One Big Doable Thing!

Elevating Comprehensive Developmental Promotion and Preventive Services With the Family-Engaged Well Visit Planner Approach

September 10, 2024

Early Childhood Developmental Health Systems

EVIDENCE TO IMPACT CENTER

Housekeeping

- Attendees are muted for the duration of the event.
- Please submit questions through the Q&A feature.
- Today's slides are available under the Handouts tab on the eLearn event page.
- A recording will be available within 48 hours and sent through a post-event email within 1 week.
- CEUs are provided for this webinar (more details on how to receive credits will be shared at the end of the presentation).

About the Early Childhood Developmental Health Systems (ECDHS): Evidence to Impact Center

- We support states and communities to build early childhood systems that improve the health and well-being of young children and their families

- Our objectives:
  - Strengthen the evidence base of state ECD systems
  - Accelerate ECD systems development
  - Increase systems-building skills and the number of early childhood and health system leaders
  - Advance the delivery of high-quality ECD promotion and support services in pediatric settings

- Learn more about our mission and structure at earlychildhoodimpact.org/about-us/

Funding Acknowledgement

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Poll #1. Which role best describes you? Select one only.

Today's Speakers

Christina Bethell, PhD, MBA, MPH
Director, Child and Adolescent Health Measurement Initiative

Barbara Leach
Family Support Specialist, UNC School of Social Work

Louis Appel, MD, MPH
Director of Pediatrics, People's Community Clinic

One Big Doable Thing!

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Dr. Christina Bethell, *PhD, MBA,* Founding director of the Child and Adolescent Health Measurement Initiative
Barbara Leach, Family Support Specialist, University of North Carolina
Dr. Louis Appel, *MD, MPH, FAAP,*
Director of Pediatrics, People's Community Clinic

September 10, 2024
Early Childhood Developmental Health Systems(ECDHS)
Evidence to Impact Center Webinar

Our Aim: To translate the science of healthy development and flourishing into everyday practice, policy and culture for early and lifelong health

Hypothesis: Advances in the sciences of human development create unprecedented opportunities to proactively advance child well-being. Breakthrough findings across disciplines point to a new science of thriving that illuminate often untapped capacities for the promotion of healthy development and healing despite adversity. Given high rates of adversity, healing is prevention.

Key to this possibility are policies and practices that enable and support families and communities to recognize and learn to heal and flourish in the face of stress and adversity.

CAHMI

Objectives
We Seek to Inspire and Support You To…..

1. Identify mindsets and pathways for ***leveraging existing systems*** to improve access to comprehensive health promotion and preventive services that engage families in ways that effectively promote the early relational health required to ***foster whole child and family flourishing***.
2. Learn about how the ***family engaged Well Visit Planner*** approach addresses key requirements and challenges related to ***assuring high quality, personalized well child care services*** that put families at the center to foster early relational health and child flourishing.
3. Explore the ***application of the Well Visit Planner*** approach through a case example in a Community Health Center and consider how this approach ***addresses existing barriers*** to the comprehensive, family engaged, personalized care needed to effectively promote early relational health and child flourishing.

Our Agenda

Our One Big Doable Thing! Story (OneBDT!)

Deeper Dive:

The Essential Shift to Real Family Engagement

Deeper Dive:

The Concrete Approach and Tools for Transformation

Embrace Possibilities

Leverage Short Term Actions to Foster System Transformation

CAHMI

JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

The presenters have no financial relationships to disclose or conflicts of interest to resolve.

Meeting the Moment Where Our Science of Healthy Development, Lived Experiences and Practices Meet: Our "One Big Doable Thing" Story!

01

The Aim:

Child Flourishing

(School Readiness, Family Resilience, Equity)

02

The Focus:

Early Relational Health; Safe, Stable Relationships & Environments

03

The Requirement:

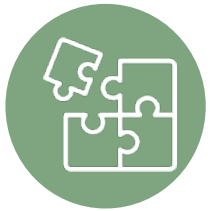
A Whole-Child, Whole System Approach

04

The Key:

Family Engagement "In Every Encounter"

05



The Opportunity:

Optimize Existing Health Promotion, Prevention Infrastructure and Well-Child Visits

06

The Approach:

"Through Any Door" Cycle of Engagement With "No Broken Links"

07

The System:

Leverage Shared Accountability to Drive System Integration

08

Impact Pathways Where "Everyone Leads"

Mindsets, Partnerships, Practices, Policies

CAHMI, 2024

Start Where We Want to End Up!

The Aim
Promote Child Flourishing

The Flourishing Paradigm
Flipping the narrative to proactively promote early and lifelong flourishing

- The absence of the negative (risk, illness) is not the same as the presence of well-being and flourishing.
- Child flourishing measures assess positive health characteristics essential for healthy development like healthy attachment, resilience, engagement and learning and emotional openness, empathy and communication.
- Child Flourishing strongly predicts school readiness and engagement, social success and mental health and is negatively associated with ACEs, poverty and having a disability. Yet.....
- Family resilience and connection, caregiver-child connection and positive childhood experiences promote flourishing, even amid high adversity

Four Components of the Child Flourishing Index: National Survey of Children's Health, 6 months-5 years assessing markers of healthy attachment, emotional well-being, engagement and resilience

Affectionate and tender with parent

Bounces back quickly when things don't go their way

Show interest and curiosity in learning new things

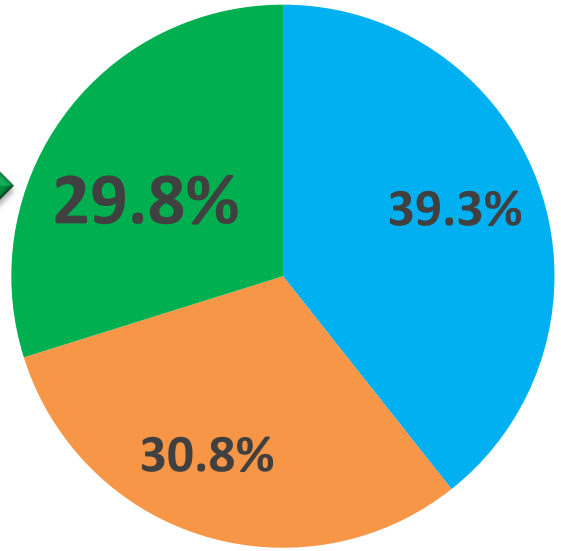
Smile and laugh a lot

Interrelated attributes that reflect, contribute to or are precursors for flourishing of the "living and relating self" & supporting living a meaningful and engaged life

Prevalence of Publicly Insured Children Aged 6 Months to 5 Years By Child Flourishing Index Score and Item Data: 2021-2022 National Survey of Children's Health

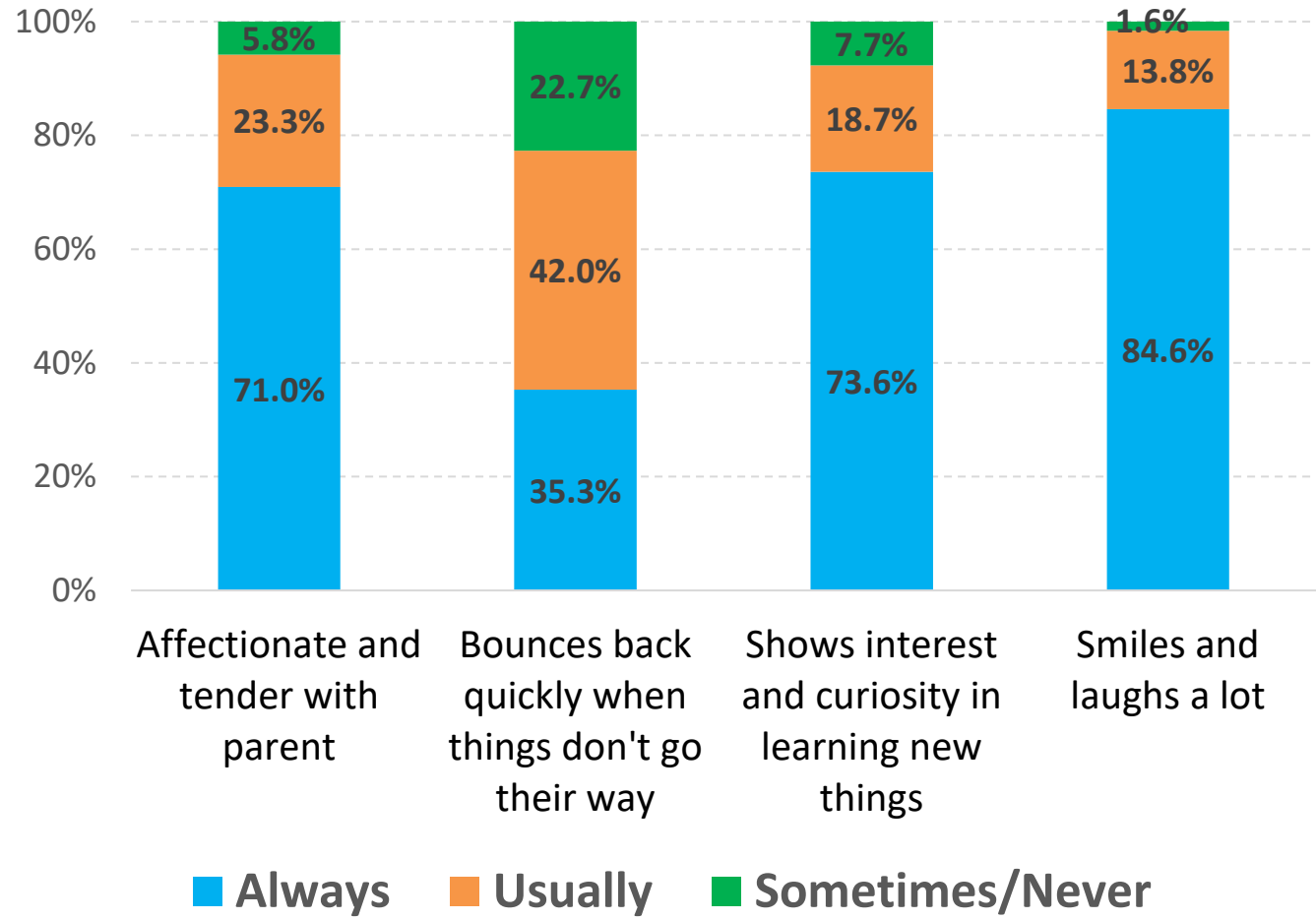
Publicly Insured Children, 6 months-5years

State Range: 18.9%-43.5%



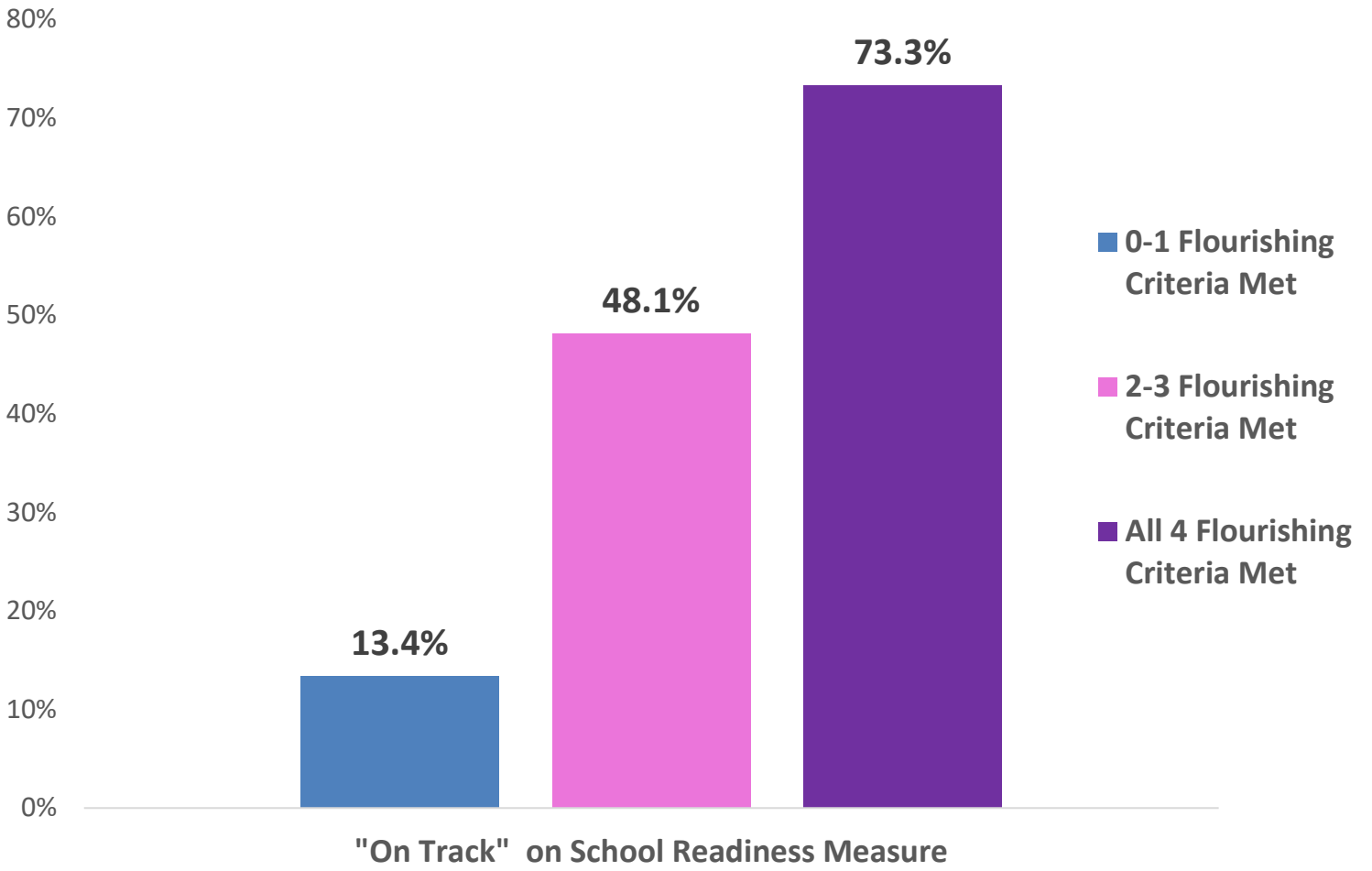
- Met 0-2 flourishing items
- Met 3 flourishing items
- Met 4 flourishing items

