Health Risk domain	Social Health Risk domain	Relational Health Risk domain
Housing instability		✓ R, C	
Food insecurity		✓ R	
Transportation problems		✓ R	
Utility help needs		✓ R	
Interpersonal safety		✓ R	✓ R
Financial strain		✓ R	
Employment		✓ R	
Family and community support			✓ R
Education			
Physical activity			
Substance use			✓ R
Mental health			✓ R, C
Disabilities	✓ R		

The Whole Child Complexity Index: Identified children and youth by the medical, social and relational health risks they experience

Medical Health Risk (MHR) – 4 criteria

- Children with More Complex Special Health Care Needs
- Overall Health Status Fair or Poor
- Two or More Chronic Conditions (Across 25 conditions)
- Experiences Functional Difficulties - 11 difficulties (frequent, chronic, serious)

Social Health Risk (SHR) - 4 criteria

- Food Insufficiency/Insecurity
- Economic Hardship/Difficulty paying for housing, transportation, basic needs
- Unsafe Neighborhood/Exposure to Violence
- Treated of Judged Unfairly Due to Race/Ethnicity

Relational Health Risk (RHR)- 4 criteria

- Two or More Household Adverse Childhood Experiences – 6 items
- Frequent Parental Aggravation and Anger With Child
- Poor/Fair Caregiver Mental Health
- Lower Parental Coping/ Emotional Support

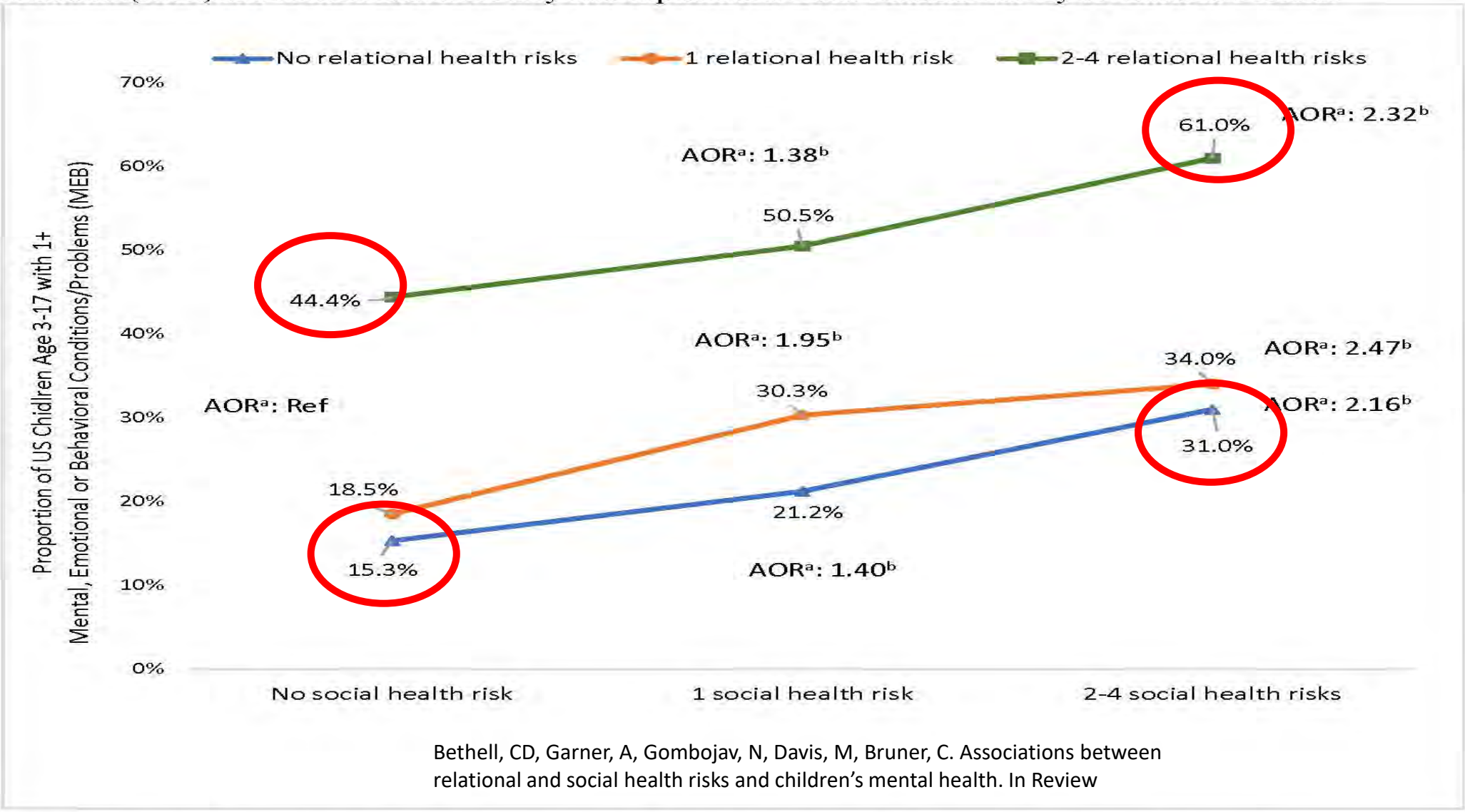
Scoring Options Evaluated

1. **Domain Count: Medicaid 46% 2+**
2. **Critera Count: 61% w/3 Domains 5+ critera**
3. **Domain Combinations** (mutually exclusive)
   a. No Domains-36.3%
   b. MHR Only-12.0%
   c. SHR Only-7.5%
   d. RHR Only-15.4%
   e. MHR and SHR Only-4.7%
   f. MHR and RHR Only-8.1%
   g. MHR, SHR and RHR -8.8%
   h. SHR and RHR Only-7.2%

Pearson's correlations coefficients ranged from 0.018 to 0.596, with only 8 cases where correlation was greater than 0.2.

Bethell, C, Blackwell, C, Gombojav, N, Davis, M, Bruner, C, Garner, A. Measurement for a Whole Child Health Policy: Design and Validation of the Whole Child Risk Index (In Review).

Figure 2: Prevalence of US children age 3-17 years who experienced one or more mental, emotional, developmental or behavioral conditions or problems (MEB), by number of Whole Child Complexity Index relational (RHR) and social health risks they also experienced. Data: National Survey of Children's Health



Bethell, CD, Garner, A, Gombojav, N, Davis, M, Bruner, C. Associations between relational and social health risks and children's mental health. In Review

[a]Adjusted Odds Ratios (AOR) are adjusted for age, sex, race/ethnicity, income and insurance coverage type. See Technical Appendix C1[40] for regression analysis details. [b]AORs are statistically significant after adjusting for age, sex, race/ethnicity, income and insurance coverage type.

CAHMI's Early Childhood Cycle of Engagement

A project of the Child & Adolescent Health Measurement Initiative

	Engages and supports parents in promoting the health and well-being of their child
	Facilitates early identification of physical, social, emotional and behavioral issues
	Fosters trusting relationships with families and providers, and in doing so, facilitates the effective provision of critical anticipatory guidance, education and resources for parents
	Promotes positive child and family health, resilience and social and emotional skills
	Provides pediatric practices with real time and continuous feedback on parent-reported aspects of Bright Futures recommended care to help focus and tailor practice efforts to improve the quality and outcomes of well child visits

What is the Early Childhood_Cycle of Engagement?

a personalized, mutual engagement model of pediatric primary care focused on building trust and personalizing care to child and family strengths, context, needs and priorities

a family centered, integrated approach to educating and empowering families and assessing child development, social, family and relational health needs aligned with Bright Futures Guidelines—data transparency (families, clinicians)

Cycle of Engagement Key Features

a measurement process for continuously updating priorities and needs and assessing and improving quality of care aligned with family-centered medical homes and value and team-based care

a population health strategy providing aggregate data reports to inform needs, quality of care and drive and inform collaborations to improve care and outcomes for children and families.

CAHMI's CYCLE OF ENGAGEMENT MODEL

Before the Well-Child Visit

WELL-VISIT PLANNER

Visit planning and customization

Well-Visit Planner®

FAMILIES: Complete the **WVP tool** for planning their child's upcoming well-visit and receive a personalized Visit Guide

PROVIDERS: Create an account to access the **WVP Portal** to tailor the WVP for their practice or organization and track WVP use by families

BENEFITS

- Parent coaching
- Parent reflection on strengths, needs and concerns
- Development surveillance
- Social determinants of health
- Psychosocial issues
- Parents pick priorities across all Bright Futures topics
- Personalized Visit Guide to support well-child visits

During the Well-Child Visit

BENEFITS

- Focus on the priorities, concerns and issues specific to the child and family
- Family environment discussed
- Developmental, behavioral, emotional and other concerns addressed
- Resources co-identified
- Relationship and trust-building between provider and family

After the Well-Child Visit

ONLINE PHDS

Post-visit assessment & reinforcement

FAMILIES: Complete the **Online PHDS tool** to give anonymous feedback about their experience and the quality of care they received

PROVIDERS: Create an account to access the **Online PHDS Portal** and tailor the PHDS for their practice or organization

BENEFITS

- Measures aligned with Bright Futures guidelines
- Continuous feedback for providers
- Parents get feedback report and guidance for next visit
- Providers can generate summary reports on quality of care based on parents' responses
- NQF Endorsed 2008
- ABP MOC and CME credit (coming soon)

Results with Implementation

Meaningful Use Criteria

Maintenance of Certification Criteria

Pay for Performance

Population Health Assessment

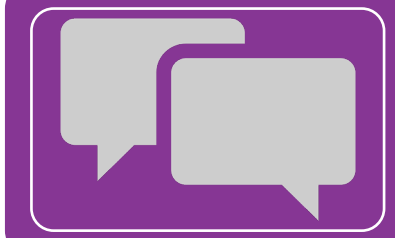
Improved parenting, attachment, self and relational health

Improved quality of care and health outcomes for children

COE Seeks to Advance 4 Aspects of Family Engagement

Common themes:

- Active partnership at all levels levels
- Family-centered approach
- Collaborative decision making
- Building relationships
- Planning, setting goals, delivering, and evaluating health care



Communication between families and providers to build trust

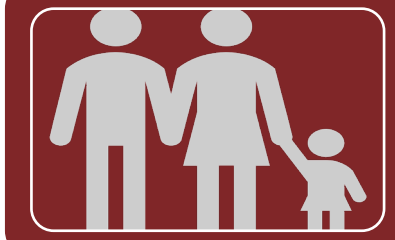
- Open and honest interactions
- Child- and family-centered care
- Building trust and relationships

Family involvement to share decision making and plans of care

- Participation in decision-making
- Joint treatment and goal planning
- Joint input on EMR/patient portal

Active collaboration with organizations and systems for results

- Family advisory boards
- Partner in program design and care delivery
- Participation in policy/program evaluation



