TEAM UP for Children
CQI Project Planning Template
V1 08.14.2019
C1CHC comments from SCM added 10.11.2019
Presented at C2CHC SCM 4.27.2020

Proposal for Phase 2 Common Elements to Support Healthy Parenting

Opportunity Statement

TEAM UP is committed to providing a continuum of services to families and children. Given TEAM UP's identification of early childhood (EC) as a priority area, our previous common EC work has focused on two areas: 1) improving the EI referral process and 2) prenatal to postpartum transitions for families at risk. In Phase 2, our goal is to further develop the TEAM UP model and identify a common approach to support healthy parenting. The proposed approach seeks to utilize the integrated team (Behavioral Health Clinician (BHC) and Community Health Worker (CHW)/Family Partner (FP)) to connect with families at two key points in early childhood: newborn period and prior to school entry. We hope that these visits will accomplish the following goals:

- ensuring that parents know what supports are available to them and their children;
- educating parents about the roles of the BHC/CHW/FP on the integrated team;
- normalizing that parents can be feel overwhelmed and stressed, and that there are resources available for support; and
- beginning to establish relationships that encourage parents to reach out for support or information.

Our long-term goal would be to expand this approach to early adolescence if health centers find the approach feasible and beneficial to the families served. We aim to ensure that this early childhood programming is integrated into the larger TEAM UP for Children mission and transformation model. Proposed activities are described below.

Activities

All health centers will work to implement the following:

- Universal BHC/CHW/FP visit for all newborns seen at the health center.
    - Visit should occur within the infant's first two months of life.
    - Visit should introduce families to:
        - the expanded pediatric team with aim of destigmatizing the role of the integrated BHC and CHW/FP and the services provided;
        - the CDC's Milestone Tracker application, or other similar application such as Vroom, as a way to support infant and early childhood development; and
        - resources available to families with infants both at the health center and in the community (e.g., Welcome Baby, Baby Café, home visiting programs [Boston only: Healthy Families, Healthy Baby Healthy Child], Boston Basics, etc.).
- Universal BHC/CHW/FP visit for **new health center patients under age 2** who did not have a visit in the newborn period.
    - Visit would have similar goals and content as the visit during the newborn period.
- Universal BHC/CHW/FP visit for 2 ½ - 5 year-olds seen at the health center.
    - Visit could occur at routine WCC or sick visit.
    - Visit should:
        - review options for preschool/early childhood education (e.g., Head Start, public school pre-K) in their community;

- support early literacy and numeracy activities (e.g., utilizing Boston Basics, Reach Out and Read); and
- explore utilizing the Ages and Stages Questionnaire (ASQ) to increase parents' understanding of their child's competencies and emerging skills and utilize the BRANCH therapeutic intervention as appropriate.

Capacity Building/Training

The BMC team will provide clinical training and implementation support to promote this work. Key elements might include developing a script for how to introduce this visit and its purpose, developing 2-3 reflective questions to engage parents and gather information, providing written information about resources, and TEAM UP staff contact information. Support will be provided both for the integrated team members and their supervisors.

Facilitators and Challenges

We recognize that implementation of any new programmatic components requires effort. We propose beginning with the implementation of the universal newborn visit. The facilitators and supports identified below will assist implementation.

- Infants are seen multiple times between birth and 2 months, which provides multiple opportunities for contact.
- Previous research has demonstrated that families of newborns are open to parenting support.
- Utilization of the SWYC beginning in the newborn period provides an opportunity to identify early risks.
- The BMC team will provide TA to health centers to:
  - support BHCs/CHWs/FPs to conduct the visit, including accessing and utilizing the CDC application;
  - assist the HCs to develop written materials to introduce TEAM UP and the expanded pediatric team;
  - create smart phrase/visit template to document newborn visit; and
  - develop workflows to support implementation of universal newborn visit.

CQI Process

To assess implementation, we will work with individual health centers to identify a measure to track activity related healthy parenting support. Our goal is to track the penetration rate (i.e., proportion of newborns who receive universal preventive visit) over the implementation period but realize each health center may have different capacity to do so at the beginning of the project period.

Impact Analysis

We will work with individual health centers to identify a realistic approach to assessing the impact of the proposed universal preventive visits among the families seen at the health center. Possibilities might include conducting periodic focus groups among targeted families, developing brief surveys or questionnaires, or speaking individually to families about their experience with the visit.