Prevalence by Individual Flourishing Items



School Readiness by Child Flourishing (age 3-5)*

2022 NSCH Data



The absence of flourishing is more strongly associated with school readiness than the presence of ACEs**

***Flourishing Items for Young Children* (how often)**

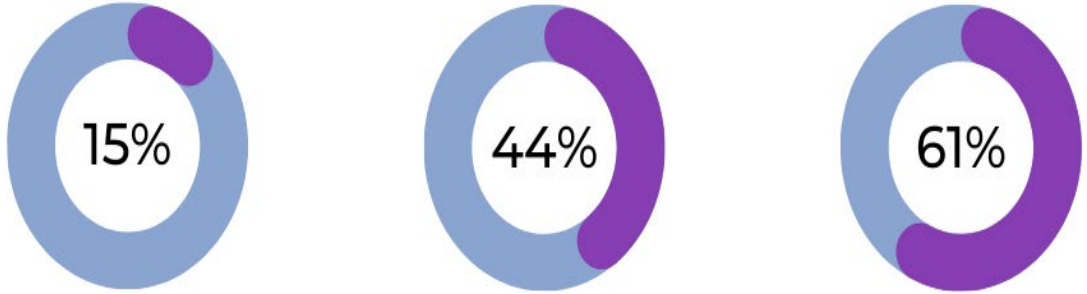
1) is this child affectionate and tender?
2) does this child bounce back quickly when things do not go their way?
3) does this child show interest and curiosity in learning new things?
4) does this child smile and laugh a lot?

School Readiness by ACEs Exposure:
0 ACEs: 70% "On Track"
1 ACE: 50.9%
2+ ACEs: 47.2%

C. Bethell, 2024

There is a four-fold difference in the prevalence of children's mental health conditions depending on the social and relational health risks they experience.

Optimize positive and relational health for children and families by acting now!



Those with 0 Relational or Social Health Risks

Those with 2 or more Relational Health Risks

Those with 2 or more Relational Health Risks and Social Health Risks

C. Bethell, Child Adolesc Psychiatr Clin N Am. 2022

A Critical Focus

Promote early relational health to establish the safe, stable and nurturing relationships and environments children need to thrive

HOW to Build Early Relational Health?

Three "Lenses" to Operationalize Relational Health

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

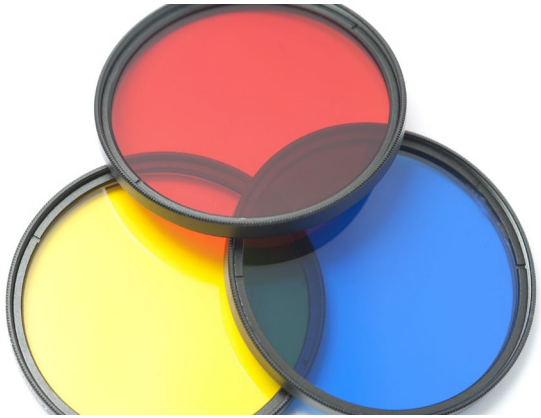
American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

- Two-Generational Approach
  - Assess caregiver health and history that may impact parenting and partner with caregivers in order to help the children
- Developmental Approach
  - Affect regulation and relational health are moving targets. Requires ongoing relationships, learning and developmental assessment
- An Integrated Services, Public Health Approach
  - Layered efforts are needed across systems of care to address social, relational and special needs of children and families

Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health

Andrew Garner, MD, PhD, FAAP[a,b] Michael Yogman, MD, FAAP[c,d]
COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS, COUNCIL ON EARLY CHILDHOOD



Gaps in Child Flourishing Narrow with Family Resilience and Connection

Existing programs could increase thriving, even for children facing adversity, large study finds

Less than half of school-aged children in the U.S. are flourishing, according to a new study led by researchers at the Johns Hopkins Bloomberg School of Public Health. However, children living in families with higher levels of resilience and connection are much more likely to flourish. This is true for children across levels of household income, health status and exposure to adverse childhood experiences.

Family Resilience and Connection Index

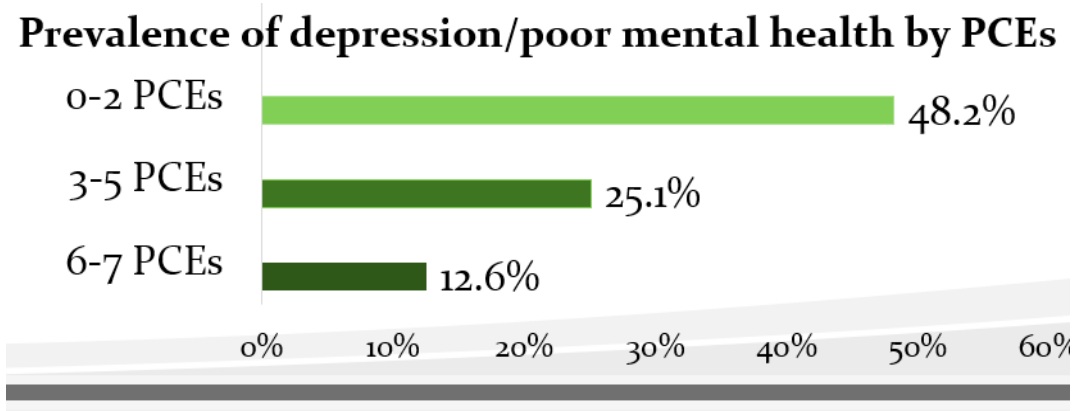
- ❑ Know they have strengths to draw on
- ❑ Stay hopeful even in difficult times
- ❑ Share ideas and talk about things that really matter
- ❑ Parent coping well with parenting
- ❑ Family reaches out and talks with each other when they face problems
- ❑ Family works together to solve problems (vs. ignoring problems)

Citation: Bethell CD, Gombojav N, Whitaker RC. Family Resilience And Connection Promote Flourishing Among US Children, Even Amid Adversity. Health Aff (Millwood). 2019 May;38(5):729-737. doi: 10.1377/hlthaff.2018.05425. PMID: 31059374.

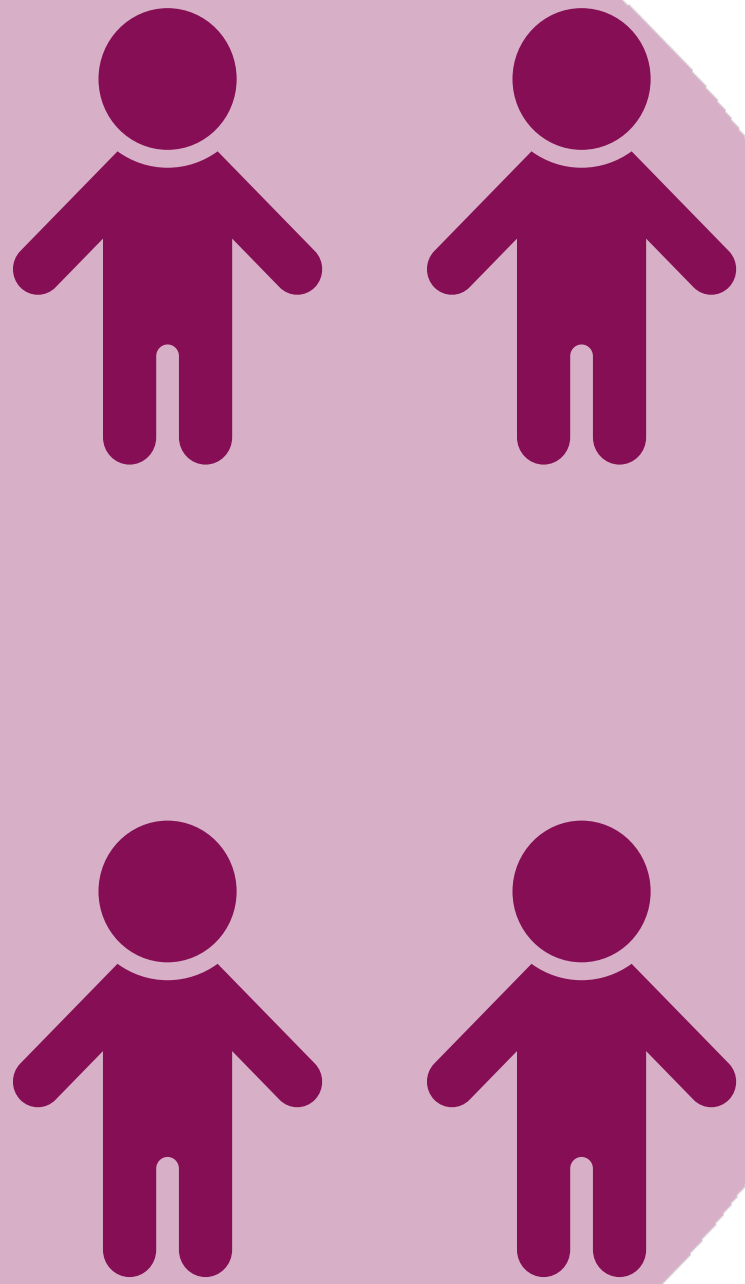
https://www.pacesconnection.com/resource/7-positive-childhood-experiences-pces

Positive Childhood Experiences (PCEs)

Our research demonstrates the lifelong impact of PCEs on health

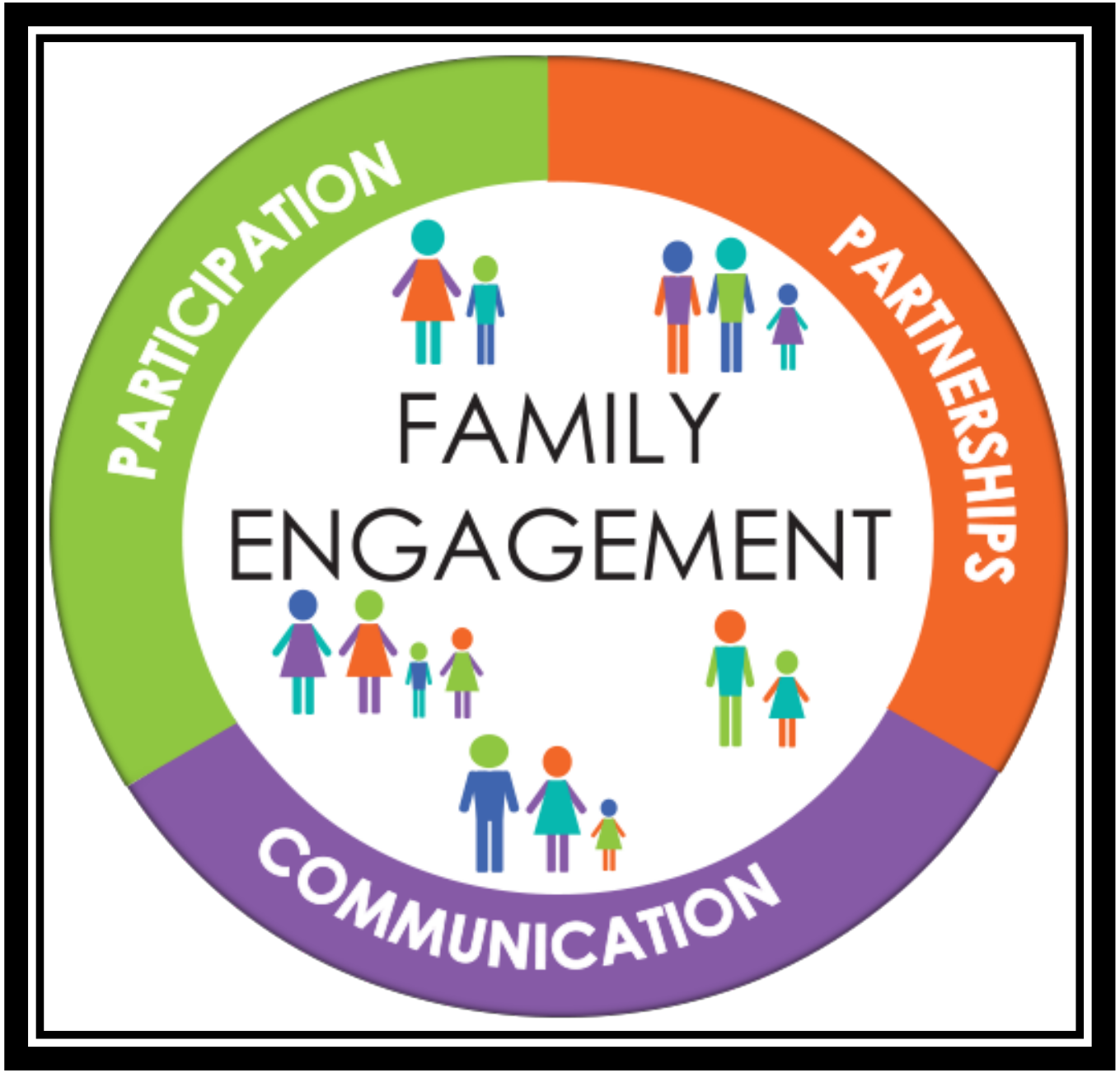


Bethell C, Jones J, Gombojav N, Linkenbach J, Sege R. Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample: Associations Across Adverse Childhood Experiences Levels. *JAMA Pediatr.* 2019;173(11):e193007. doi:10.1001/jamapediatrics.2019.3007