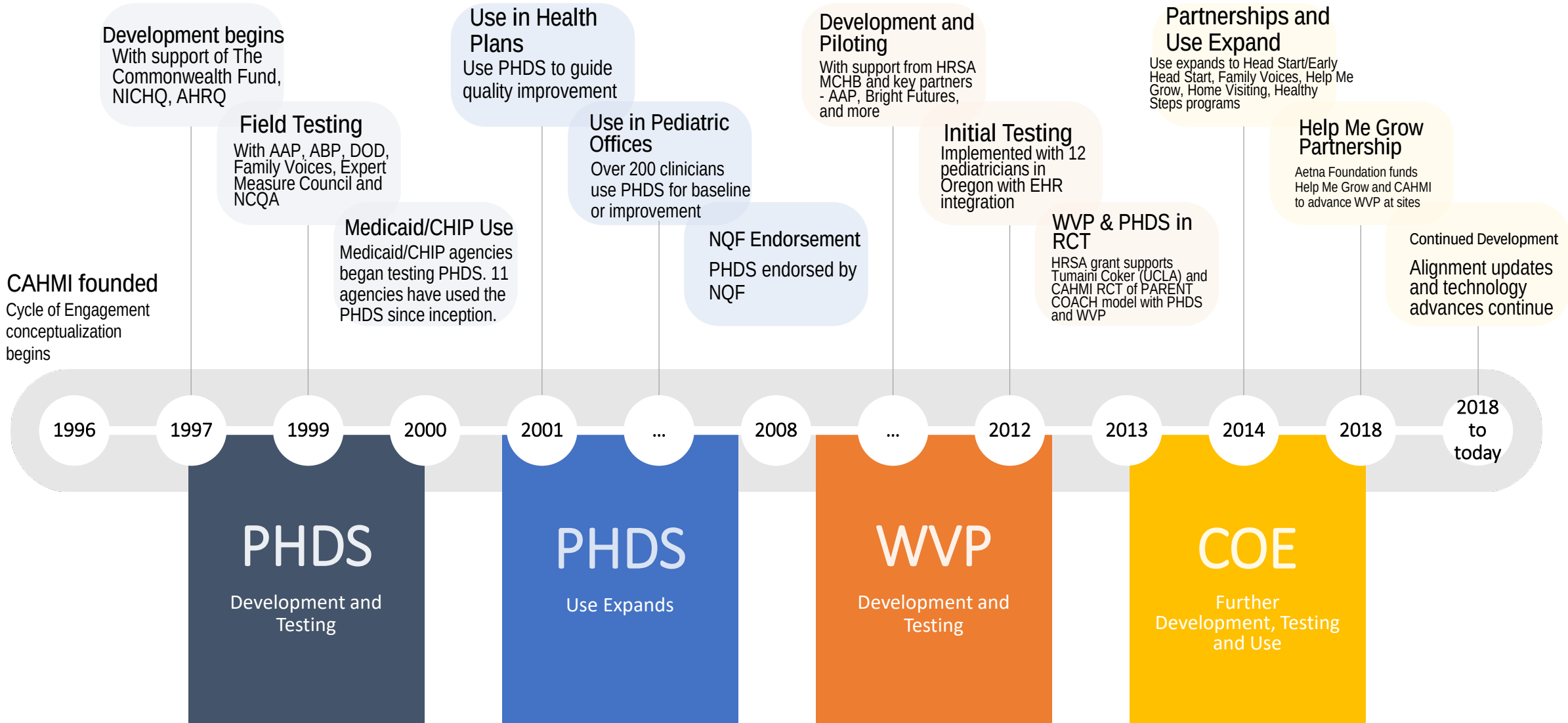
Engage to improve health and well-being

- Proactive health seeking and pursuit of well-being
- Capacity and will to heal, change and learn
- Health promoting behaviors
- Self-management of conditions

Summary of the History of the CAHMI's Cycle of Engagement

Promoting early and lifelong health of children, youth and families using family-centered data and tools

Key Milestones and Partners



National, State, Community, Health System and Direct to Public Testing and Applications (2001-present)

Bright Futures™
Prevention and health promotion for infants, [illegible]lescents, [illegible]amilies™

Nation
State
Community
Health Plan
Practice
Patient

nsech
NATIONAL SURVEY OF EARLY CHILDHOOD HEALTH

NATIONAL QUALITY FORUM

13 states

1) Louisiana
2) Minnesota
3) Mississippi
4) Ohio

VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

Head Start
Birth to Age 5

BOSTON MEDICAL CENTER

Help me grow

UCLA MATTEL Childrens Hospital

MAHEC

CHADIS®
Child Health & Development Interactive System

KAISER PERMANENTE

The Children's Clinic
welcoming families since 1911

PPOC
Pediatric Physicians' Organization at Children's

LIFEBRIDGE HEALTH®
Pediatrics

BRIGHT FUTURES:
FAMILY MATTERS
FAMILY VOICES®

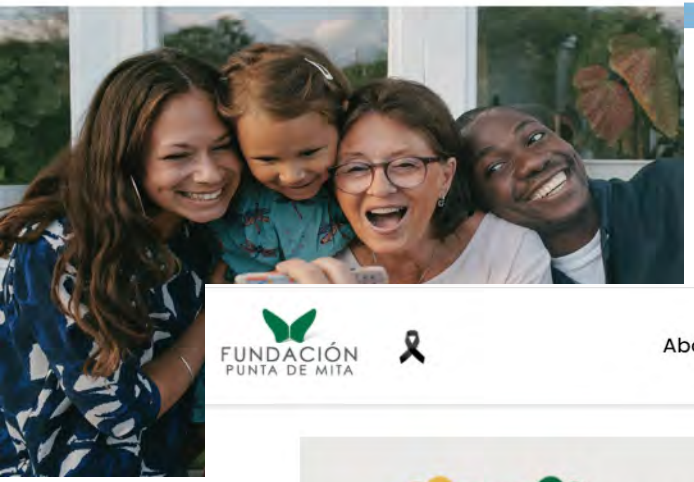

APRIL 2015
The Well Visit Planner: Making the Most of Your Child's Health Care Checkups
Well-child visits are all about prevention and promotion of healthy habits. Recommended vaccinations are given during these visits, as well as routine screenings for such things as vision or hearing problems, anemia, autism, etc.
It is the perfect time to share what your child is doing and learning, and to
In This Issue:
- What is a Well-Child Visit?
- Introducing the Well Visit Planner
- Step by Step
- When Your Child has Special Needs

CENTRO SOL
JOHNS HOPKINS

FUNDACIÓN PUNTA DE MITA

COMMUNITY HEALTH CENTER
FQHC QUALITY SM

Relevance to the "Resilience and Healing" Movement



Bhushan D, Kotz K, McCall J, Wirtz S, Gilgoff R, Dube SR, Powers C, Olson-Morgan J, Galeste M, Patterson K, Harris L, Mills A, Bethell C, Burke Harris N, Office of the California Surgeon General. *Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health*. Office of the California Surgeon General, 2020

"Other efforts focus on providing patients with data-sharing platforms to complete screening tools and share data with providers voluntarily in ways that do not violate privacy or confidentiality regulations, such as the ***Well-Visit Planner®***"

Relevant to community-drive public health approaches

"La Salud en Tus Manos" is a program that initiated through a two-year grant from Canada to ***promote family engagement in preventive healthcare for children from 4 months to 6 years of age and adolescents. The model is based on Fundación Punta de Mita research on the context of health among the families in Punta de Mita and Higuera Blanca from 2017 and an online tool for family engagement that was developed at Johns Hopkins Bloomberg School of Public Health.***

Observed Value in RCT & QuasiExp Studies

(n = approx. 14,000)

Child and family strengths, priorities & recommended developmental, psychosocial and maternal depression screening and follow up rates are dramatically increased. Parent priorities are addressed.

Time is freed up in encounters to build relationships and partner with families, to address needs and priorities, conduct observational assessment, build skills & better link to community resources.

Child use of urgent care is reduced. Visit adherence improves. Families learn about opportunities to improve child & family health and partner to get needs met.

Care teams' joy, effectiveness, and efficacy in care is improved along with renewed focus on resources & skill building to meet needs.

Family Experiences (studies to date)

92.4% reported that they were *comfortable with the amount of time it took to complete the Well Visit Planner (WVP) tool.*

92.2% reported that they *would recommend the WVP tool to other parents.*

The majority of parents reported each of the following features as "extremely useful" or "useful:

1) ability to complete the questions at home (97.2%);
2) ability to complete the tool before every visit, with age-specific questions (95.6%);
3) delivery of a report to the provider before the visit (88.5%);
4) access to online educational materials (84.3%);
5) availability of customized Visit Guide to take to the visit (64.7%); and
6) availably of a report to keep as a record for the family (57.8%).

Inherent Value Gained With Engagement of Families	**Observed Value in RCT & QuasiExp Studies** (n = approx. 14,000)	**Hypothesized Value Requiring Further Research**
Parents engage via the Well Visit Planner to reflect on strengths, context & concerns, learn about & select priorities, complete standardized assessments using a whole person, integrated approach (English/Spanish)	Child and family strengths, priorities & recommended developmental, psychosocial and maternal depression screening and follow up rates are dramatically increased. Parent priorities are addressed.	Sustainable trust is built with families & children across all visit contexts (in person, group & virtual) & whole child view establishes integrated approaches to address social, relational, physical & mental health needs
Family visit guide generated in real time reflecting parent responses & shared with provider team (parent choice) to customize use of encounter time & focus on relationship-centered care & community-resource linkages	Time is freed up in encounters to build relationships & partner with families, to address needs & priorities, conduct observational assessment, build skills & better link to community resources.	Stigma is reduced enabling more effective approaches to address social & relational determinants of health& promote equity in collaboration with community partners to promote well-being even amid adversity
Required surveillance & screening occurs & practices receive ongoing reports on quality of care based on Bright Futures guidelines using the Promoting Healthy Development survey	Child use of urgent care is reduced. Visit adherence improves. Families learn about opportunities to improve child & family health and partner to get needs met	Child/family and population-based data that is provided can be used to tier children into levels of care and enable effective tiered, targeted, bundled payments & sustainable services
Population-based data is provided to enable targeted improvement efforts, tailored services & coordination of resources with community	Care teams' joy, effectiveness & efficiency in care is improved along with renewed focus on resources & skill building to meet needs	Available quality of care data can be used to qualify for value based purchasing and pay for performance criteria set by payers.

Alignment with Professional Standards and Requirements

The CAHMI's EC_COE model and tools are carefully aligned to help you meet your goals, standards, and performance requirements.

Meet Standards of Care: The WVP and PHDS align with national *Bright Futures* Guidelines implementation standards set forth by the American Academy of Pediatrics and other standards set forth for home visiting (MIECHV), early care/Head Start, and Child Welfare. ***Click here to learn more.***

Complete Required Screenings Using Valid Screening Tools: All screening tools and items included in the WVP draw on validated measurement and reporting methods tested with families and providers. The WVP is aligned with *Bright Futures* criteria for standardized development surveillance, developmental screening, maternal depression screening, and other screening recommendations. ***Click here to learn more.***

Improve Quality of Care: The WVP and PHDS are designed to foster improvements in quality as measured by the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures and the Medicaid Core Measurement Set. The WVP and PHDS align with 7 of the 19 HEDIS measures for children, adolescents, and maternal health, 2 of the 4 HEDIS measures related to preventive care for children, and 5 out of 8 Medicaid Core Set "Primary Care Access and Preventive Care" measures (62%).

Beginning in 2024, State Medicaid agency reporting of the Child Core Set will become mandatory as a result of the Bipartisan Budget Act of 2018. The Well Visit Planner and Promoting Healthy Development Survey can help you meet these standards.

Click here to learn more.

The WVP and PHDS align with 7 of the 19 HEDIS measures for child, adolescent & maternal health, 2 of 4 HEDIS measures on child preventive care and 4 of 8 Medicaid Core Set "Primary Care Access and Preventive Care" measures

AAP **Bright Futures** *Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition* **recognizes the SWYC** as a commonly used screening tool in the Promoting Healthy Development section of its Health Promotion Themes:

> *"In monitoring development during infancy and early childhood, ongoing surveillance is supplemented and strengthened by* ***standardized developmental screening*** *tests that may be used at certain visits (9 Month, 18 Month, and 2½ Year) and at other times at which concerns are identified. Commonly used developmental screening tools include the Ages and Stages Questionnaires (ASQ), the Parents' Evaluation of Developmental Status (PEDStest), and the* ***Survey of Well-being of Young Children*** *(SWYC)…The* ***SWYC****, which also includes autism screening; PEDStest; and ASQ all include* ***psychosocial screening*** *that can be used to identify cognitive, emotional, and behavioral concerns from birth through age 5 years."*

Promoting Healthy Development. Bright Futures: *Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition. Retrieved from here.