The Requirement

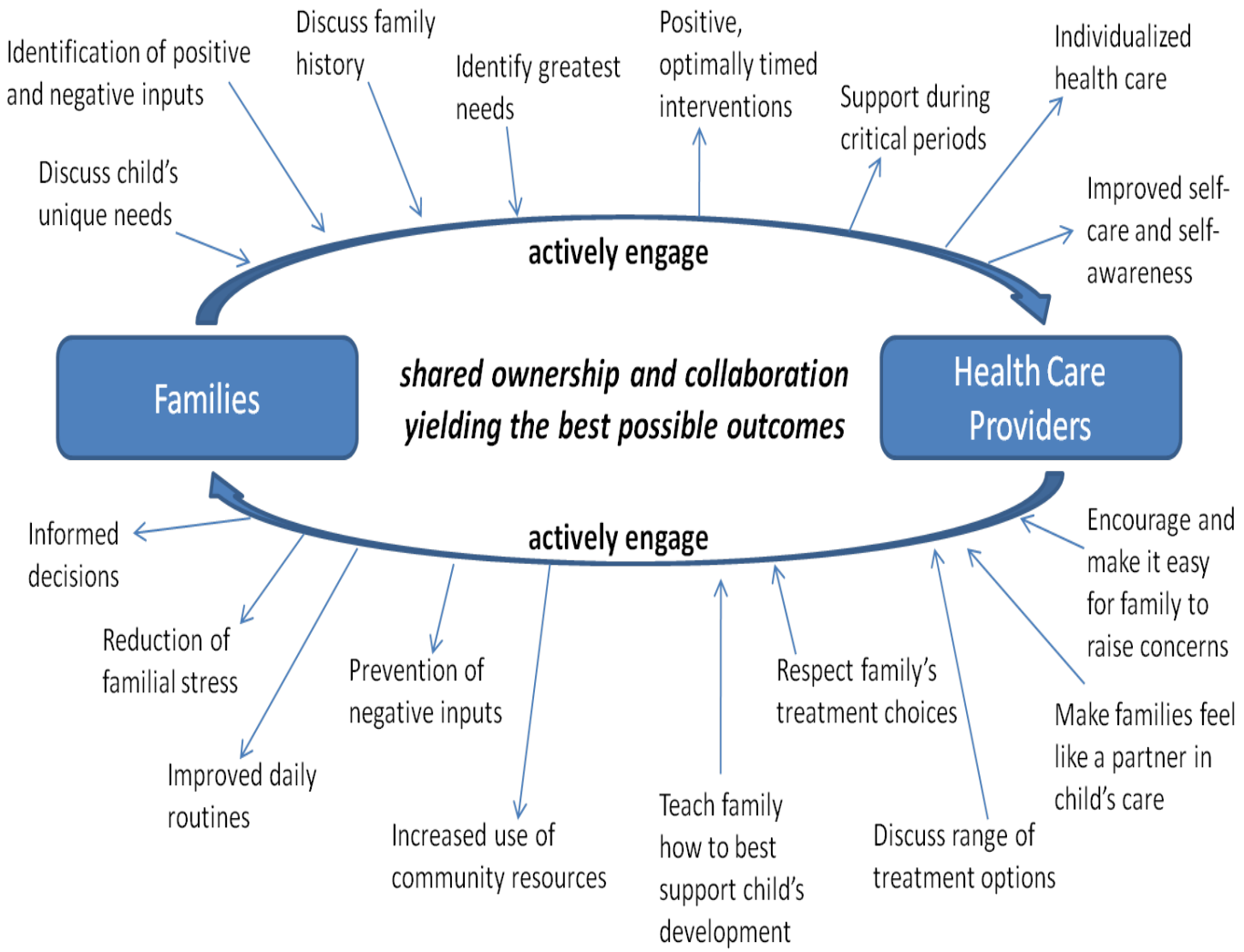
A whole child and family approach to assessment and the integration of services and supports to address needs and promote healthy development



The Key

Engage families "*Through Any Door" , "In Every Encounter"* with *"No Broken Link" where "Everyone Leads"*

Active Engagement and Time to Connect are Fundamental to Quality Care and Outcomes



	Family often practices 4 qualities of resilience when facing problems
How often providers spend enough time*	
Always	73.1%
Sometimes/Never	47.9%
How often providers listen carefully to parents*	
Always	71.0%
Sometimes/Never	46.1%
How often specific information needed is provided	
Always	70.7%
Sometimes/Never	45.9%

Bethell CD, Gombojav N, Whitaker RC. Family Resilience And Connection Promote Flourishing Among US Children, Even Amid Adversity. Health Aff (Millwood). 2019 May;38(5):729-737. doi: 10.1377/hlthaff.2018.05425. PMID: 31059374.

The Opportunity

Optimize Existing Developmental Promotion and Prevention Well Child Visit Infrastructure to Streamline National Bright Futures Comprehensive Developmental Promotion and Screening

HRSA Maternal & Child Health

Find Funding | Maternal & Child Health Topics | Programs & Initiatives | Data, Epid

Home > Bright Futures

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.

Bright Futures™

prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Why are well visits important?

Well visits are an opportunity for families and health providers to connect and celebrate what's going well, meet family needs, and address child health concerns. These visits allow for age-specific:

- Surveillance & Screening
- Anticipatory Guidance
- Disease prevention
- Health Promotion

Bright Futures Guidelines recommend **15 well visits** in the first **six years** of life.

Children and families thrive when they stay on track with well visits!

Well Visit Planner®
A project of the Child & Adolescent Health Measurement Initiative

One Big Doable Thing: Equitable access to high-quality well-child care services for all young children and families-60 million encounters recommended; ½ occur; 90% missing core elements of guideline-based care. 15 age-specific visits in the first 6 years of life.

☐ 1wk ☐ 1m ☐ 2m ☐ 4m ☐ 6m ☐ 9m ☐ 12m ☐ 15m ☐ 18m

☐ 2y ☐ 30m ☐ 3y ☐ 4y

☐ 5y ☐ 6y

Closing the Gap! National Performance Measure Well Child Visit Rates (CMS Data)*

Proportion of publicly insured children **under 15 months** of age that had at least **6 of 9** recommended well visits

→ 2022: 55.7%
Range Across States:
28.2%-77.5%
(1/2 visits occur)

Proportion of publicly insured children **15-30 months** of age that had at least **2 of 4** recommended well visits

→ 2022: 64.9%
Range Across States:
36.5%-84.4%
(2/3 visits occur)

Nationally, nearly half of the estimated well child visits that should happen do not occur

*https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html

We Can Close the Gap!

Even today, only 1 in 3 young children receive the appropriate developmental screenings.

Publicly Insured: 28.7%
Range Across States:
8%-54.6%

National Performance Measure: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

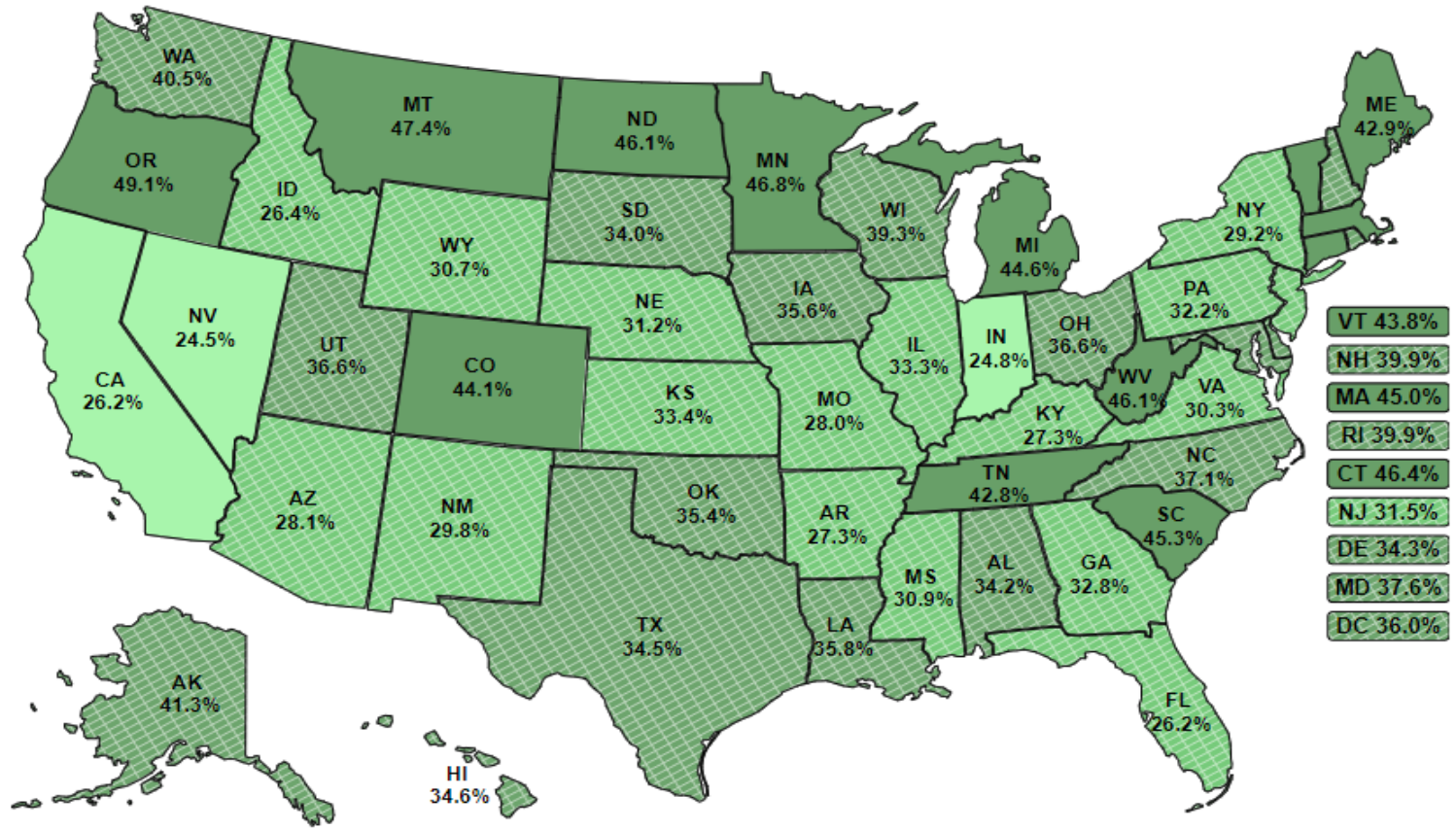
Data Source: 2021-2022 National Survey of Children's Health
Nationwide: 33.7% of children met indicator
Range Across States: 24.5% to 49.1%

Note: Click on any state to compare national and state level data and to access subgroup level data (i.e. age, race, income, insurance type).

Higher=better performance

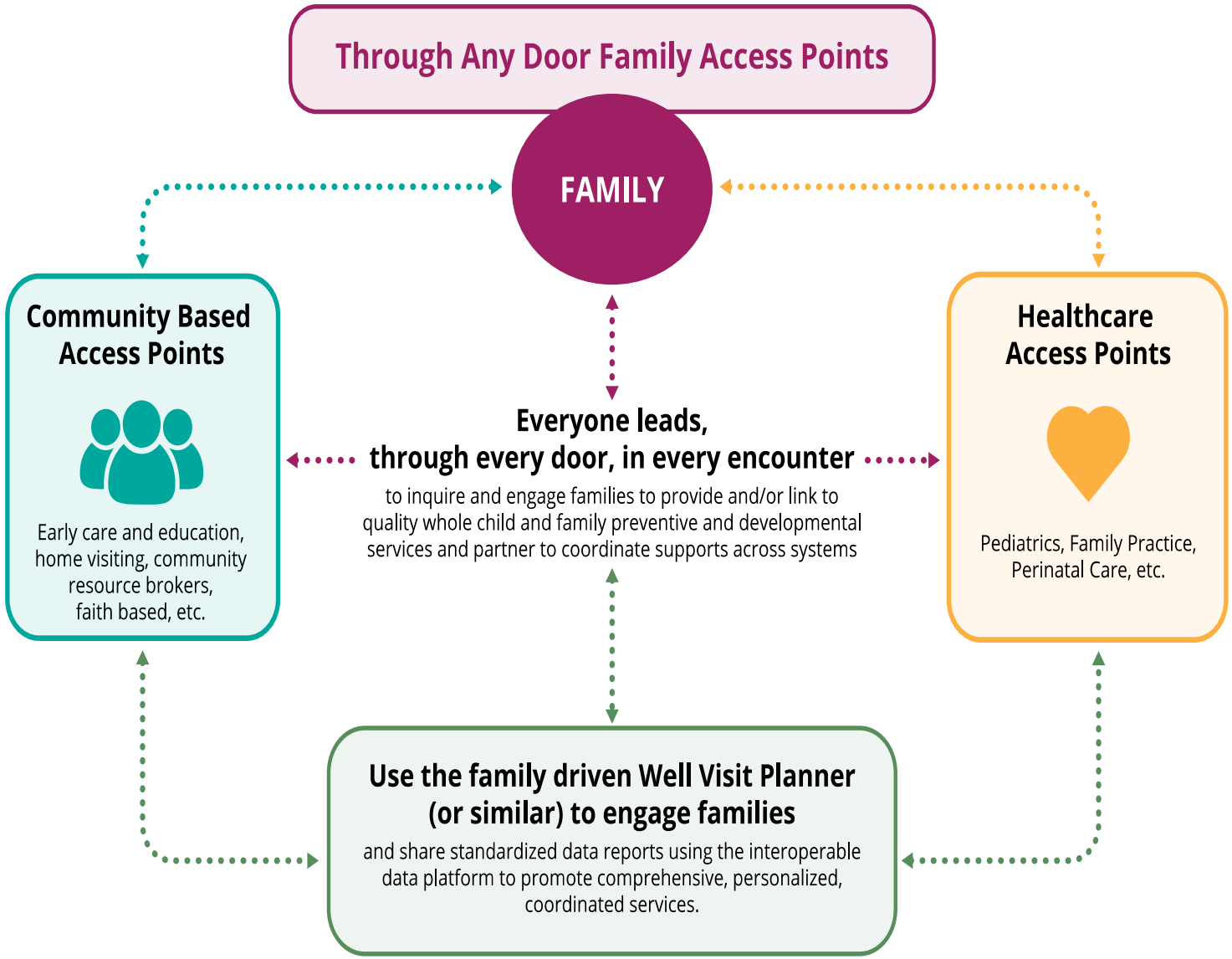
- Significantly higher than U.S.
- Higher than U.S. but not significant
- Significantly lower than U.S.
- Lower than U.S. but not significant

The significance of differences between state and national prevalence was assessed using a nested t-test at p<0.05



Citation: Child and Adolescent Health Measurement Initiative. "National Performance Measure: Percent of children, ages 9

Poll #2. Which best describes your familiarity with the Bright Futures Guidelines? Select one only.



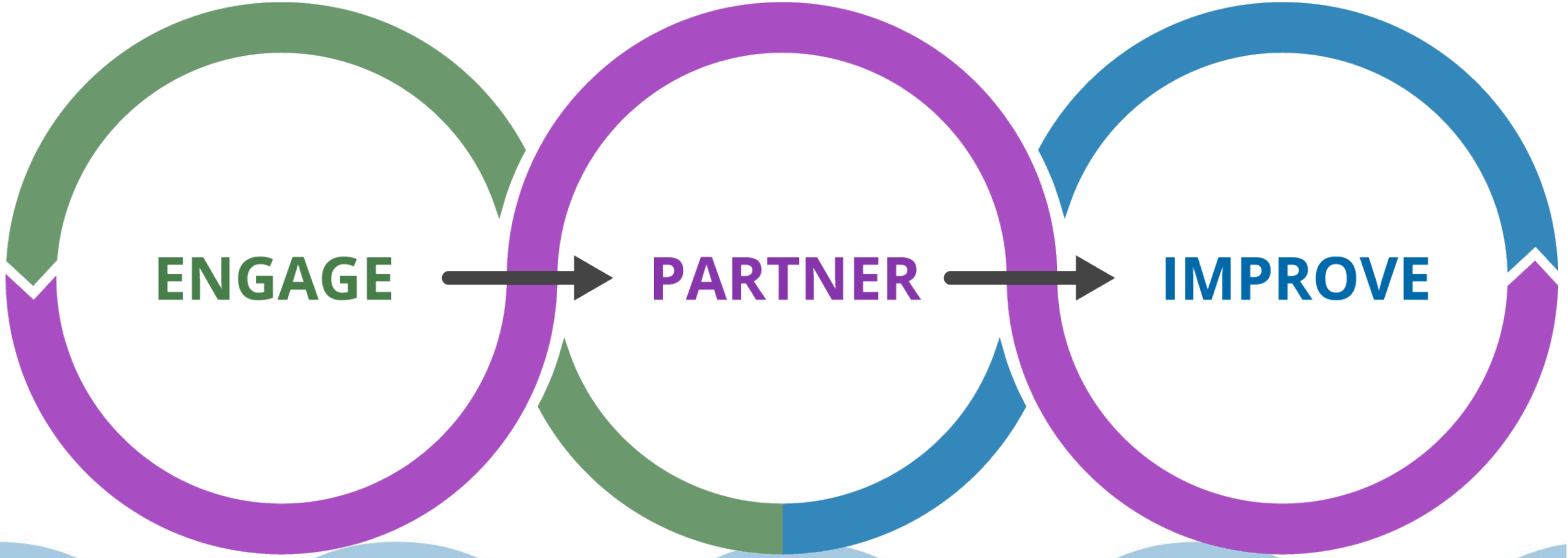
Source: Child and Adolescent Health Measurement Initiative, Feb. 2023

The Approach

Enabling a Through Any Door **G**uideline-Based, **P**ersonalized and **S**ystems Integrated (GPS) Interoperable Approach to Optimize Services

(4 criteria identified by cross-sector EC program teams)

The Cycle of Engagement Well Visit Planner Approach to Care



What is the Cycle of Engagement?

A personalized, relationship centered model of care

A whole child, integrated approach to assessment

A feasible and standardized measurement process

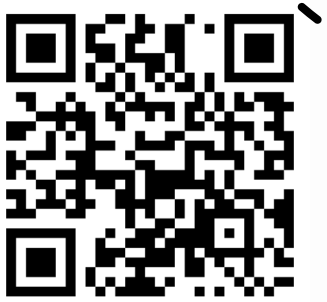
A population health strategy aligned with Bright Futures

CAHMI

The Well Visit Planner

1. Complete **all Bright Futures Guidelines-Based** Screeners/ Assessments (age specific)
2. Identify **Guidelines-Based priorities** to **discuss with provider** at the well visit (age specific)
3. Family and providers get the same **Well Visit Guide** and **Clinical Summary** (two views, same data)

Designed to Work In Broader System of Supports!



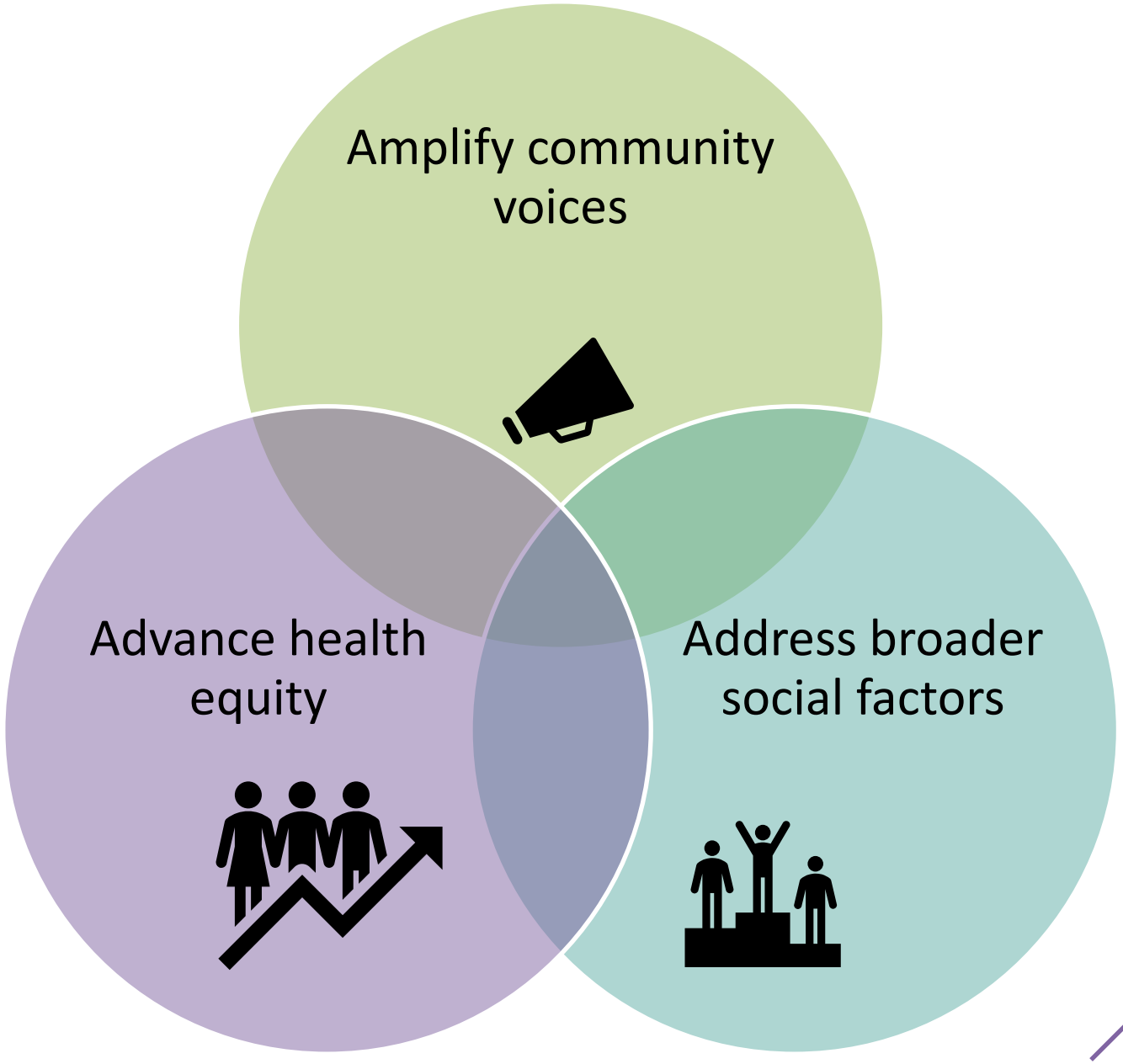
Your Child, Your Well Visit

Well Visit Planner®

A project of the Child & Adolescent Health Measurement Initiative

Studies funded by HRSA and RWJF (2008-present) with over 20,000 children demonstrate that the Well Visit Planner tool improves quality, personalizes care, builds trust and makes more time for providers to focus on family priorities and connect to resources and supports.

A 2021 independent review by Mathematica confirmed value of the COE/WVP approach to lift family and community voice, improve care for all and address broader social factors



Mathematica

Building Bridges

The Essential Role of Real Family Engagement and Community-Based Supports in Child Flourishing and Family Well-Being

Exploring the WVP approach, overcoming barriers, and fostering trust for early relational health and family well-being

Who am I?