The EC_COE's WVP and PHDS—Alignment child serving programs:

Maternal, Infant, Early Childhood Home Visiting Program (MEICHV): 16 of 19 measures (84%)

Head Start/Early Head Start: Aligned with 23 standards across 5 HS/EHS performance standards sections related to child development: 1304.20; 1304.20; 1304.21; 1304.24; 1304.40

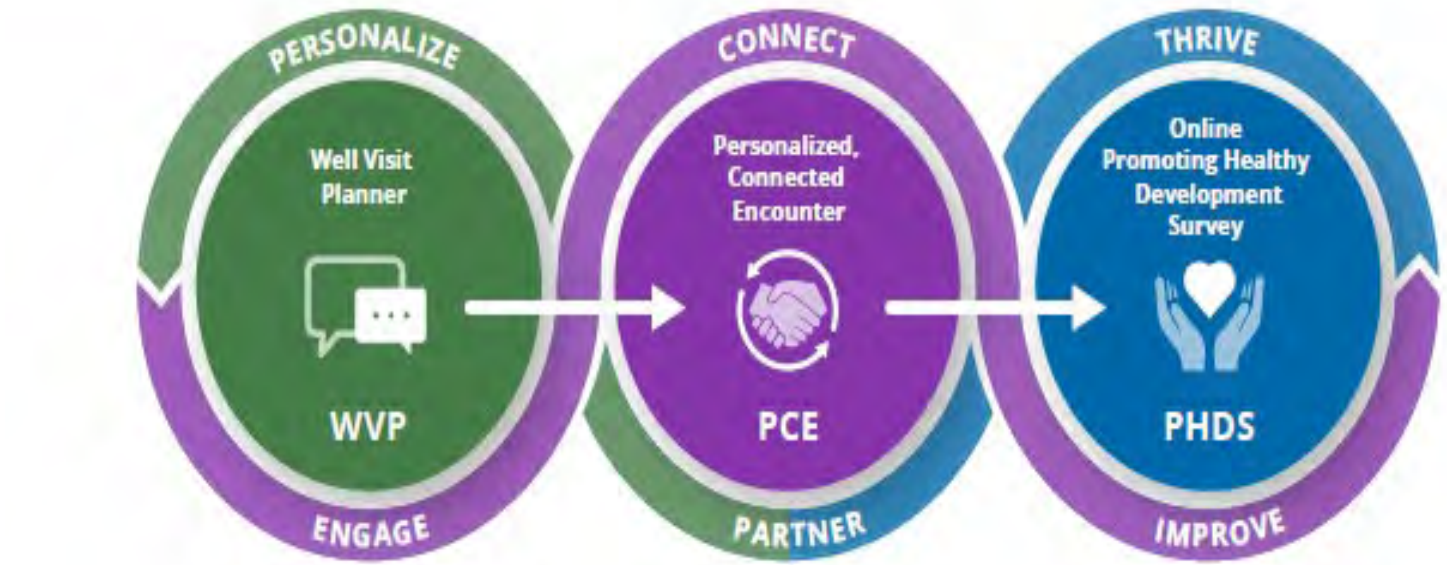
AAP Bright Futures Implementation, Quality Improvement Measures: Aligned with 13 of 14 QI measures (93%)

HEDIS/NCQA: Aligned with 7 of the 19 HEDIS measures for child, adolescent & maternal health & 2 of 4 HEDIS measures on child preventive care

Medicaid/CHIP Core Measures: Aligned with 4 of 8 Medicaid Core Set "Primary Care Access and Preventive Care" measures.

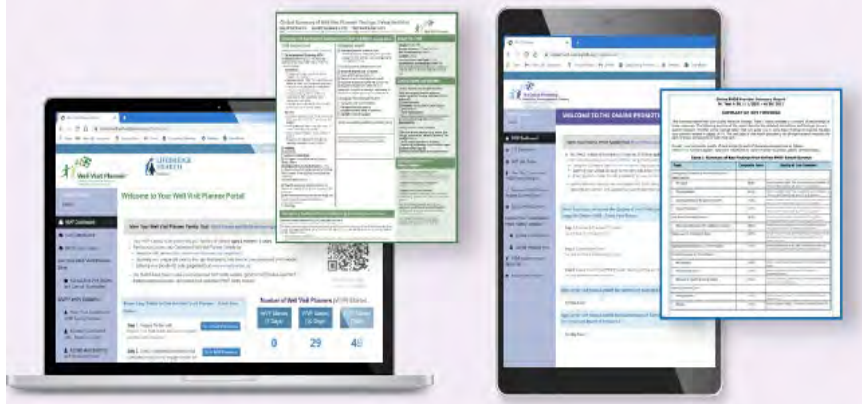
CAHMI's Early Childhood Cycle of Engagement

A project of the Child & Adolescent Health Measurement Initiative



Family Tools and Reports

Provider and Care Team Dashboards and Reports



The Early Childhood Cycle of Engagement was built to help you personalize your child's care.

Your child's health care providers want to partner with you to meet the unique needs of your child and family.

Well Visit Planner®

- ✔ Take ***10 minutes to use the online Well Visit Planner*** before each of your child's well visits and get your personalized visit guide to keep and share with your child's provider or anyone else! English and Spanish.
- ✔ Be ***confident knowing you have considered the most important questions*** about your child's development and pick your priorities for discussion during well visit check-ups.
- ✔ ***Streamline and get a personalized summary*** of results from questions about how your child and family are doing. No more rushing to fill out forms in the waiting room.
- ✔ ***Get your own free, secure family account*** to manage and track your child's well visits and their development. You can use on a mobile device and for multiple children at the same time.

During the Well Visit:

- ✔ When you use the Well Visit Planner before each visit, you and your child's providers start well visit check ups knowing **how things are going and what matters most to you!**
- ✔ TheWell Visit Planner frees up **more time to connect, address your priorities, and give you the support, information, and resources you need.** Fewer forms, more time to talk.
- ✔ **Your child's well-being depends on your and your family's well-being.** The Well Visit Planner and your personalized Visit Guide make sure your family gets the support, care, and help you need to thrive!

The Online Promoting Healthy Development Survey

- ✔ Complete the Promoting Healthy Development Survey (PHDS) when your provider asks you to or whenever you want to make sure you ***get the best care possible.***
- ✔ Using the PHDS also reinforces what you should expect in your child's care and gives you a **personalized feedback report** on the quality of your child's care.
- ✔ Your **provider gets results from this anonymous survey** to continue to partner with you and other families to **improve care** and help **your child, you and your family thrive!**
- ✔ Your answers are confidential and ***your provider wants your feedback!***

Not Secure — wellvisitplanner.org

Well Visit Planner®
A Project of The Child & Adolescent Health Measurement Initiative

Home | About | Educ

LIFEBRIDGE HEALTH

Create a Family Account

WELCOME TO THE WELL VISIT PLANNER!

Paige P of Paige's Practice invites you to take **10 minutes to complete the** **get your customized Visit Guide** to use during your child's well visit to ma get the best health care possible. The Well Visit Planner will help you and P address your child and family's most important priorities and needs.

Paige P will have access to your Visit Guide, and we encourage you to send through email or your patient portal.

The Well Visit Planner is a simple, online tool that helps

- **REFLECT** on what's going well for you and your family
- **IDENTIFY** your needs and concerns
- **PICK** your top priorities and get educational information
- **SHARE** your personalized Visit Guide with your child's provider
- **PARTNER** with your child's provider to make the most of your child's w

Reflect & Assess — Pick Your Priorities — Get & Share Your Visit Guide

The Well Visit Planner tool takes approximately 10 minutes to comple

Well Visit Planner®
A Project of The Child & Adolescent Health Measurement Initiative

LIFEBRIDGE HEALTH Pediatrics

English

Make the most of your child's well visit.
Save and share your Visit Guide.

Have a family account? Login here

Home/WVP | About | Information and Resources on Your Priorities | FAQ | Help | Contact Us

www.wellvisitplanner.org/paigestest3

TELL US WHAT YOU THINK

Your Child, Your Well Visit

Your Child's Personalized 15 Month Well Visit Guide

Your special keyword is:
TestClinicalSummary

Child's Name:
Name Test

Child's initials:
CNT

Child's birth month/year:
3/2020

WVP Completed:
5/11/2021

Parents: This Well Visit Planner Visit Guide includes:

- **Priorities you want to discuss with your child's provider**
- Any special issues or concerns to discuss about how your child is growing or developing
- **Special resources and links from your child's provider**

Don't forget to review **resources and assessments from Paige P at the bottom of this Visit Guide and get ready to partner!**

Click the buttons below to save and submit this Visit Guide with your child's provider.

Click the ⓘ icons to learn about your options. This Visit Guide is confidential and does not include your child's name or date of their well visit. To be sure your child's provider gets this Visit Guide from you personally, please click on 'Save and Submit' below and choose among your options for sharing with your child's provider. Note: If you created a private family account on the Well Visit Planner website, this Visit Guide will also be saved to your family dashboard. ⓘ

SAVE AND SUBMIT ⓘ | MAKE THE MOST OF YOUR CHILD'S WELL VISIT ⓘ | PRINT THIS VISIT GUIDE ⓘ

information you provide is confidential and will only be shared with your provider.
id allow anyone other than you and your provider to identify your child's Visit Guide.
name or your email address.

Family account benefits

Keep track
Keep track of and save your Visit Guides

Complete and save
Complete unfinished WVP (within 48 hours)

Review
Review educational materials

Create a family account

OR

Continue as a guest

Are you interested in using the Well Visit Planner with the families you work with?

FIND OUT MORE

About the CAHMI

LEARN MORE

greement | Privacy Notice | Educational Materials | FAQ | Help | Contact Us

MJ | Johns Hopkins | innovate HEALTH

id and Adolescent Health Measurement Initiative, Center for the of Innovative Health Practices (2005), OHSU (2013), JHU (2021).

Topics Assessed Using the Well Visit Planner (WVP)

The Well Visit Planner® is a brief family-completed, pre-visit planning tool anchored to *Bright Futures* guidelines for children ages 4 months to 72 months (other ages coming soon!)

CORE CONTENT

- Tailored for 11 recommended visits based on *Bright Futures* guidelines (ages 4 months to 72 months)
- English and Spanish
- Mobile optimized
- Not all content applies for all ages

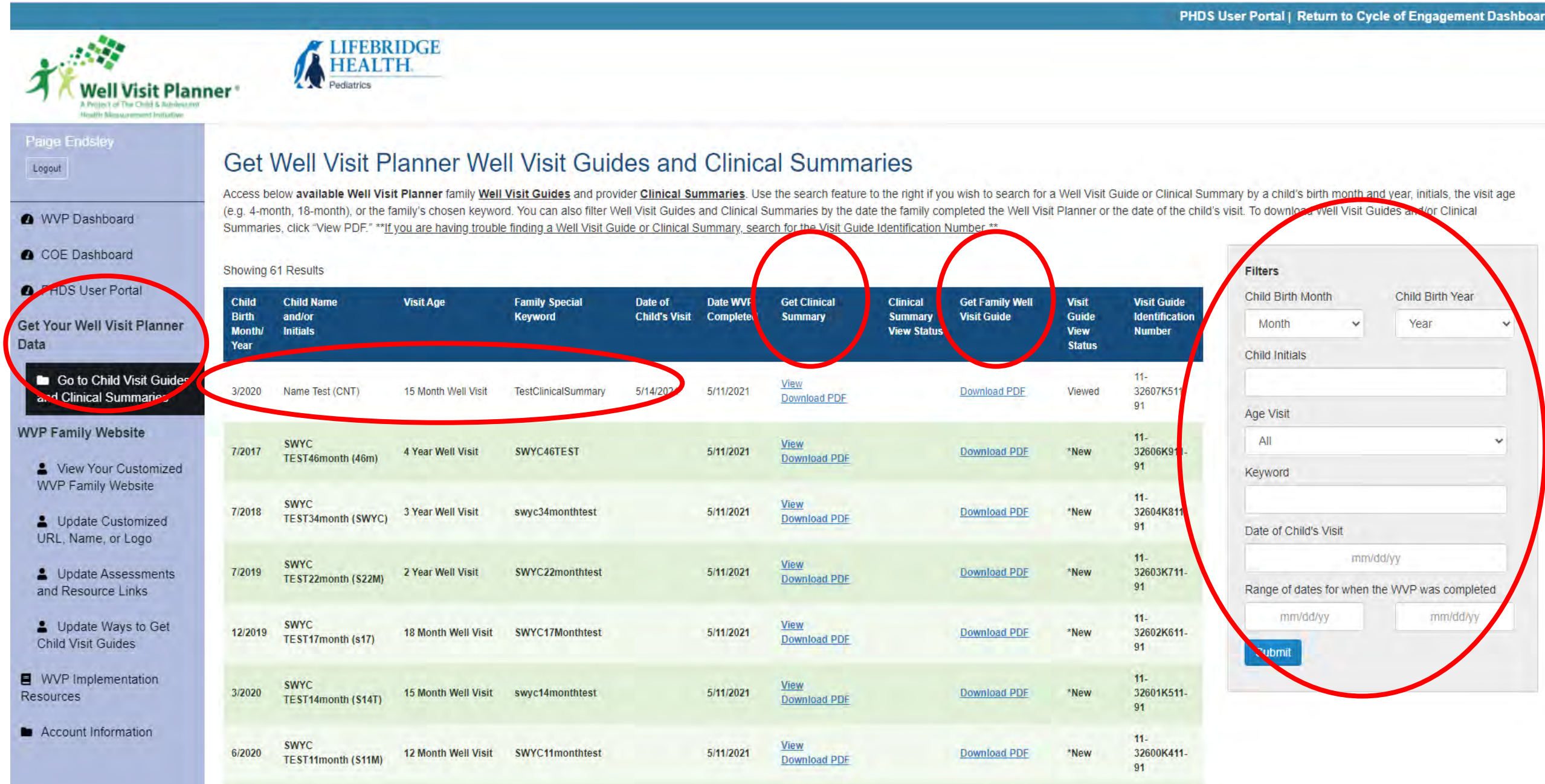
- Child and parent/caregiver **strengths** (what is going well!)
- Developmental **surveillance and standardized developmental screening** using the Survey of Well-Being of Young Children (**SWYC**)
- Caregiver concerns about speaking, vision, hearing
- Other caregiver concerns about development (open ended response)
- Caregiver **depression** using the Patient Health Questionnaire-2 (**PHQ-2**) or Edinburgh Postnatal Depression Scale (**EPDS**)
- Family **psychosocial issues** (e.g., meeting basic needs, alcohol and substance use, smoking, emotional support, coping, experiencing racism, etc.)
- **Intimate Partner Violence** using the Women Abuse Screening Tool-Short (**WAST-Short**)
- **Anticipatory guidance and parental education** prioritization checklist (can pick up to 5 across all recommended; average selected is 3)
- **Other child health** and updates (age-specific; e.g., nutrition, medications, vitamins, having a special health care need, etc.)
- **Other family health** history and updates (heart, stroke, blood pressure, new problems, recent changes or stressors)
- **Other environmental** assessments (e.g., living situation, lead, fluoride)

OPTIONAL ASSESSMENTS AND TOPICS

- **Child Flourishing Index (CFI)**
- **Family Resilience Index (FRI)**
- Parent-Child **Emotional Connection** Items (derived from the Welch Emotional Connection Screen (WECS))
- **Protective Family Routines and Habits (PFRH)**
- **Pediatric ACEs and Related Life-events Screener (PEARLS)**
- **Other social-emotional screening** (Baby Pediatric Symptom Checklist (BPSC) and Preschool Pediatric Symptom Checklist (PPSC))
- Impact of COVID-19

Additional assessments will be added as requested by users. Other assessments can be added by you during customization of your WVP.