Professional and Family Member

Mom, Grandmother, Great Grandmother

My journey

30+ Years of Lived Experience

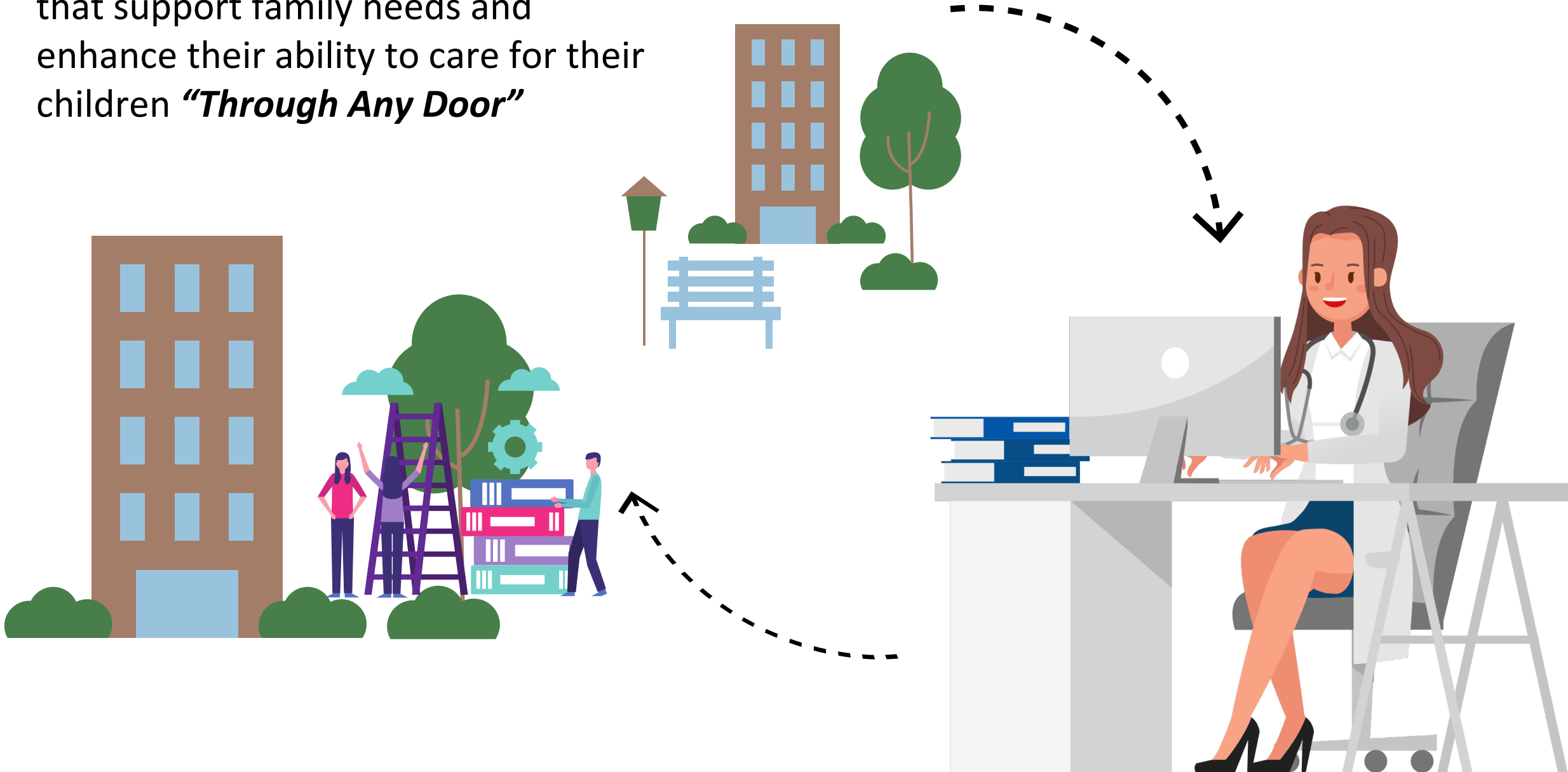
Real Family Engagement Is a Real Paradigm Shift! It Means....

1. **Understanding that families ARE in the drivers-seat** when it comes to their child's health and are not passive recipients of care. Without engagement it is not clear WHAT care is actually being provided or its value!
2. **Building competencies to engage families so they are actively involved** in planning and decision-making processes regarding their children's health and well-being and are energized and feel supported to follow through with recommendations. This is a change—patience and new skills are required!
3. **Empowerment**: Families **FEEL empowered** to advocate for their children and contribute to their communities.

Real Family Engagement Is a Real Paradigm Shift! It Means…. (cont'd)

4. **Facilitating strong collaboration and partnership** between families, healthcare providers, and community organizations and making sure there is "***No Broken Link***" as families move across the "system"
5. **Building trusting relationships that support** open, honest, and communication between families and providers ***"In Every Encounter"*** – having trust with one professional and not others is not good enough!
6. **Keeping a whole child and family focus** where families can share not only child development concerns, but also whole family priorities that impact child well being as set for the in Bright Futures Guidelines.

7. Supporting families to access a broad array of resources and services that support family needs and enhance their ability to care for their children ***"Through Any Door"***



Current Barrier
Preparing Providers, Not Families

- Traditional focus has been on preparing providers for well visits (yet screening is still low and barriers are high for providers to know about and achieve guideline-based care)

- Need for families to be prepared and understand role in the visit (otherwise, there can be a sense that good care was provided even when quality was low and families left without seeing the value)

Current Barrier
Whose information?

- Providers are asked to collect information from families (vs. families choosing to share data knowing why and what it is used for)

- Families often do not understand what this is for and how it is being used (vs. informing them about the goals, guidelines and what to expect)

- This can lead to miscommunication and feelings of mistrust between families and the medical community (lack of response to screeners and sense that they are not for the family is common)

True or False – Myth Busting

Claim	True or false?
Families know what to expect and what information to talk about at their child's well visit	**FALSE**
Families don't schedule or come in to their child's well-visit because they don't see it as important	**FALSE**
Families want to know what quality care is and prefer a comprehensive tool with more information about their child and family's health & care	**TRUE**
It's sufficient to send families a text with a link to a screen with questions through a "My Chart" type system	**FALSE**

The **Well Visit Planner** empowers families with knowledge to effectively partner with their child's care team while ensuring Bright Futures guideline-based, personalized care is provided

"I agree that the WVP can increase the value of my child's well visit because it is ***empowering to me to feel like I am a part of the health care team in a way that I can properly advocate for my child's needs…***

[I can] get additional information that I wouldn't normally know to discuss had it not been for this useful tool."

Parent

Currently Available for each of the 15 early childhood well visits in both English and Spanish

Well Visit Planner®
The Child & Adolescent Health Measurement Initiative

PEOPLE'S COMMUNITY CLINIC

Select Language: English

Do you have a family account? Log in here
Are you a provider? Log in to your COE account

Share with others!

Home/WVP | About | Family Resources | FAQ | Contact Us

You are using the Well Visit Planner® on a website tailored for your child's provider or family support professional. (wellvisitplanner.org/PCC)

Welcome to the Well Visit Planner®

Your Child, Your Well Visit

A quick and free pre-visit planning tool to focus care on your unique needs and goals.

Covers all 15 age-specific well visits from your child's first week of life to age 6

GET STARTED NOW

Learn more about creating a family account

People's Community Clinic invites you to take about **10 minutes to complete the Well Visit Planner and get a personalized Well Visit Guide**. You and will use your Well Visit Guide to make sure you get the best care focused on your child and family's unique goals and needs.

What is a Well Visit?: Well visits are regular check-ups with your child's personal doctor, nurse, or other child health professional. At least 15 visits are recommended in the first six years of life when children are growing rapidly. Be sure to stay on track with well visits to help your child and family

*"The WVP helped me think about what's going well with my child and family. I have a **better relationship with my child's doctor now** that we focus on my concerns and priorities.*

*Our time together is **more productive and satisfying."***

Well Visit Planner®
The Child & Adolescent Health Measurement Initiative

PEOPLE'S COMMUNITY CLINIC

Select Language: Español

¿Tiene una cuenta familiar? Ingrese aquí
¿Es un proveedor de salud? Ingrese a su cuenta

¡Compártalo con otros!

Inicio/WVP | Acerca del WVP | Recursos para familias | Preguntas frecuentes | Contáctenos

Usted está utilizando una versión del Well Visit Planner personalizada por su proveedor de salud infantil. (wellvisitplanner.org/PCC)

Bienvenido/a al Well Visit Planner®

Su hijo/a, su visita de salud infantil

Una herramienta gratis y fácil de usar antes de la visita de salud infantil para enfocarla en sus necesidades y metas.

Cubre las 15 visitas específicas de salud infantil desde la primera semana de vida de su hijo/a hasta los 6 años

EMPIECE AHORA

Aprenda más sobre cómo crear una cuenta familiar

People's Community Clinic le invita a **tomar 10 minutos para completar el Well Visit Planner y obtener su guía personalizada**. Usted y utilizarán su guía personalizada para asegurarse de que obtenga la mejor atención centrada en las metas y necesidades únicas de su hijo/a y su familia.

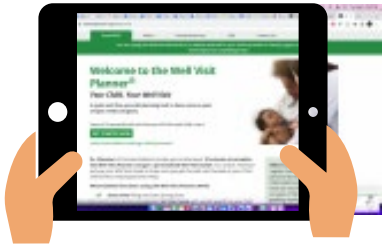
¿Qué es una Visita de Salud?: Las visitas de salud son chequeos regulares con el médico, la enfermera u otro profesional de la salud infantil de su hijo/a. Se recomiendan al menos 15 visitas en los primeros seis años de vida porque los niños están creciendo rápidamente.

3 Parts to the Well Visit Planner Take About 10 Minutes to Complete

1. Complete **Bright Futures Guidelines-Based** Screeners/ Assessments (age specific)
2. Choose **Guidelines-Based priorities** to **discuss with provider** at the well visit (age specific)
3. Receive a **Well Visit Guide** and **Clinical Summary** (choose to share with provider)

"The WVP *empowers families to direct the visit* so we can support their goals and needs. It gives us the *reassurance all screens are done and we meet family priorities*. Saves time to connect, build trust and link to supports." (Pediatrician)

Core Bright Futures Screeners and Assessment Topics (Plus Options to Add Other Assessments)



Reflect and Assess

What's going well?

General health information

e.g. special needs, insurance, family health history, etc.

Context and environmental assessments

(e.g., lead, fluoride, etc.)

Overall goals and concerns

Developmental surveillance and screening - SWYC

Autism screening - M-CHAT-RTM

Concerns about speaking, vision, hearing

Caregiver depression - PHQ-2 & EPDS

Healthy relationships and social determinants (IPV/WAST-Short; ACEs/PEARLS, SEEK; economic hardship)

*ACEs/PEARLS, SEEK, BPSC, PPSC, optional-many other optional additions.

Caregiver anticipatory guidance and education priorities

Parent/caregiver emotional support, coping and self-care

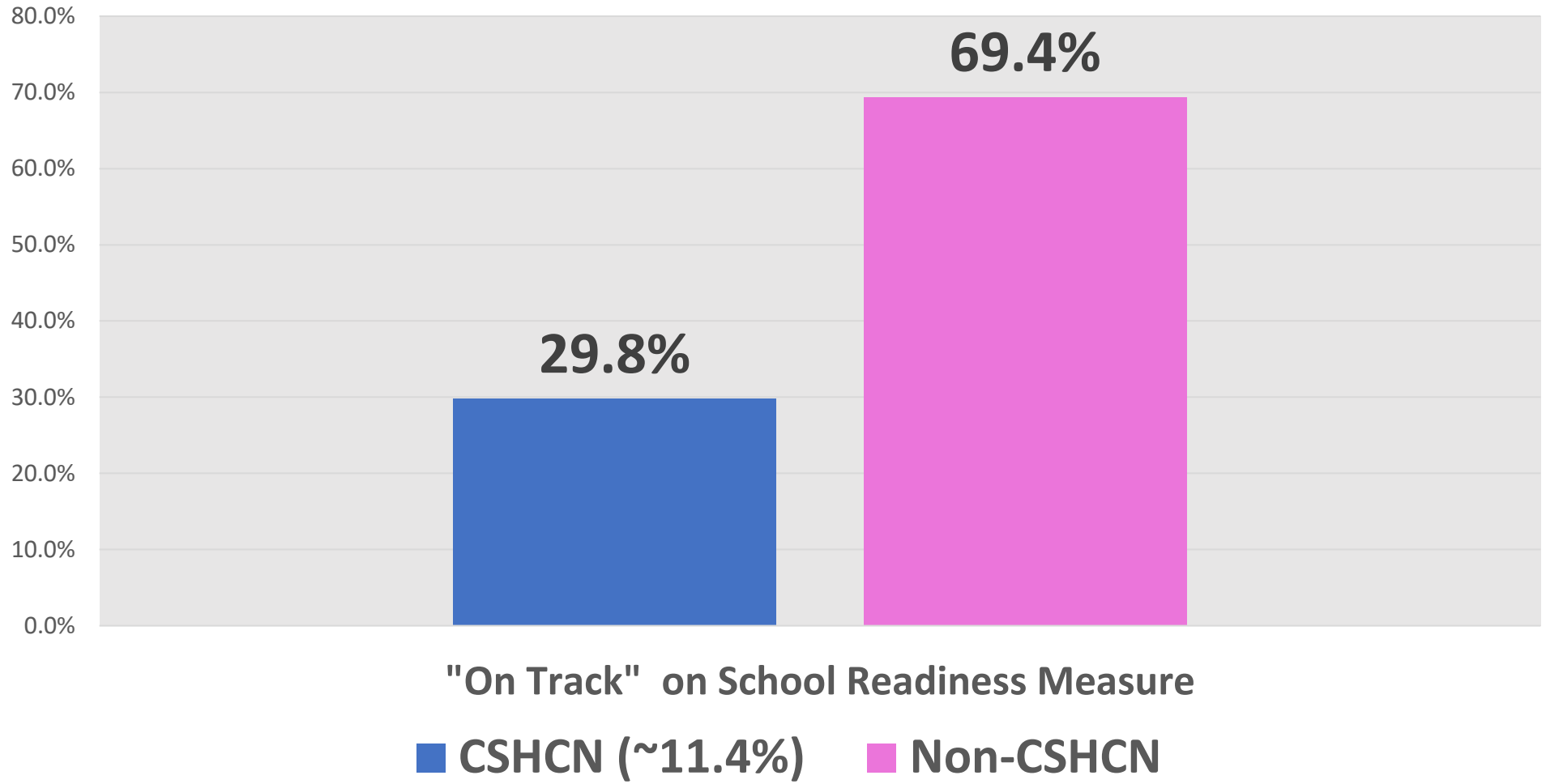
Household smoking and substance use

Other options:

- Child social and emotional development
- Family resilience
- Child flourishing
- + More

Critical for early identification of children with special health care needs who are especially vulnerable but whose flourishing can be promoted with effective supports