Accessing family Well Visit Guides and provider Clinical Summaries



ADDRESSING Mental Health CONCERNS IN PRIMARY CARE A CLINICIAN'S TOOLKIT

MNEMONIC FOR COMMON FACTORS COMMUNICATION METHODS: HELP

H = Hope

Hope facilitates coping. Increase the family's hopefulness by describing your realistic expectations for improvement and reinforcing the strengths and assets you see in the child and family. Encourage concrete steps toward whatever is achievable.

E = Empathy

Communicate **empathy** by listening attentively, acknowledging struggles and distress, and sharing happiness experienced by the family.

L^2 = Language, Loyalty

Use the child and family's own **language** (not a clinical label) to reflect your understanding of the problem as they see it and to give the child and family an opportunity to correct any misperceptions.

Communicate **loyalty** to the family by expressing your support and your commitment to help now and in the future.

P^3 = Permission, Partnership, Plan

Ask the family's **permission** for you to ask more in-depth and potentially sensitive questions or to make suggestions for further evaluation or management.

Partner with the child and family to identify any barriers or resistance to addressing the problem, find strategies to bypass or overcome barriers, and find agreement on achievable steps (or simply an achievable first step) that are aligned with the family's motivation. The more difficult the prob- lem, the more important is the promise of partnership.

On the basis of the child and family's preferences and sense of urgency, establish a **plan** to expand the assessment, change a behavior or family routine, try out a psychosocial intervention, seek help from others, work toward greater readiness to take one or more of these actions, or monitor the problem and follow up with you. The plan might include, for example, completing additional checklists or questionnaires, keeping a diary of symptoms and triggers, gathering information from other sources such as the child's school or child care center, making lifestyle changes, applying new parenting strategies or self-management techniques, reviewing educational resources about the problem or condition, seeking mental health specialty care or social services, or simply returning to the medical home for further discussion.

Use of the HELP mnemonic builds a therapeutic alliance between the clinician and the patient and family and improves the likelihood of follow-through on a plan of care. This approach is well suited to the care of patients who would benefit from a behavior change, patients whose symptoms are undifferentiated and patients whose symptoms do not reach a diagnostic threshold, patients who are resistant or otherwise not yet ready to pursue further diagnostic assessment or treatment, and patients who are awaiting further diagnostic assessment and treatment. Use of the HELP mnemonic should not delay a full diagnostic evaluation or definitive therapy if the patient's symptoms suggest a psychiatric emergency, severe impairment, or marked distress.

Adapted from American Academy of Pediatrics, *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit*. Elk Grove Village, IL: American Academy of Pediatrics; 2010. Updated May 2017.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit*. Copyright © 2010 American Academy of Pediatrics, revised January 2019. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.

H Hope

Increase the family's hopefulness by describing your realistic expectations for improvement and reinforcing the strengths and assets you see in the child and family.

E Empathy

Communicate empathy by listening attentively.

L^2 Language

Use the child or family's own language to reflect your understanding of the problem as they see it and to give the child and family an opportunity to correct any misperceptions.

Loyalty

Communicate loyalty to the family by expressing your support and your commitment to help.

P^3 Permission

Ask the family's permission for you to ask more in-depth questions or make suggestions for further evaluation or management.

Partnership

Partner with the child and family to identify any barriers or resistance to addressing the problem, find strategies to bypass or overcome barriers, and find agreement on achievable steps aligned with the family's motivation.

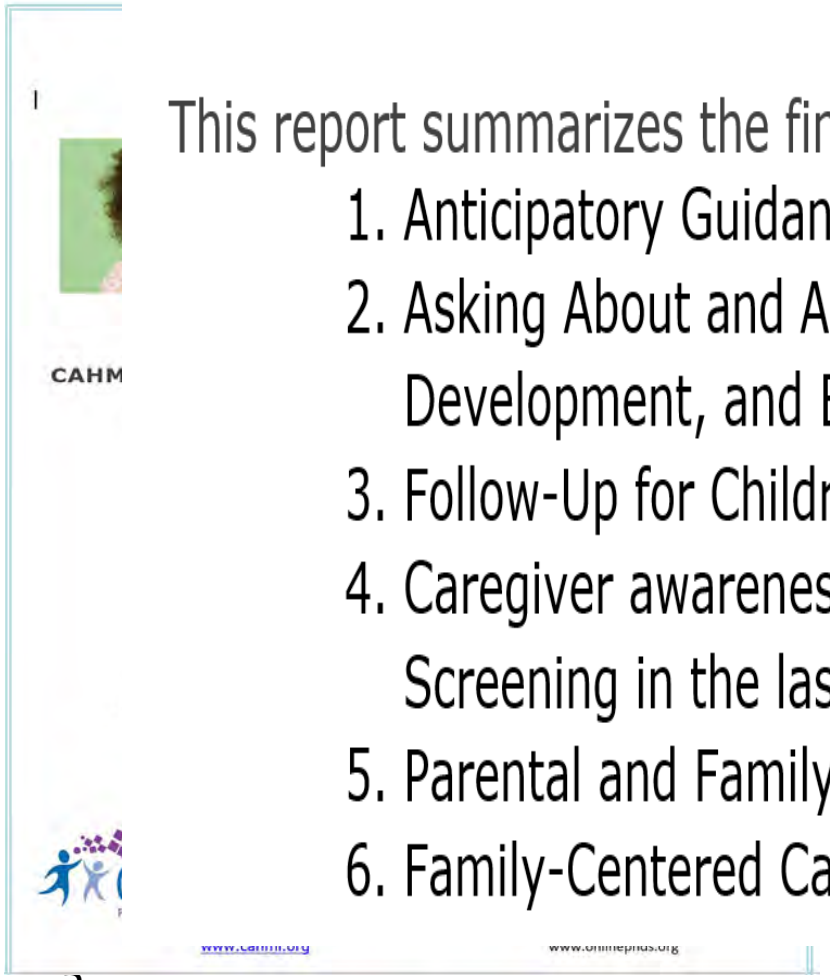
Plan

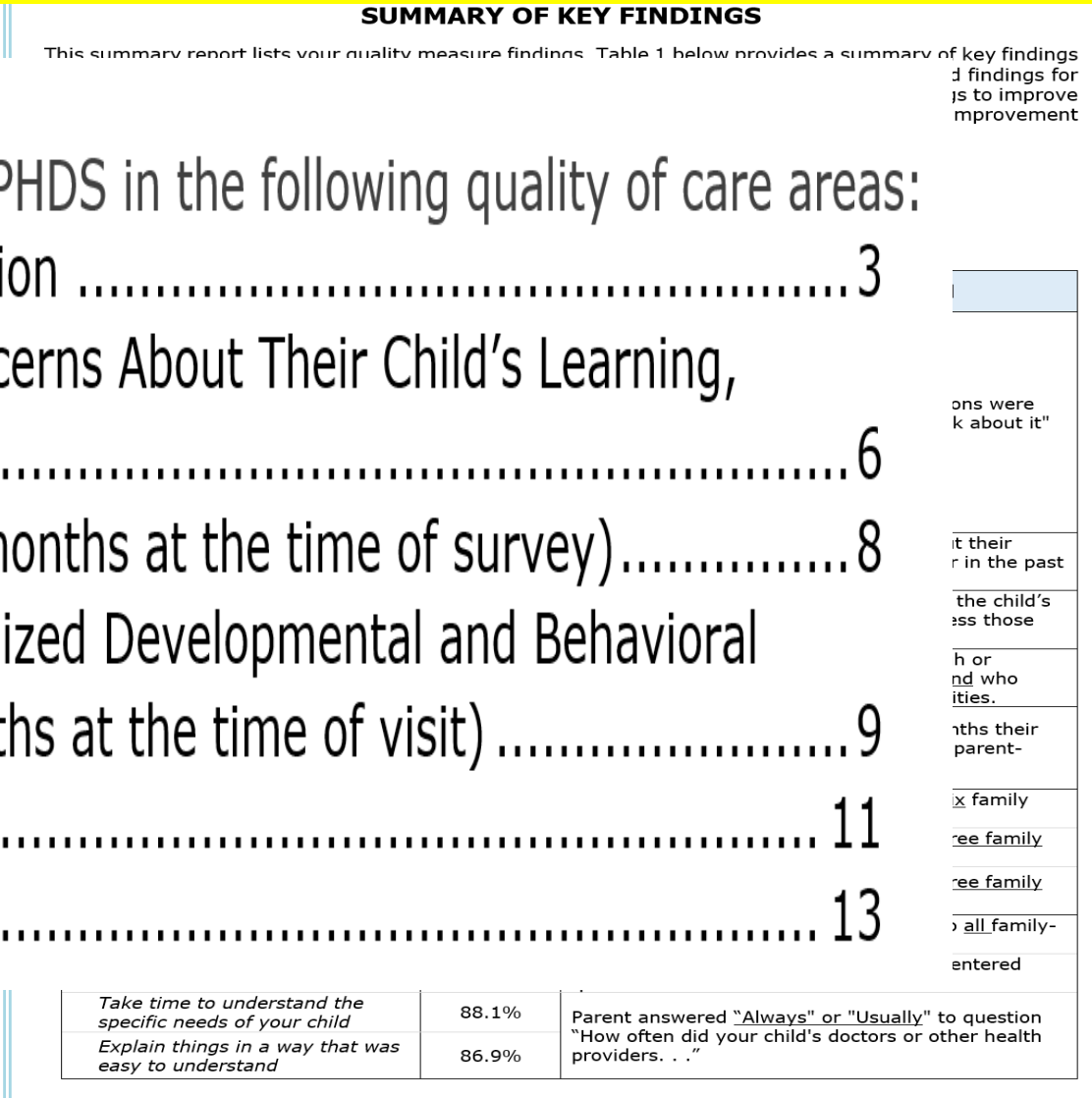
Establish a plan (or incremental first step) through which the child and family will take some action(s), work toward greater readiness to take action, or monitor the problem, then follow up with you, based on the child and family's preferences and sense of urgency. (The plan might include, for example, gathering information from other sources such as the child's school, making lifestyle changes, applying parenting strategies or self-management techniques, reviewing educational resources about the problem or condition, initiating specific treatment, seeking referral for further assessment or treatment, or returning for further family discussion.)

Considerable evidence suggests that medical generalists can readily learn and retain these techniques.[4–6]

Promoting Healthy Development Survey Overview

Purpose: To measure the quality of well child care as set forth in Bright Futures. **Developed/Validated**: 1997-2001.NQF endorsed: 2008. **Use Highlights**:12 State Medicaid Agencies, 100's providers; health plans, National Survey of Early Childhood Health, , Research/ABCD Evaluation;





The Online Promoting Healthy Development Survey

Darian Witting

Logout

- Dashboard
- Your Customized Online PHDS Website for Families
- Review Online PHDS Content
- Generate Reports
- Get CME Credits (Coming Soon)
- ABP Application (Coming Soon)
- Implementation and Quality Improvement

WELCOME TO THE ONLINE PROMOTING HEALTH DEVELOPMENT SURVEY PORTAL!

SUCCESS! You have completed the customization of your Online PHDS.