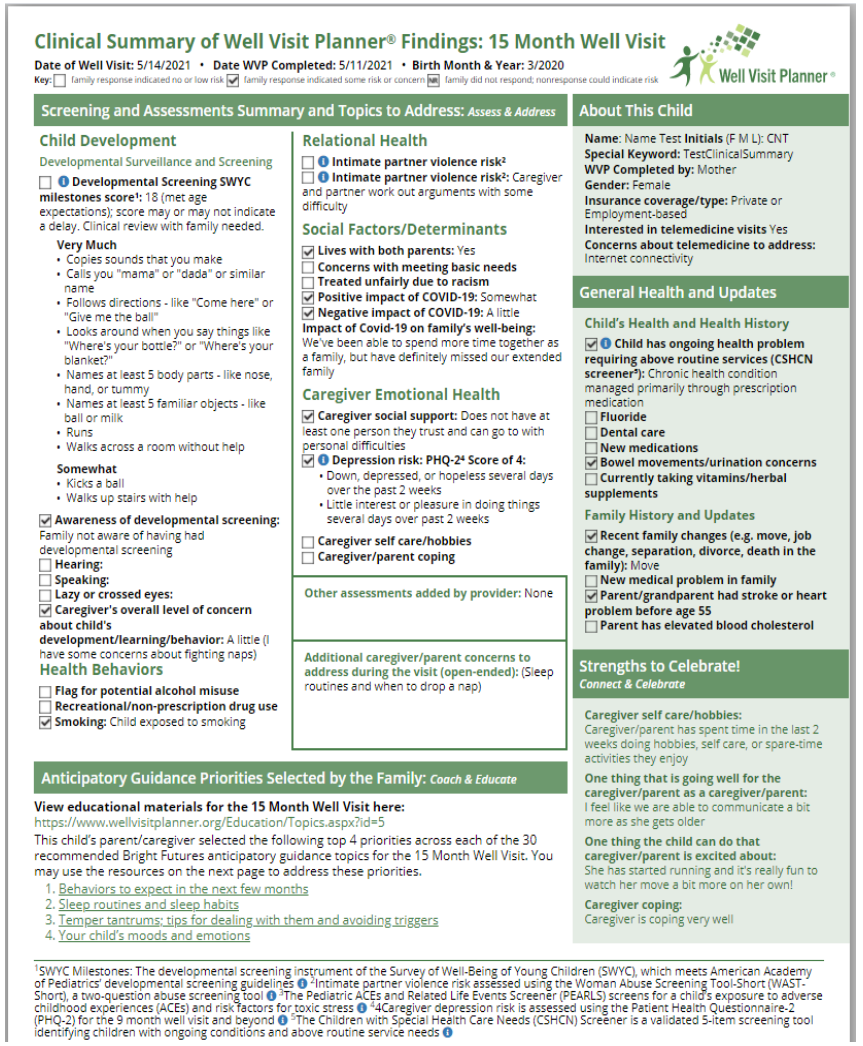
School Readiness (Age 3-5) by Children With Special Health Care Needs Status
2022 NSCH Data: National



C. Bethell, 2024

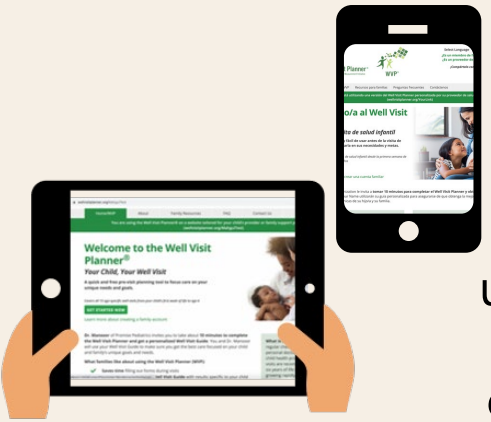
Both families and “providers” get auto-generated summaries to save, share, send and use to partner with each other and across care teams

Can be led by the community in partnership with child serving professionals and services.



- ✓ Providers can use to **document and secure payment** for screening and care.
- ✓ Families can **save to track child and family well being** over time.
- ✓ Families can **share across family members** and/or care team members.
- ✓ Families and provider can be **confident** all required screening was conducted and child and family priorities were met
- ✓ **Aggregate WVP data** can be used to track community and population needs, health and strengths and **advocate for change** using your family centered data

How It Works for Family: It takes families about 10 minutes to complete the WVP at home, in the waiting room, or anywhere else



1. Access

Family is invited to access provider's unique WVP website through any computer or mobile device

2. Complete

Family completes age-specific screeners and assessments and picks their priorities

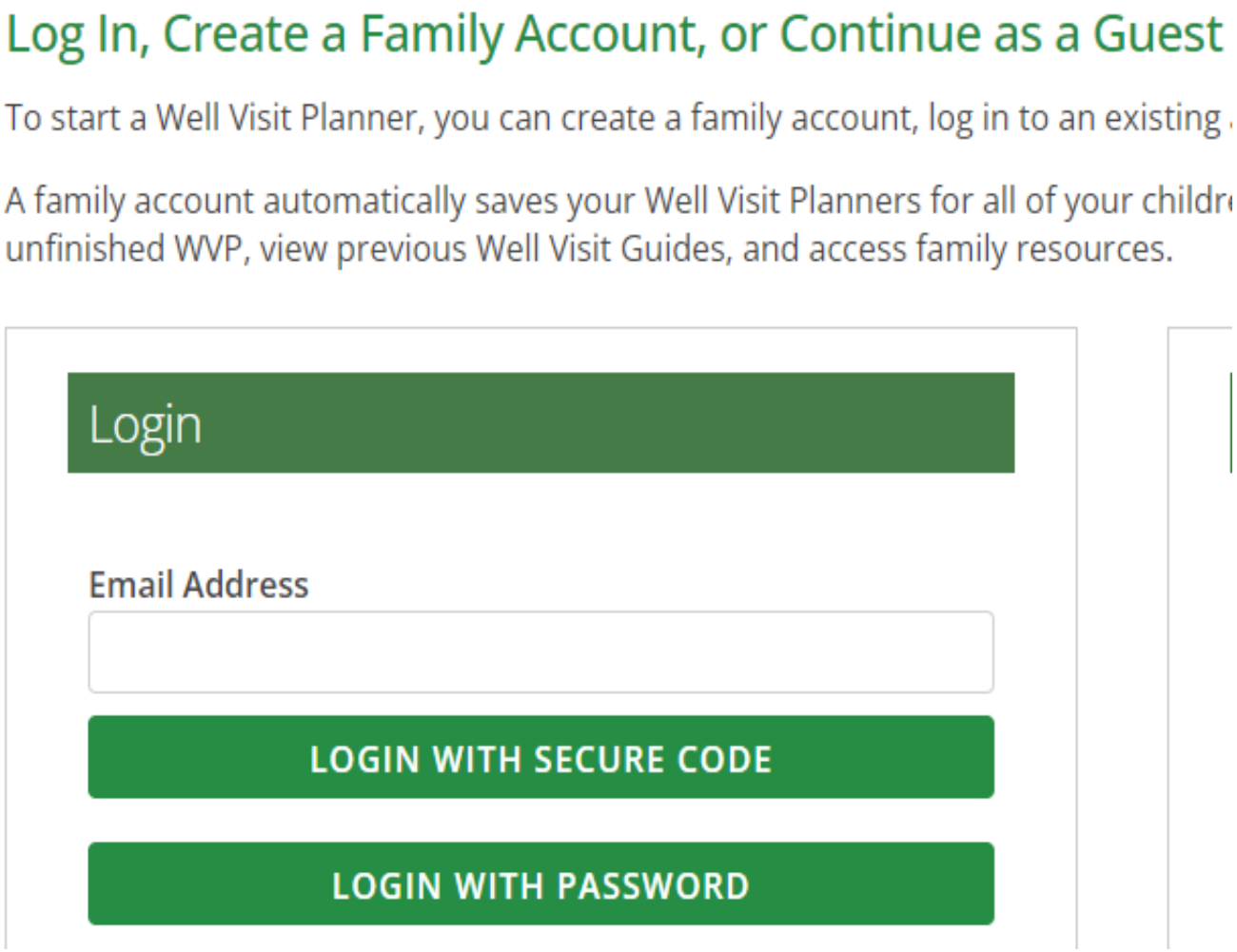
3. Review

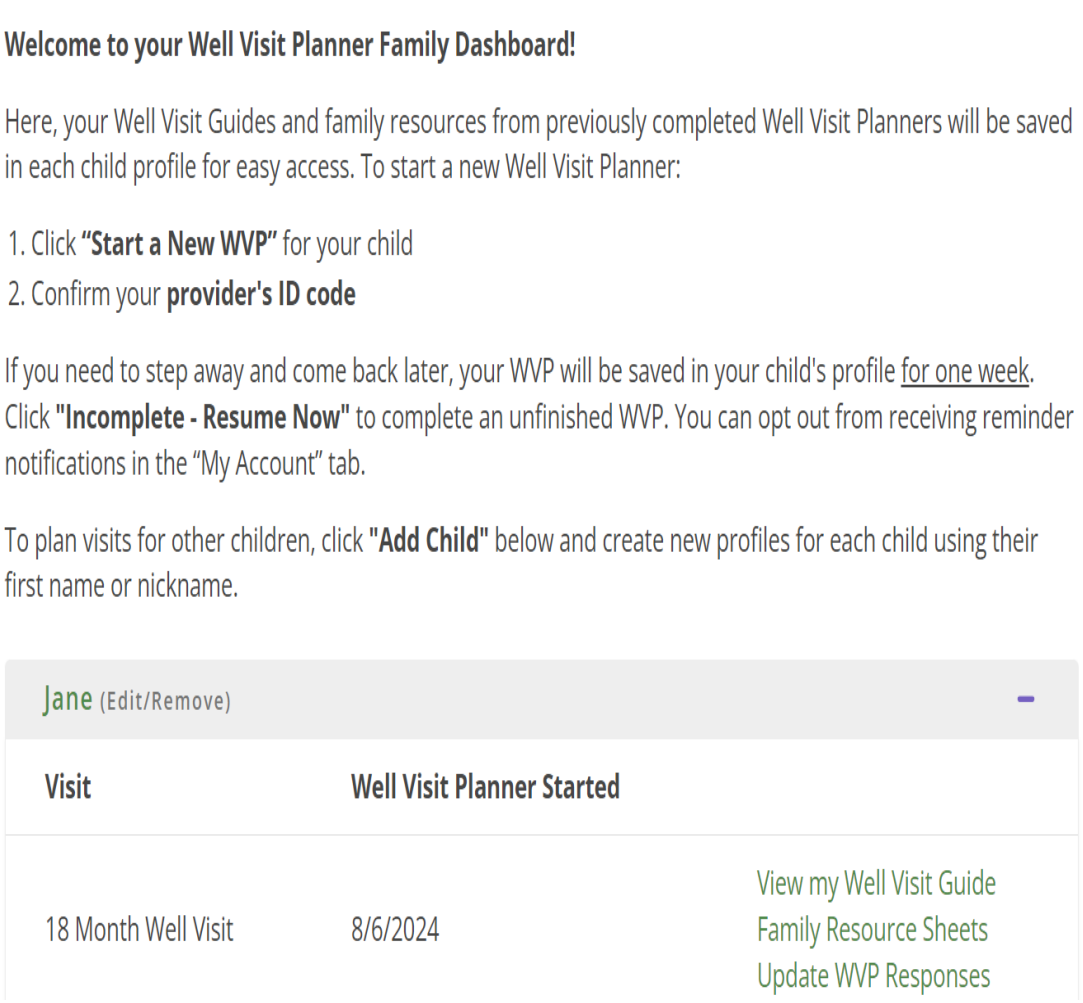
Family receives a Well Visit Guide report with WVP results, example questions to ask, resources from their provider, and more

4. Partner in Care

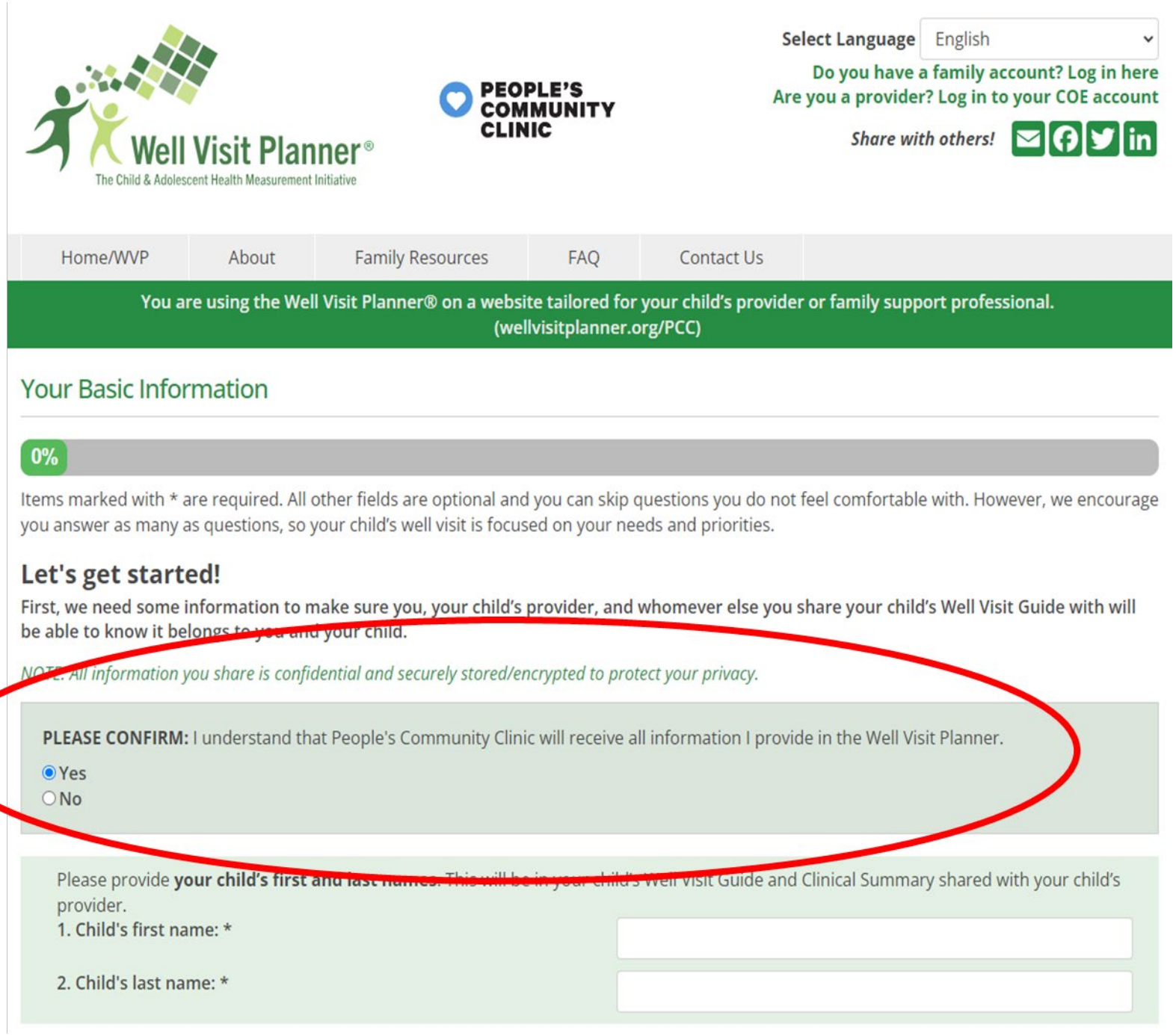
An enhanced encounter led by the family's agenda, highlighting their strengths and positive experiences

Family signs up for an account and personal, secure dashboard-- or they can use as a guest! Families "own" their data!

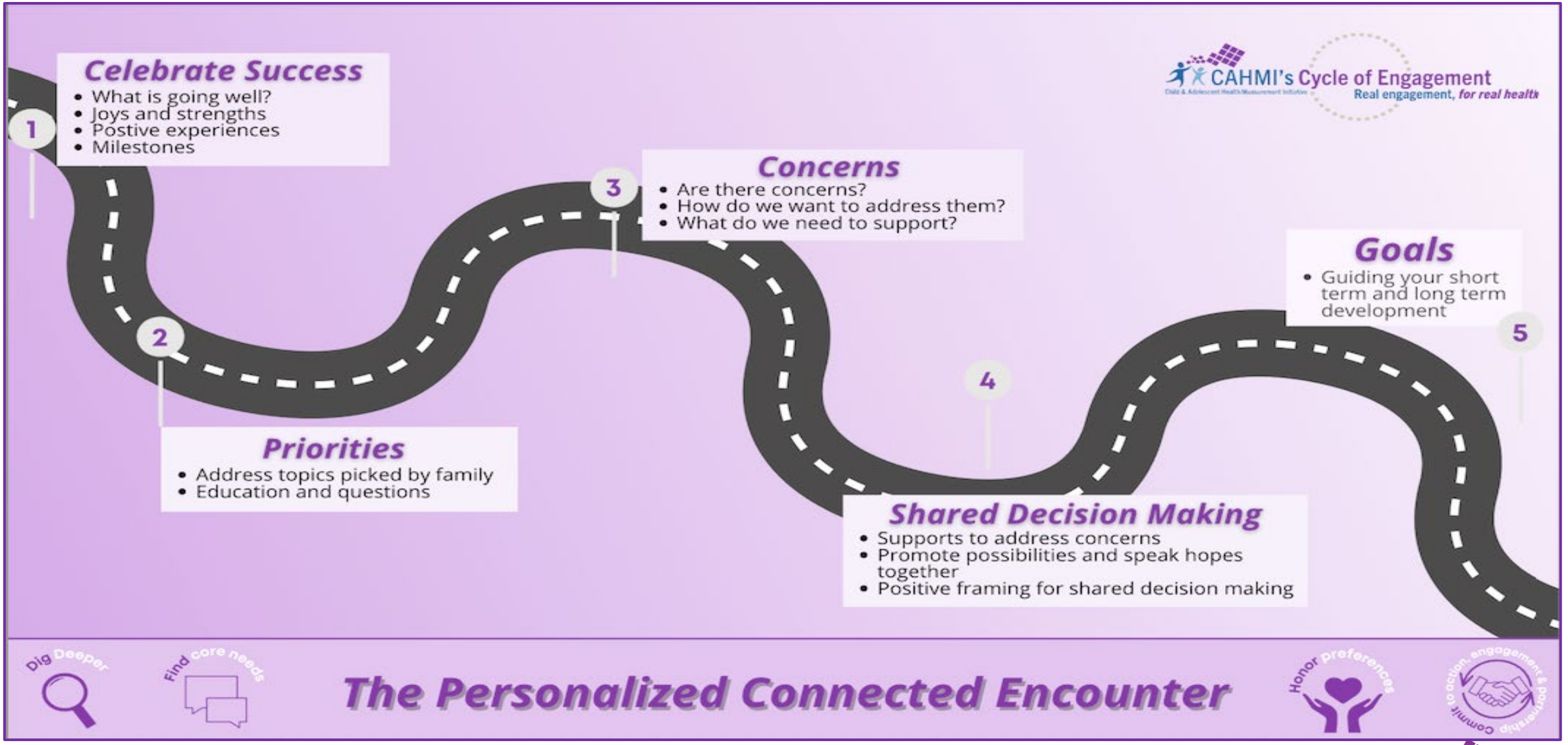




Families consent to sharing their WVP data with their provider. Only respond to what they want to share. Get all results/resources ASAP!



The Goal: The Personalized Connected Encounter

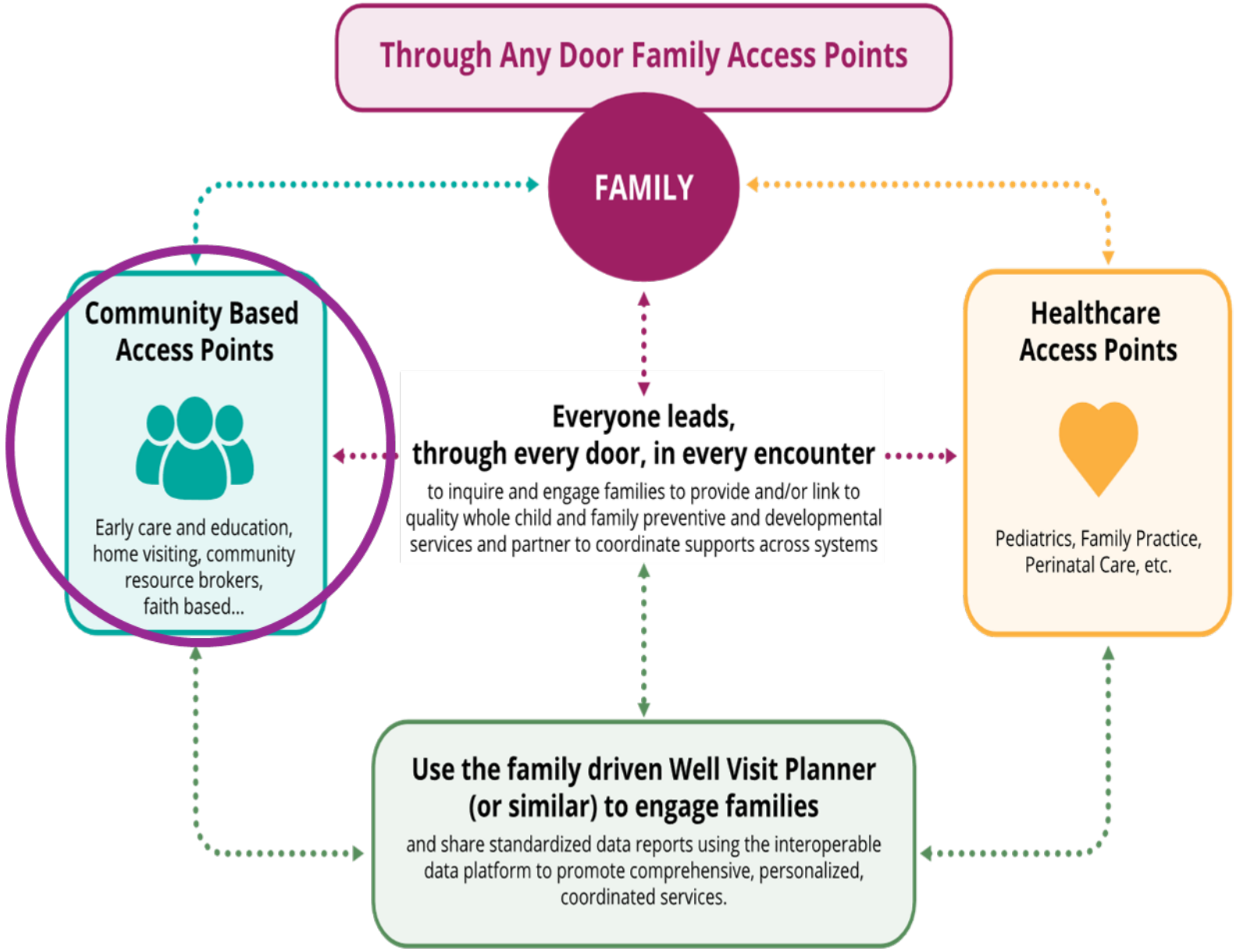


CAHMI

Through Any Door!

Health Care and Family and Community Support Professionals Can Partner to MEET FAMILIES WHERE THEY ARE!

An Interoperable, Standardized Tool Like the WVP is Essential!



Source: Child and Adolescent Health Measurement Initiative, Feb. 2023

Example: Mississippi Families for Kids / Help Me Grow (MFFK/HMG)

Example workflow

Initial engagement with families at school-based site

- Care coordinators introduce the WVP to families
- Families are given resources and encouraged to complete WVP
- WVP assesses their child's development, strengths, needs, and priorities

Families complete the Well Visit Planner

- Families use MFFK's customized WVP website for assessments aligned with Bright Futures Guidelines
- Care coordinators assist in navigating the WVP to generate a personalized Well Visit Guide based on screening results

Well Visit Guide/Clinical Summary shared with providers

- Care coordinators share the WVG/Clinical Summary with pediatric providers via their WVP data dashboard and help schedule well-visits
- Providers access the Clinical Summary through their data dashboard to review assessment results and family priorities to prepare for the well visit

Follow-ups and referrals ensure care is being received

- MFFK/HMG staff can use the WVP data dashboard to identify children needing referrals for additional services
- Follow-ups to track if referrals and services are initiated, promoting effective care coordination

Key Success Factors Identified

Implementation and team engagement

- All team members were on the same page regarding goals and motivation – systems change mindset/HMG model
- Consistent engagement from leadership positions
- Identified team roles
- Training for team members to use the WVP platform

Ensuring family engagement

- Sufficient and adequate sharing of WVP family resources
- Transparent and open communication with families about their benefits and role throughout
- MFFK/HMG team were able to answer questions
- Meaningful conversations were easy to have using the results presented in the family-facing Well Visit Guide

Fostering partnerships and relationships with health providers

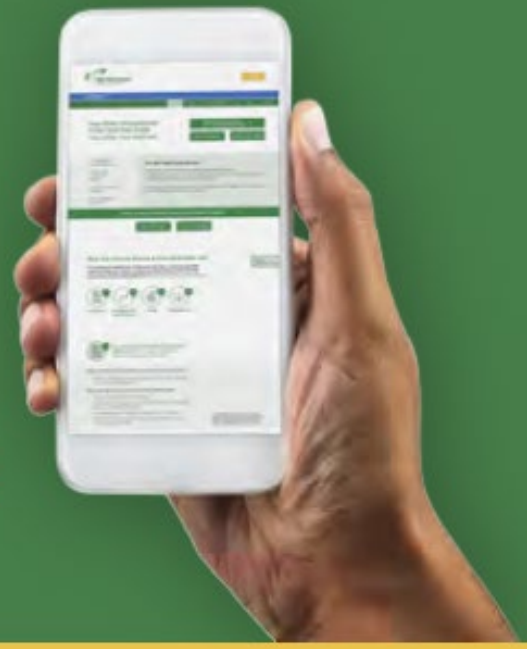
- Mutual respect and understanding of expectations and goals (an MOU was established)
- Documenting a workflow for data sharing
- Families were empowered to share the WVP Well Visit Guide with providers that did not already know about the WVP

Your Providers, **Your Partners!**

What Families Say?