Your unique URL link for the Online PHDS http://demostaging.onlinephds.org/trantow8588 is ready to be shared with your families of children **age 3 to 48 months.** Your unique name for the Online PHDS trantow8588 is ready to be shared with families as well (direct them to www.onlinephds.org and have them search your unique name).

Visit your **customized Online PHDS website by clicking on "Your Customized Online PHDS Website for Families"** in the left-hand menu. When you are on the website, you can copy the link/URL and share it with families. Here you can also review and edit your PHDS link/URL name and logo.

To manage your practice or organization information, please visit the Profile page on the Cycle of Engagement Portal.

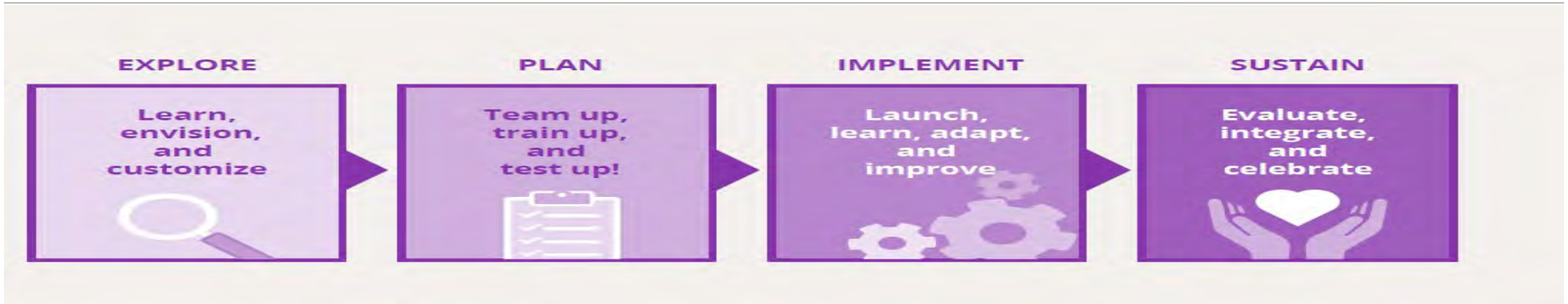
Three Easy Steps to Assess the Quality of Well-Child Care in Your Practice Using the Online PHDS – Track Your Status

Step 1. Provider & Practice Information — Complete

You are ready to collect parent data.

Number of PHDS Surveys Completed by Parents

Surveys Completed (7 Days)	Surveys Completed (30 Days)	Surveys Completed (Total)



Implementation phases	Phase I: Exploration Educate and Engage Focus: Decide whether and how to use the COE model and tools	Phase II: Planning Plan and Prepare Focus: Prepare and proceed to lay a foundation for success	Phase III: Implementation Implement and Innovate Focus: Launch, learn and innovate to make it work for you	Phase IV: Sustaining Show and Sustain Focus: Demonstrate success and integrate into operations
At-a-Glance CAHMI Cycle of Engagement Model and Tools, Implementation Milestones & Resources				
Key Milestones for each implementation phase	**Discover**: Learn about the COE model, the Well Visit Planner, Personalized Connected Encounter and Promoting Healthy Development tools, options and requirements and tips for use.	**Team Up**: Gather a team to prepare and plan steps, roles and resources needed. Create a team charter and commit to success.	**Launch & Learn**: Implement the COE with your team as planned (phases, stages, adaptive process), conduct rapid-cycle learning and improvement	**Reflect & Celebrate**: Continuously reflect, celebrate what's working and identify what could be improved.
	Assess: Determine fit of COE model and tools with your aspirations, goals, strengths, and capacity.	**Train Up**: Conduct team learning sessions to plan workflows, processes & materials you need.	**Partner & Engage**: Continuously partner and engage with families to gain value and improve on outcomes and goals for the COE	**Embed & Engage**: Establish operational capacity to embed the COE/WVP as standard of care; keep supporting existing and new teams to use, innovate, improve.
	Design: Create, customize & test drive your own COE implementation vision and goals.	**Test Up**: Sign up for COE accounts, customize your WVP and/or PHDS and phase implementation as you finalize your processes and plan.	**Adapt & Evolve**: Learn from implementation and continue to adapt and use best practice quality improvement approaches (PDSA).	**Integrate & Incentivize**: Integrate the COE/WVP into training, incentives, performance measurement, branding, etc.

WVP Postcard

To be used:

1. Given to families in waiting room to complete WVP before visit
2. Given to families when scheduling after visit
3. Attached to emails/patient portal messages

QR Codes for Inviting Families to Complete the WVP and PHDS

To be printed and posted:

1. In waiting rooms
2. In scheduling areas
3. In visit rooms
4. Attached to emails/patient portal messages
5. Printed and handed out as a flier

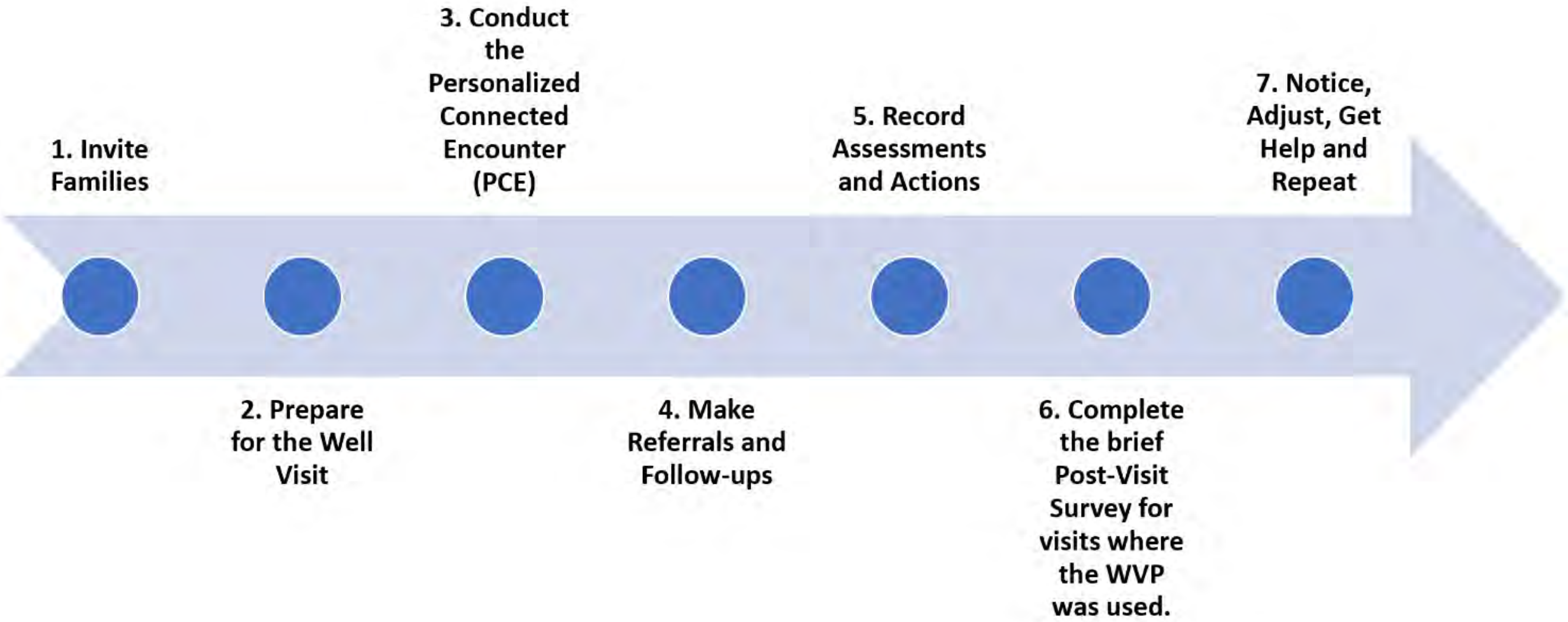
How can families use a QR code?

1. Open the camera app on their smart phone/tablet/device and point it steadily for 2-3 seconds at QR code.
2. When scanning is complete, a notification will appear directing you to open the QR code's URL.
3. Click on the notification to go directly to that URL!
4. If no notification appears, family may need to change settings on their device to enable QR scanning.

To WVP (www.wellvisitplanner.org):

To PHDS (www.onlinephds.org):

EC_COE Family Engagement and Visit Workflow Example



eclkc.ohs.acf.hhs.gov/physical-health/article/well-visit-planner-families

U.S. Department of Health & Human Services | Administration for Children & Families | Contact Us | 1-866-763-6

ECLKC

About Topics

The Well-Visit Planner for Families

The Well-Visit Planner is an Internet-based tool (www.wellvisitplanner.org) developed to improve well-child care for children 4 months to 6 years of age. Information in this tool is based on recommendations established by the *American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition.* The tool helps parents and caregivers to customize the well-child visit to their family's needs by helping them identify and prioritize their health risks and concerns before the well-child appointment. This means that parents and health care professionals are better able to communicate and address the family's needs during the well-child visit.

The Well-Visit Planner and Head Start

The Child and Adolescent Health Measurement Initiative (CAHMI) has worked with the Offi
Well-Visit Planner through age 6 years and has prepared materials to help Head Start and E
serve. Knowing that school readiness begins with health, Head Start and Early Head Start pr
being of every child enrolled in a program. The Well-Visit Planner has been tested in several
parents to complete well-child visits and become familiar with what is expected at each visit
for their child's needs—including those related to health.

Using the Well-Visit Planner in Head Start and Early Head S

In partnership with the National Center on Health, CAHMI h
begin using the Well-Visit Planner as a standard part of their
programs with step-by-step implementation of the Well-Visi
among parents. Materials are also there to help reach out to
their patient families.

These materials will be housed on the Early Childhood Learn
http://www.cahmi.org/projects/wvp/, the implementatior

How does the Well-Visit Planner help families?

Completing the tool, which takes about 15 to 20 minutes, will help empower parents and ca
child visit; it will also prepare them for what to expect at that visit. The content of the Well-V
developed to be used before each well-child visit through 6 years of age. The Well-Visit Plan

Not secure | fv-impact.org/publications/well-visit-planner-media-toolkit/

IMPACT on HEALTH & WELLNESS

FAMILY VOICES ... keeping families at the center of children's health care

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TRANSLATE Select Language

Home > IMPACT Products > Well Visit Planner Media Toolkit

SHARE

How was the Well Visit Planner Developed?

The Well Visit Planner (WVP) was developed and created by the Child and Adolescent Health Measurement Initiative (CAHMI) (www.cahmi.org). National experts, families, and pediatric providers worked together in the design, development, and testing of the WVP. The information contained in the WVP is based on the American Academy of Pediatrics *Bright Futures Guidelines for the Health Supervision of Infants, Children, and Adolescents* (https://brightfutures.aap.org)

The Child and Adolescent Health Measurement Initiative (CAHMI) is a national initiative based out of the Bloomberg School of Public Health at Johns Hopkins University in Baltimore, MD. The WVP tools were developed and tested for use in pediatric practices under a four year grant from the federal

The Well Visit Planner

The Well Visit Planner is an online tool to help families prepare for their children's upcoming well-child visits to the health care provider. It's free to use; is available in English and Spanish; takes 10-15 minutes to fill out before each visit; and can be printed and taken to a visit to help your and your child's doctor discuss your child. It helps families be better partners in their child's health care, and helps health care providers better serve the needs of the child and the family. To use the Well Visit Planner, go to: www.WellVisitPlanner.org.

Please help spread the word about this useful tool to families, including families of children with special needs. Feel free to use the following resources, many now available in Spanish, in your newsletters, websites, Facebook pages, and any other outlet to reach families about this practical, informative tool.

Handouts

Please print these and disseminate or share electronically.

Family Voices Bright Futures Family Matters Newsletter

Well Visit Planner Flyer

Frequently Asked Questions for Families

Frequently Asked Questions for Providers

Join us to improve the early and lifelong health of children and families!

cbethell@jhu.edu
info@cahmi.org

How the Well Visit Planner® Helps Your Family Thrive:

Stay on track. Identify what you want to discuss prior to your child's visit.

Save time at the visit. Send your Visit Guide straight to your child's provider to review and plan for your child's visit.

Know what to look for. Learn what to expect developmentally for your child's age and discover topics that experts recommend for you to discuss with your child's provider.

Get support. Reliable educational materials, accessible 24/7, speak to your priorities as a family.

Create open dialogue. Use your Visit Guide to partner with your child's provider and ensure your needs are met.

Parent and pediatrician recommended. Over 92% of providers and families recommend the Well Visit Planner®. 97% of parents reported it was helpful or very helpful in preparing for their well visit.

"It helped me keep focus on what I was going to talk about." – **Parent & WVP User**

"The truth is that the first time, I was a little afraid that it would be a long process or that it would be a little complicated but even from the first time it was fast and it helped me a lot because...I planned my visit, all the questions that I might have, the doubts that I had. Then when I went to the appointment, they were prepared to tell me. So then, I liked it." – **Parent & WVP User**

Questions?

Extra Slides as Needed During Questions

Aspects of Quality Assessed Using the Promoting Healthy Development Survey

The Online PHDS is a valid family-reported, post-visit assessment of quality of care for families of children 3 months to 6 years.

QUALITY OF CARE MEASURES

- **Anticipatory guidance and parental education** needs are met
- Receives recommended developmental **surveillance** and standardized **developmental screening** occurs
- **Follow up occurs** for children at risk for developmental problems (using PEDS)
- Basic **psychosocial screening occurs**
- Surveillance of caregiver **mental health conducted**
- **Family concerns** about child development are addressed
- Surveillance about problems/issues in the **community** occurs and resources provided
- **Core medical home criteria are met** (e.g., personal doctor or nurse; access to and coordination of care, family centered care)

*Quality measures are stratified by child/family demographics, caregiver mental health, child developmental status and having a special health care need (**CSHSCN Screener**).*

OPTIONAL CONTENT

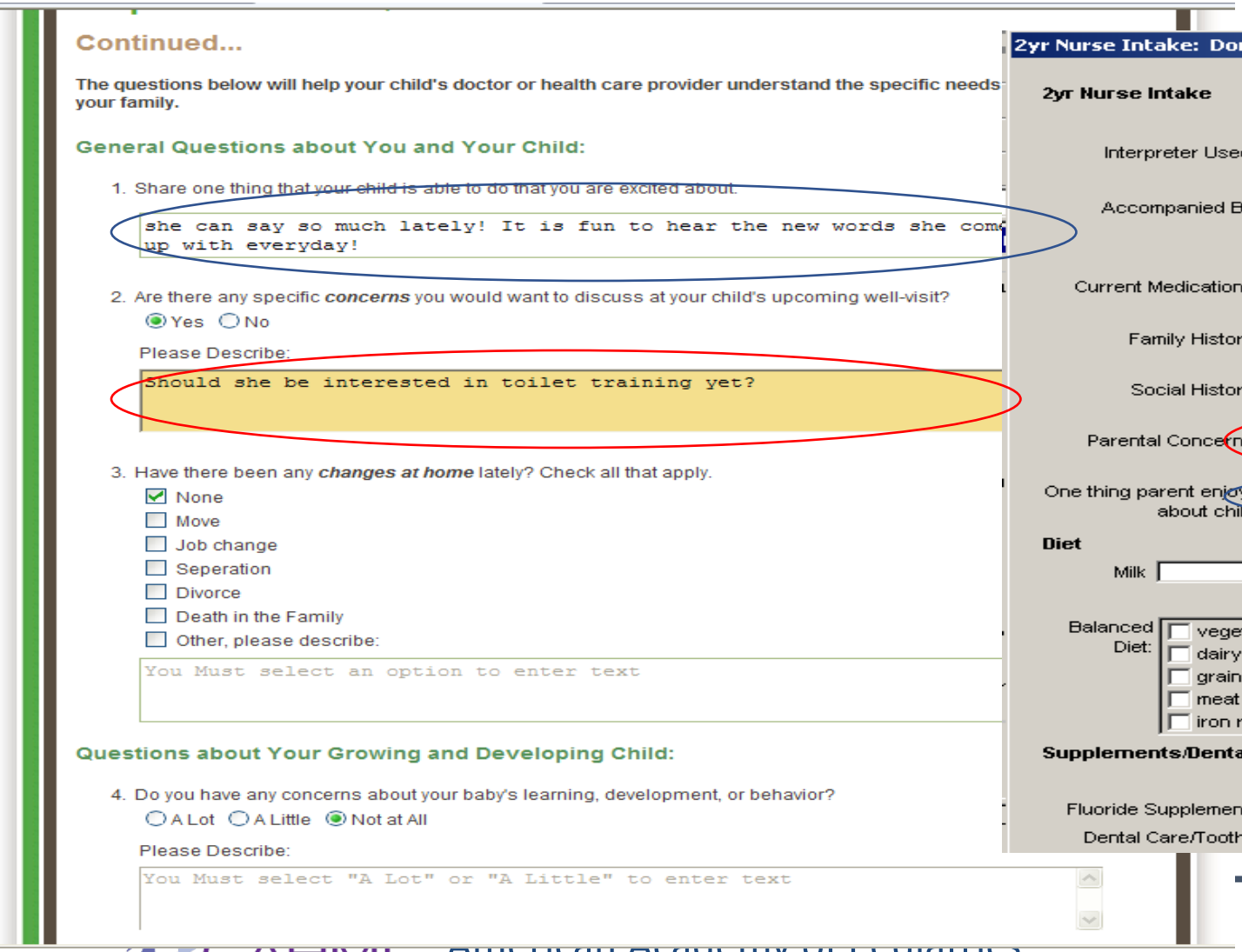
- Caregiver interest in telemedicine and concerns/barriers to telemedicine
- Impact of COVID-19 on child's well visits and daily life
- Feedback on the use of the Well Visit Planner (if using this tool)

Additional assessments will be added as we discern their need by EC_COE users.

COE Office Workflow for Engaging Families

Before the Visit (before arriving at the office)	Before the Visit (in the office)	During the Visit (at the office)	After the Visit (in office and at family home)
T1. Invite families to complete PHDS about last visit, and WVP for next visit. Resources: *Options and resources for inviting families to complete WVP and PHDS*	**T1. Begin to engage/educate families:** • Hang COE Posters in waiting area, scheduling area, visit rooms • Hand out WVP and PHDS postcards • Answer questions about COE, WVP and PHDS	T5. Family does ***not complete the WVP ahead of visit, complete with provider during visit.***	T6. Family is ***invited during visit or after to complete PHDS at home, after the visit*** Resource: *Options and resources for inviting families to complete PHDS2*
T2. Family ***completes the WVP*** ahead of visit, and either *emails/uploads Visit Guide to Patient Portal*	T2. Family does ***not complete the WVP*** ahead of visit, but ***complete WVP and receive Visit Guide*** on phone in ***waiting room.***	T5. Provider and family have ***relationship-centered encounter***, making the most of limited time available.	T6. Family is ***reminded to complete WVP and share their Visit Guide before their next well visit*** *Resource: Options and resources for inviting families to complete WVP*
T2. Family ***completes the WVP*** ahead of visit, but does not share it with provider	T3. Family ***Visit Guides retrieved from WVP User Portal*** (printed or opened on provider's computer) by office lead/provider		T7. If family ***did not complete WVP before or during visit***, they are invited to ***complete WVP and share Visit Guide before next well visit.*** *Resource: Options and resources for inviting families to complete WVP*
T2. Family ***completes the PHDS*** ahead of visit about last well visit.	T4. Provider ***prepares for visit*** with Visit Guide and tailors encounter to ***family's concerns, needs and priorities***; personalized ***resources and referrals as needed***	**Consider**: Who will be doing this? When? How?	

Examples of the EHR Feed: Open Ended items



Continued...

The questions below will help your child's doctor or health care provider understand the specific needs your family.

General Questions about You and Your Child:

1. Share one thing that your child is able to do that you are excited about.

she can say so much lately! It is fun to hear the new words she com up with everyday!

2. Are there any specific ***concerns*** you would want to discuss at your child's upcoming well-visit?

(•) Yes ( ) No

Please Describe:

Should she be interested in toilet training yet?

3. Have there been any ***changes at home*** lately? Check all that apply.

- [x] None
- [ ] Move
- [ ] Job change
- [ ] Seperation
- [ ] Divorce
- [ ] Death in the Family
- [ ] Other, please describe:

You Must select an option to enter text

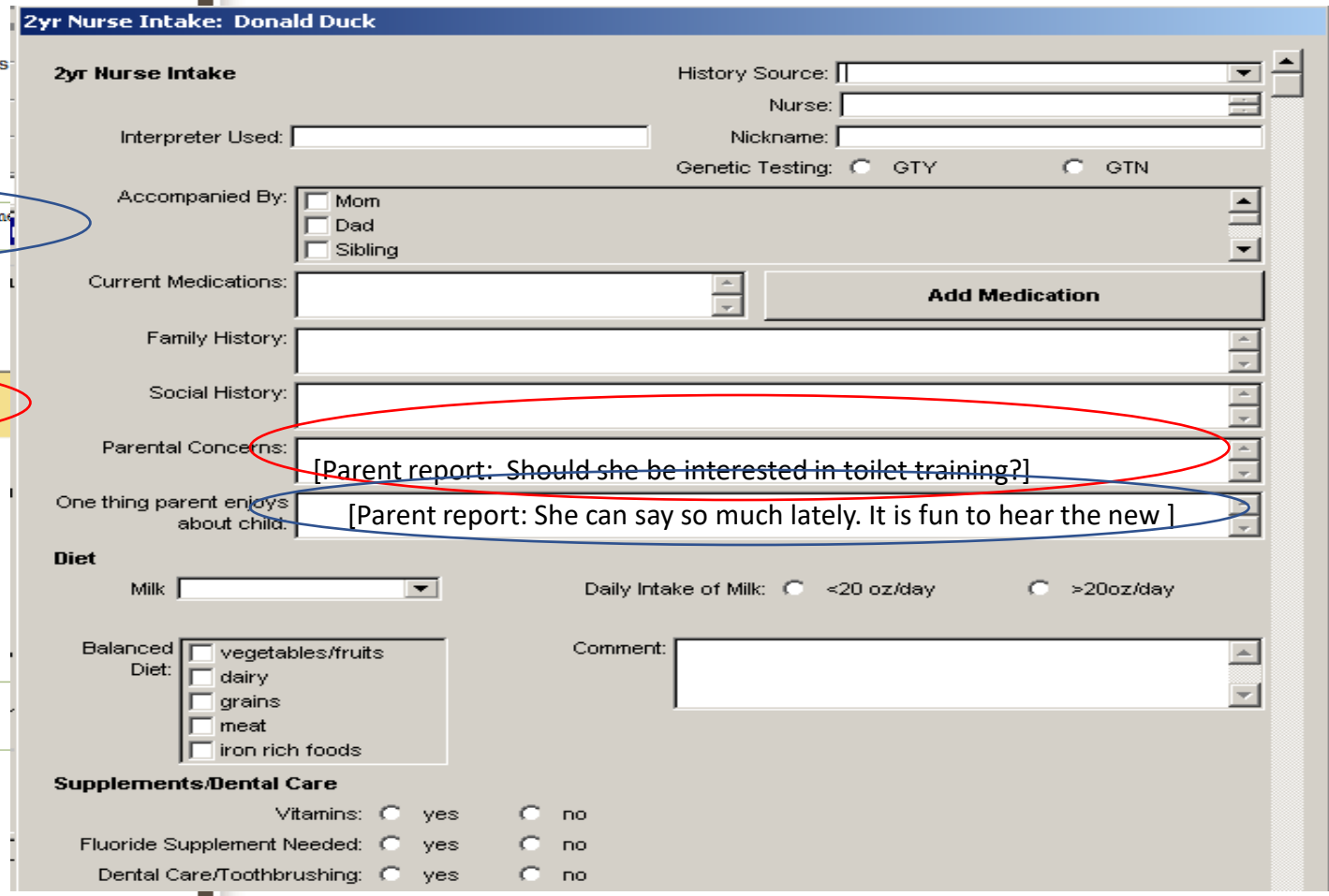
Questions about Your Growing and Developing Child:

4. Do you have any concerns about your baby's learning, development, or behavior?

( ) A Lot ( ) A Little (•) Not at All

Please Describe:

You Must select "A Lot" or "A Little" to enter text



2yr Nurse Intake: Donald Duck

2yr Nurse Intake

History Source:

Nurse:

Interpreter Used:

Nickname:

Genetic Testing: GTY GTN

Accompanied By: Mom, Dad, Sibling

Current Medications:

Add Medication

Family History:

Social History:

Parental Concerns:

[Parent report: Should she be interested in toilet training?]

One thing parent enjoys about child:

[Parent report: She can say so much lately. It is fun to hear the new]

Diet

Milk

Daily Intake of Milk: <20 oz/day >20oz/day

Balanced Diet: vegetables/fruits, dairy, grains, meat, iron rich foods

Comment:

Supplements/Dental Care

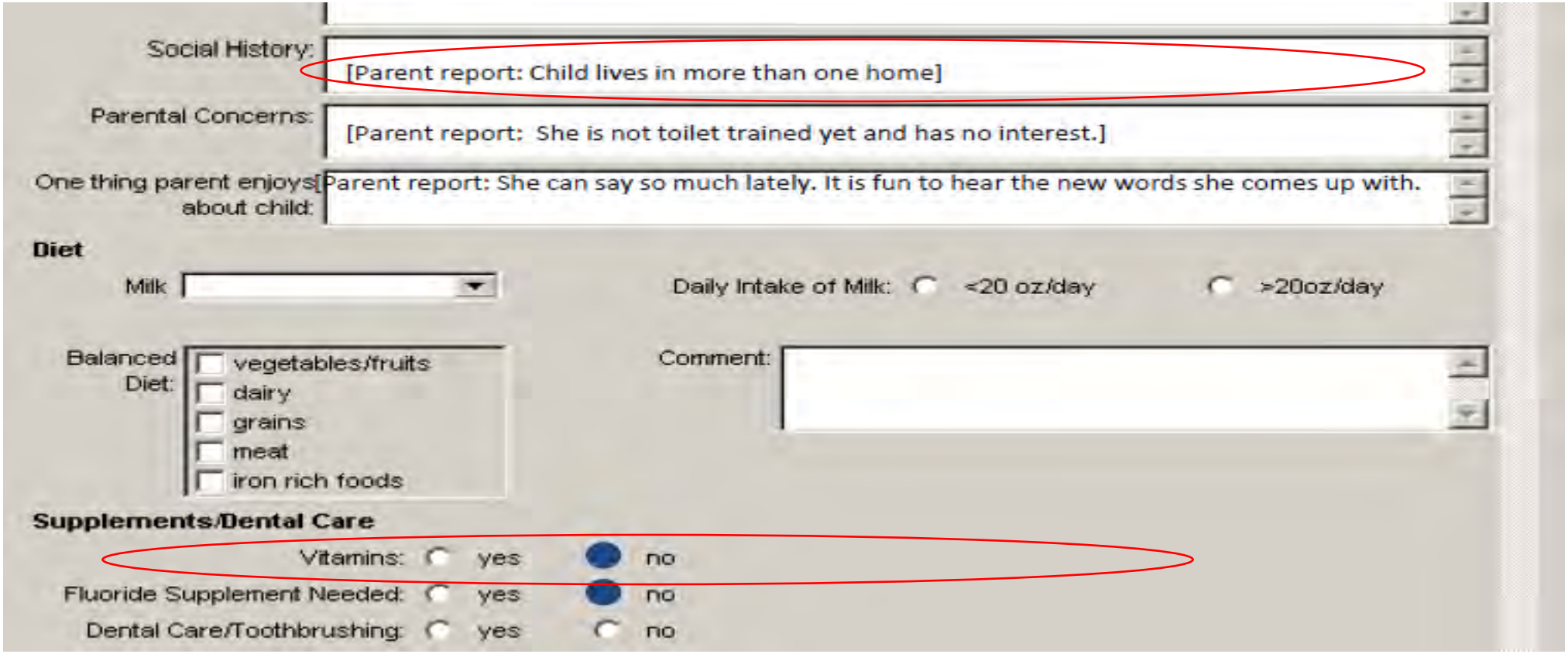
Vitamins: yes no

Fluoride Supplement Needed: yes no

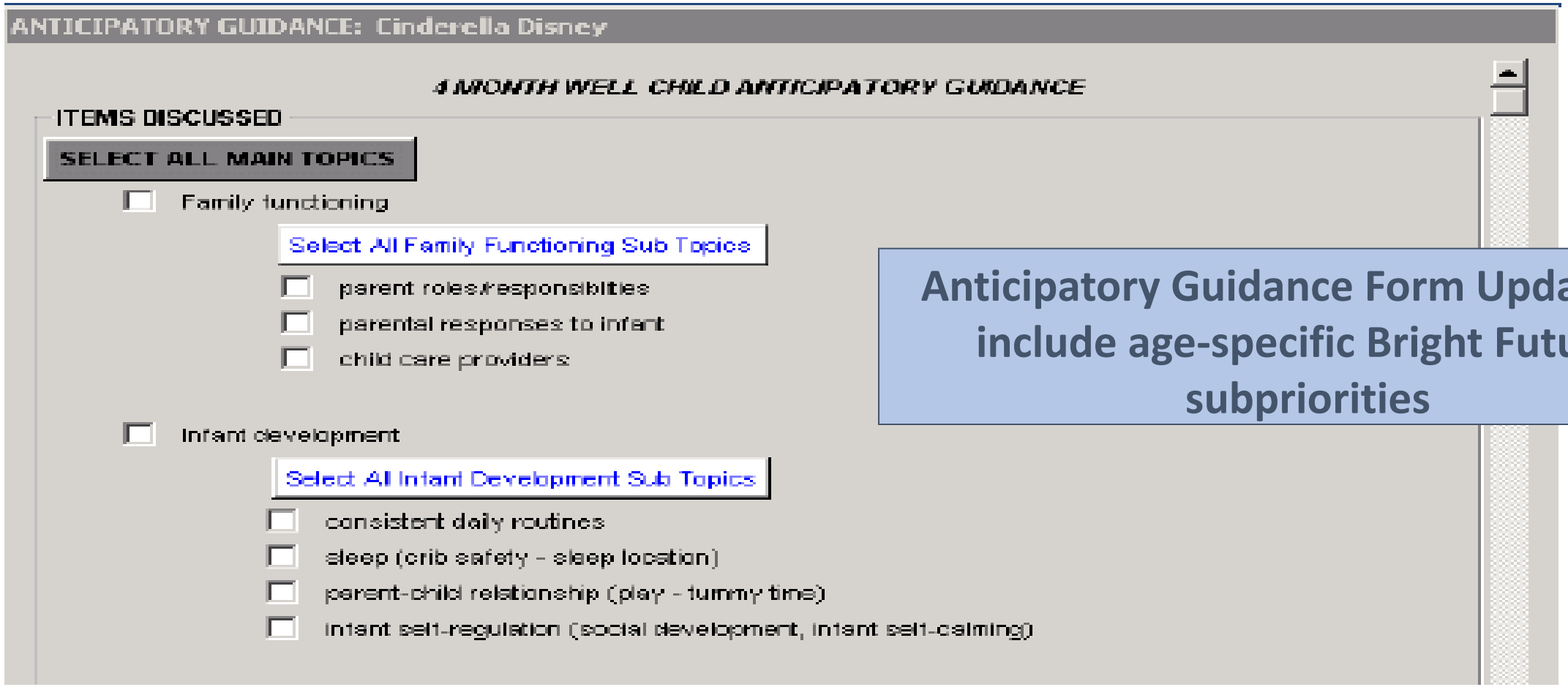
Dental Care/Toothbrushing: yes no

Examples of the EHR Feed: General Child Screeners

4. Do you give your child any vitamins or herbal supplements?	○	◉
5. Does your child live with both parents in the same home?	○	◉



Example of the EHR Revisions: Anticipatory Guidance



Anticipatory Guidance Form Updated to include age-specific Bright Futures subpriorities

MUTUAL PARTICIPATION MODEL

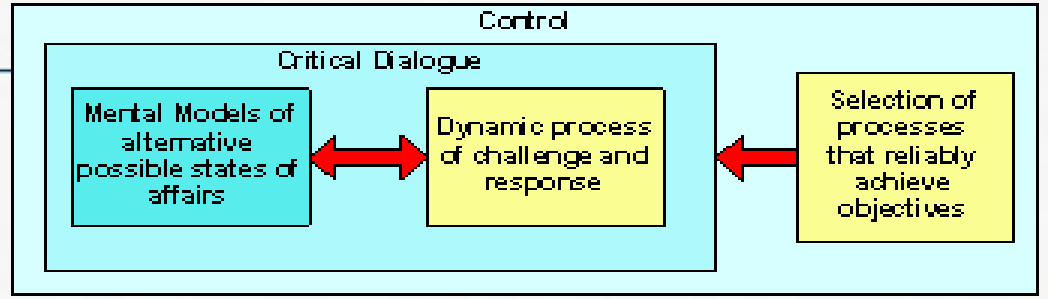
The **model** of **mutual participation** (also advocated by Balint (1964)[10]) is based on the belief that equality amongst human beings is mutually advantageous. In this **model** the doctor does not confess to know exactly what is best for the patient.

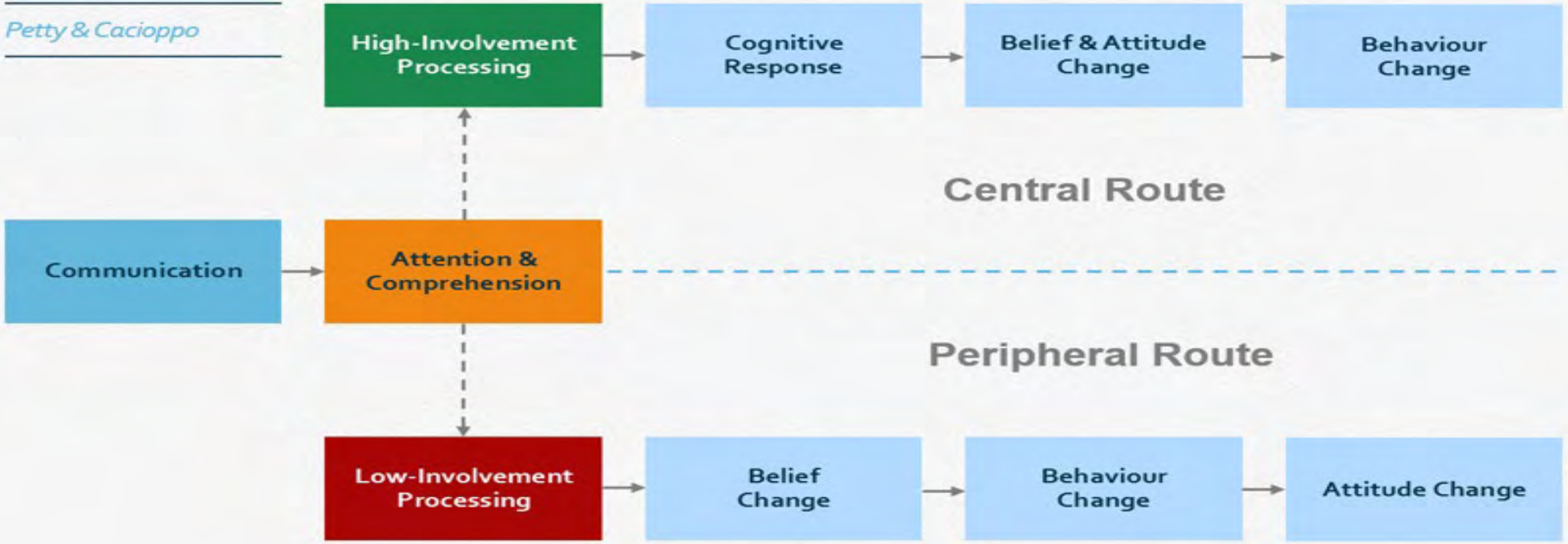
- Active involvement of patients as more equal partners ('meeting of experts')
- Both parties share power and responsibility, exchange of ideas & sharing of belief systems, need each other and will work towards choices and actions satisfying to them both
- Open questioning, interested in psycho-social aspect of illness history & examination investigation results in a diagnosis
- Hence there is integration

The neuroscience of patient engagement, health promotion and healing

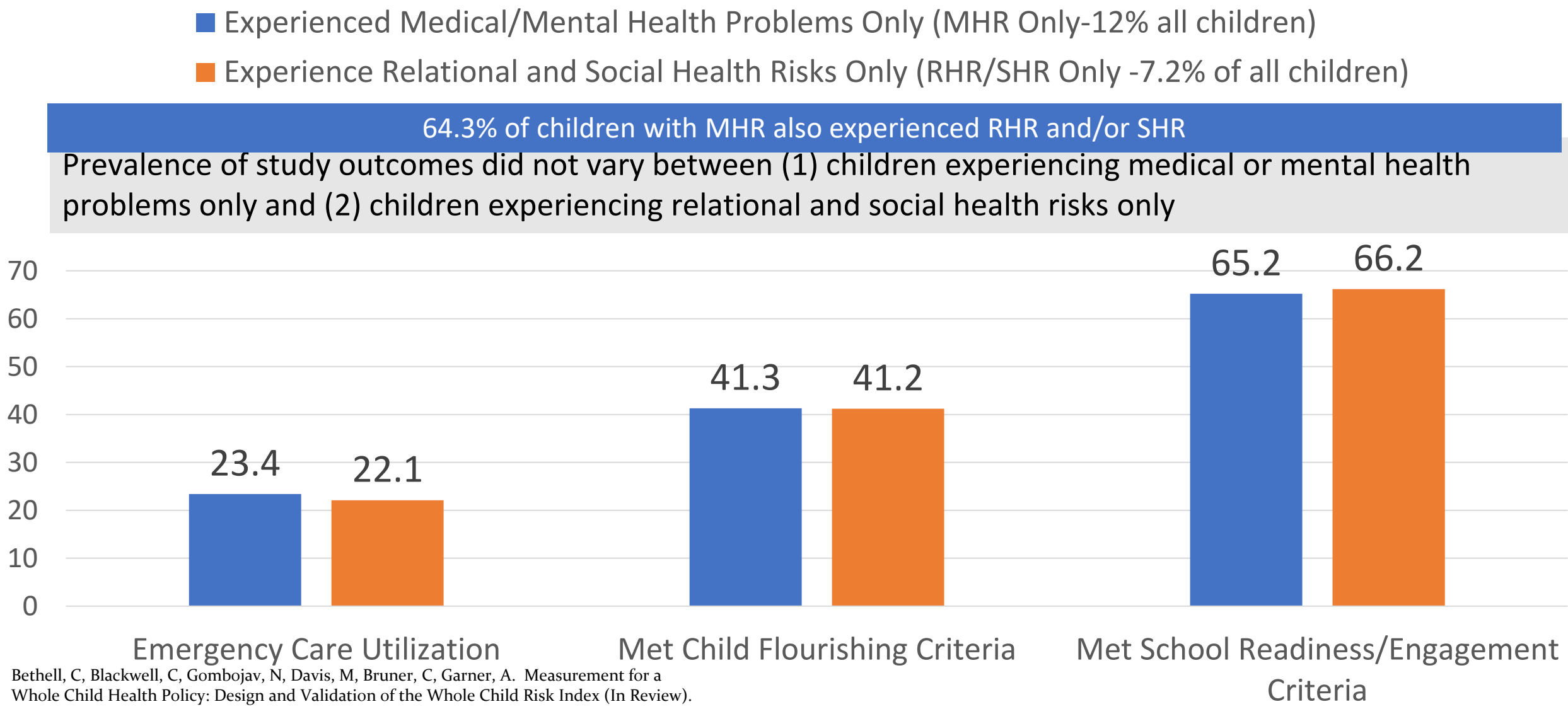
Elaboration Likelihood Model

Petty & Cacioppo



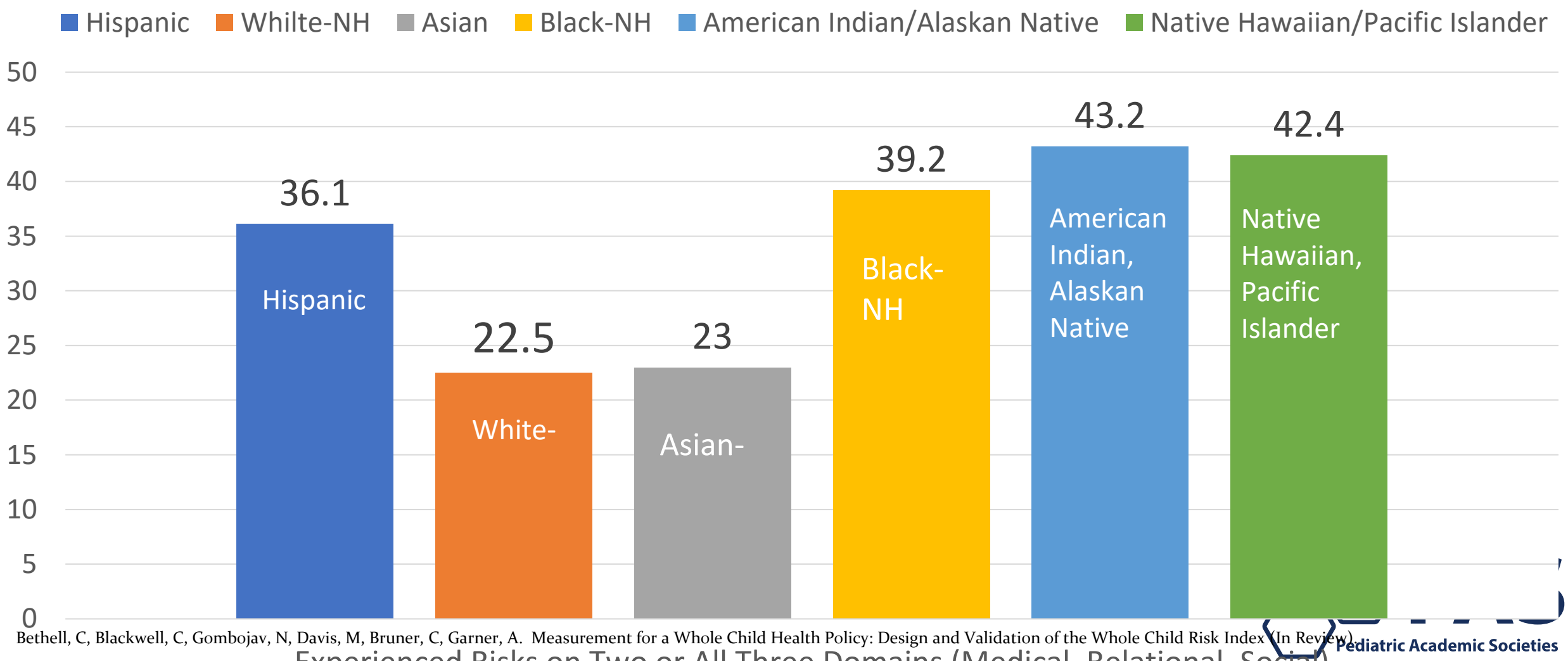


Outcomes by Medical, Social and Relational Domains



Bethell, C, Blackwell, C, Gombojav, N, Davis, M, Bruner, C, Garner, A. Measurement for a Whole Child Health Policy: Design and Validation of the Whole Child Risk Index (In Review).

Prevalence of US Children Experiencing Risks on 2 or all 3 Whole Child Complexity Index Domains, By Race/Ethnicity



Bethell, C, Blackwell, C, Gombojav, N, Davis, M, Bruner, C, Garner, A. Measurement for a Whole Child Health Policy: Design and Validation of the Whole Child Risk Index (In Review).

Q&A

Please unmute yourself to ask a question

Next Session

Session 4:

- June 1st at 2pmET-3pmET
- Integrating Screening Practices into EHRs and Managing Workflows
- Guest Speaker Dr. Zara Marselian

Funding Opportunities

- **Funding for Health Centers**
  Health centers have until Monday, May 31, to complete and submit American Rescue Plan Funding for Health Centers (H8F) award submissions in HRSA's Electronic Handbooks (EHBs). See the H8F TA webpage for submission guidance, steps to add your H8F grant to your EHBs portfolio, and recordings of the question and answer sessions. We continually update our American Rescue Plan Funding for Health Centers FAQs, and recently added some examples related to potential uses of H8F funding to enhance early childhood health to the H8F Activities and Allowable Uses of Funds webpage.

- **Funding Opportunity for Health Center Construction and Capital Improvements**
  Health centers have until Thursday, June 24, to submit their American Rescue Plan - Health Center Construction and Capital Improvements (C8E) applications in EHBs. Visit the C8E TA webpage for award submission guidance, information about upcoming question and answer sessions, and other resources. See also the C8E FAQs webpage, which we continually update.

- **Emergency Broadband Benefit Program Applications Open May 12**
  Applications for the Federal Communications Commission's (FCC) Emergency Broadband Benefit (EBB) program opens, Wednesday, May 12. The FCC's EBB toolkit has resources and materials to help you prepare to assist your patients with their application. See our recent bulletin for background information on this exciting program. If you missed the HRSA Telehealth Learning Series session on federal broadband programs, watch the recording.

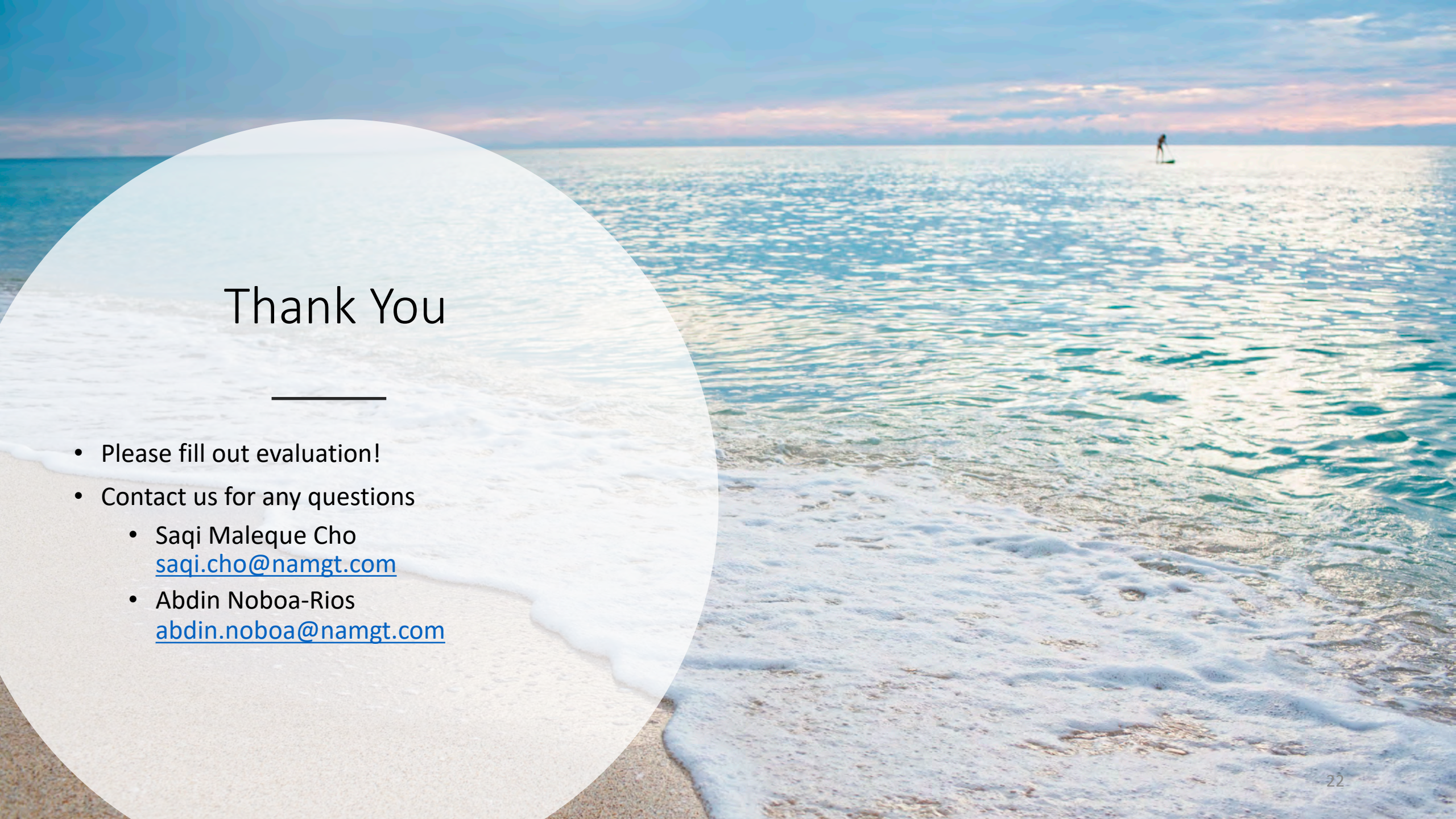
- **Funding Opportunity for Rural Maternity Care**
  This HRSA funding opportunity is part of the Rural Maternity and Obstetrics Management Strategies (RMOMS) program, introduced in 2019 to address the lack of services in rural areas. Recipients will be networks that have already been established by three or more separately-owned entities and include one HRSA-funded health center or LAL, among other requirements. Applications are due on Friday, June 4.

Chat :

What type of training or technical assistance do you need to improve COVID-19 vaccination in your communities? Please be specific.

Evaluation Poll

- Answer the poll...
- Add to the chat **to Organizer**
  - Which aspects of this learning collaborative session did you find most useful?
  - How could this learning collaborative session be improved in the future?
  - What other topics would you like training and technical assistance on?



Thank You

- Please fill out evaluation!
- Contact us for any questions
  - Saqi Maleque Cho
    saqi.cho@namgt.com
  - Abdin Noboa-Rios
    abdin.noboa@namgt.com