92%

of families using the **Well Visit Planner** report they were **comfortable with the amount of time it took and they would recommend the WVP to other parents.**



"[The Well Visit Planner] asks me if I have any questions that I would like to discuss with the doctor before the physical. So, then it *makes my job easier* when I go in to see the doctor, everything is written down back there."

"I had no idea I could talk with my child's doctor about how I was doing or my child's behavior—I just thought I was a bad parent. Having example questions to asked and knowing what my doctor is supposed to ask me and talk about made all the difference."

- Parent

- Would recommend to other parents 90% phase 1 input; 100% phase 2 input
- Creates more time to talk with the pediatrician 100%
- I like using the WVP to ensure that the visit is based on my priorities 100%
- I was comfortable sharing about the questions asked 89%
- Does not take too much time 86%

Caregivers/Parents Learn, Engage and Want to Partner

Online PHDS Results Showed:

- **92% of study families completing the PHDS said they are interested in using online pre-visit planning tool to partner in care**

- "For me, having the Well-Visit Planner **would be a necessity to have a tele- well visit"** - a caregiver
- "I thought it [VG] **was helpful. I liked having it in my phone**, as I always don't have time to get it printed." - a caregiver
- "I thought it [WVP] was a **helpful way to organize my thoughts** and it kind of gives you a structured plan and some kind **information to take with you and take notes** for the visit" – a caregiver
- **"I didn't find time to be an issue**. I think the very first time it [filling WVP] took me a little longer..But once we get used to it, it is set up in a way that it is pretty simple" – a caregiver

Well Visit Planner: A Primary Care Clinic Perspective

People's Community Clinic (PCC)

- Founded in 1970
- Became FQHC in 2012
- Annual patients (total, pediatric/adolescent, pediatric < 6 yrs. old)

Pediatrics

- Primary care and wraparound services
- Team-based approach to care
- More than a decade developing our ability to focus on **early brain development and early relational health:**
  - HealthySteps
  - Filming Interactions to Nurture Development
  - Promoting First Relationships in Pediatric Primary Care

HealthySteps

Well Visit Planner®
The Child & Adolescent Health Measurement Initiative

The FIND Program

PROMOTING first RELATIONSHIPS®


PEOPLE'S COMMUNITY CLINIC

PCC'S EARLY CHILDHOOD INITIATIVES

Goals

Support families to set their children on a **trajectory for lifetime health and well being by**…

Making the promotion of **early brain development and early relational health** the organizing principle of our well-child care for young children

STRATEGIES OF PCC'S EARLY CHILDHOOD INITIATIVES

- ***Increase parents'/caregivers' understanding of how powerfully their interactions*** can promote children's brain development
- ***Build parents'/caregivers' responsive parenting skills*** through strengths-based approaches
- ***Build pediatric providers' and other staff's skills*** to support caregivers in developing nurturing, responsive relationships with their children
- ***Reconfigure the well-child check*** *visit to allow for more strengths-based focus on early relational health and responsive parenting*
- ***Reduce underlying sources of stress*** for parents/caregivers by connecting them to resources and working upstream on social drivers of health

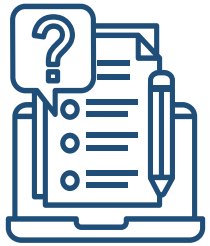
PEOPLE'S COMMUNITY CLINIC

Losing the forest for the trees

- Screenings started **getting in the way** of building stronger relationships with our families:
  - Number of screenings
  - Complexity of screening schedule (which screeners at which visits)
  - Process of completing and scoring screenings
- **Screenings are not enough**—we need to educate and engage families so they can identify their priorities and needs and partner to address each of these

Screening the "old" way was not meeting goals and resulted in less time to engage with our families on relational health issues and discussing families' priorities.

Context for Wel Visit Planner (WVP) adoption



Multiple paper screening instruments

- ASQ, MCHAT, SDOH, post-partum depression, Welch Emotional Connection Screen
- Largely on paper during check-in
- Complicated schedule to spread out different screenings

Long-standing issues of pediatric screening questionnaires

- Informally raised by families and staff
- Resulted in formal family interviews, MA focus groups, and provider focus groups

Program required switching screenings

- Needed to switch from WECS social-emotional screen to Baby/Preschool Pediatric Symptom Checklist
- Needed to add screening for intimate partner violence and household substance use

Context for WVP adoption: family and staff feedback

Family feedback indicated willingness, but pressure

- Willing to complete questionnaires if helpful in care
- Questionnaires were long, hard to complete with time pressure, especially with siblings
- Unclear why questions were asked, what results were, and how they figured into care

Staff feedback revealed flaws in the system

- Process was complicated due to the schedule of which screeners to use at visits
- Time-consuming, hard to complete
- Some families confused by some questions on ASQ and MCHAT, necessitating MA clarification

Parent/caregiver feedback

> *"…I honestly **don't always have a good idea or understanding of what comes out of filling them all out**. I can only really remember a few I have filled out and I feel like any time I am asked to fill something out I don't have enough time to do it.*
>
> ***I feel rushed in asking questions about it** or I forget, because **I am too scared to ask to take up more time**, but I wouldn't mind being asked more if it meant my doctors learned more about us."*

- Parent from an interview on clinic's screening process

Parent/caregiver feedback (cont'd)

> *"I think the amount [of questionnaires] is fine, but I feel like if we could fill them all out before we came in it could relieve a lot of stress. As well as **give time to explain the goal of each form** versus filling it out and turning it in.*
>
> *In addition, if **we received more information** from whoever wants this filled out, I would feel more confident in filling them out accurately."*

- Parent from an interview on clinic's screening process

Provider feedback

> *“And then we're asking so many questions. I mean, at some visits **it's like we spend our whole time doing [a developmental screen],** this, that, that, that. I mean, I wish we could streamline and do the ones that really are giving us what we want. We've got way too much, to me. **I'm overwhelmed**.”*

- Provider at a focus group on clinic’s screening process

Reconfigure the well-child check visit to allow for more strengths-based focus on early relational health and responsive parenting

We are trying to…

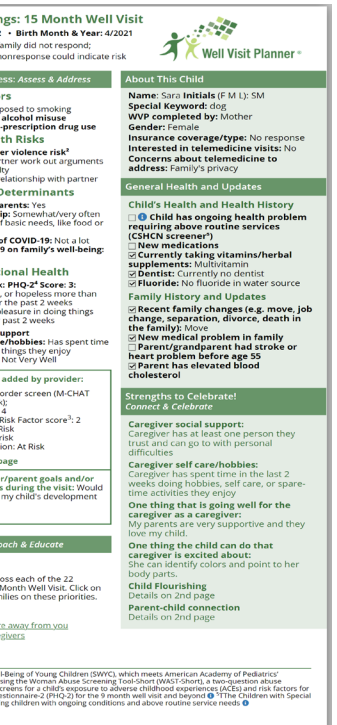
- Engage better
- Explain better
- Understand family priorities
- Focus on strengths
- Strengthen our relationship with the parent/caregiver
- Recognize the parallel process occurring in provider-caregiver and caregiver-child relationships

And we need all this to be time efficient and sustainable.

Beyond screening

The Well Visit Planner aligns with our goals and needs to reconfigure the well child check visit in the service of early relational health.

- Family engagement
- Workflow and efficiency (MA and provider engagement)
- Comprehensive Content and Clinical Summary



Clinical Summary of Well Visit Planner® Findings: 15 Month Well Visit

Date of Well Visit: No response • **Date WVP Completed:** 9/1/2022 • **Birth Month & Year:** 4/2021

Key: ☐ family response indicated no or low risk ☑ family response indicated some risk or concern ☒ family did not respond; nonresponse could indicate risk

Well Visit Planner®

Screening and Assessments Summary and Topics to Address: *Assess & Address*

Child Development

Developmental Surveillance and Screening

☑ **Developmental Screening SWYC milestones score[1]:** 10 (Results from 15 Month SWYC: did not meet age expectations); score may or may not indicate a delay. Clinical review with family needed.

Very Much
- Looks around when you say things like "Where's your bottle?" or "Where's your blanket?"
- Names at least 5 body parts - like nose, hand, or tummy
- Walks across a room without help

Somewhat
- Copies sounds that you make
- Calls you "mama" or "dada" or similar name
- Follows directions - like "Come here" or "Give me the ball"
- Names at least 5 familiar objects - like ball or milk

Not Yet
- Kicks a ball
- Runs
- Walks up stairs with help

☑ **Caregiver reports completing standardized developmental, behavioral screening:** No
☑ **Caregiver's overall level of concern about child's development, learning, behavior:** A little
☐ **Hearing concerns:** No
☑ **Speaking concerns:** Yes
☐ **Lazy or crossed eyes:** No
☐ **Bowel movements/urination concerns:** No

Health Behaviors

☑ **Smoking:** Child exposed to smoking
☐ **Flag for potential alcohol misuse**
☐ **Recreational/non-prescription drug use**

Relational Health Risks

☐ **Intimate partner violence risk[2]**
- Caregiver and partner work out arguments with some difficulty
- Some tension in relationship with partner

Social Factors/Determinants

☐ **Lives with both parents:** Yes
☑ **Economic Hardship:** Somewhat/very often hard to cover costs of basic needs, like food or housing
☐ **Negative impact of COVID-19:** Not a lot
☑ **Impact of Covid-19 on family's well-being:** Somewhat

Caregiver Emotional Health

☑ **Depression risk: PHQ-2[4] Score: 3:**
- Down, depressed, or hopeless more than half the days over the past 2 weeks
- Little interest or pleasure in doing things several days over past 2 weeks

☐ **Caregiver social support**
☐ **Caregiver self care/hobbies:** Has spent time in last 2 weeks doing things they enjoy
☑ **Caregiver coping:** Not Very Well

Other assessments added by provider:

Autism spectrum disorder screen (M-CHAT R/F): 7 (Moderate risk)
PEARLS ACEs score[5]: 4
PEARLS Toxic Stress Risk Factor score[5]: 2
Child flourishing: At Risk
Family resilience: At risk
Parent-child connection: At Risk

See details on 2nd page

Additional caregiver/parent goals and/or concerns to address during the visit: Would like to discuss about my child's development and expectations

About This Child

Name: Sara **Initials** (F M L): SM
Special Keyword: dog
WVP completed by: Mother
Gender: Female
Insurance coverage/type: No response
Interested in telemedicine visits: No
Concerns about telemedicine to address: Family's privacy

General Health and Updates

Child's Health and Health History

☐ **Child has ongoing health problem requiring above routine services (CSHCN screener[3])**
☐ **New medications**
☑ **Currently taking vitamins/herbal supplements:** Multivitamin
☑ **Dentist:** Currently no dentist
☑ **Fluoride:** No fluoride in water source

Family History and Updates

☑ **Recent family changes (e.g. move, job change, separation, divorce, death in the family):** Move
☑ **New medical problem in family**
☐ **Parent/grandparent had stroke or heart problem before age 55**
☑ **Parent has elevated blood cholesterol**

Strengths to Celebrate! *Connect & Celebrate*

Caregiver social support: Caregiver has at least one person they trust and can go to with personal difficulties

Caregiver self care/hobbies: Caregiver has spent time in the last 2 weeks doing hobbies, self care, or spare-time activities they enjoy

One thing that is going well for the caregiver as a caregiver: My parents are very supportive and they love my child.

One thing the child can do that caregiver is excited about: She can identify colors and point to her body parts.

Child Flourishing Details on 2nd page

Parent-child connection Details on 2nd page

Anticipatory Guidance Priorities Selected by the Family: *Coach & Educate*

View educational materials for the 15 Month Well Visit here: https://www.wellvisitplanner.org/Education/Topics.aspx?id=5

This child's parent/caregiver selected the following top 5 priorities across each of the 22 recommended Bright Futures anticipatory guidance topics for the 15 Month Well Visit. Click on the links below to access information and resources to share with families on these priorities. See page 2 for additional resources.

1. Behaviors to expect in the next few months
2. How your child may start to become more independent and explore away from you
3. Separation anxiety, how your child responds to new people or caregivers
4. How you balance taking care of yourself while being a parent
5. Ways to guide and discipline your child

[1]SWYC Milestones: The developmental screening instrument of the Survey of Well-Being of Young Children (SWYC), which meets American Academy of Pediatrics' developmental screening guidelines [2]"Intimate partner violence risk assessed using the Woman Abuse Screening Tool-Short (WAST-Short), a two-question abuse screening tool [3]"The Pediatric ACEs and Related Life Events Screener (PEARLS) screens for a child's exposure to adverse childhood experiences (ACEs) and risk factors for toxic stress [4]"Caregiver depression risk is assessed using the Patient Health Questionnaire-2 (PHQ-2) for the 9 month well visit and beyond [5]"The Children with Special Health Care Needs (CSHCN) Screener is a validated 5-item screening tool identifying children with ongoing conditions and above routine service needs

Clinical Summary

- ☐ Screening Results
- ☐ Family Goals
- ☐ Concerns
- ☐ Educational Priorities

Screening	Codes
Developmental Screening (SWYC)	96110
Autism spectrum disorder (M-CHAT-R™)	96110 with modifier KX
Caregiver depression (PHQ-2 or EPDS)	96161, G8510, G8431
Adverse Childhood Experiences (PEARLS)	96160, G9919, G9920
Baby Pediatric Symptom Checklist (BPSC)	96127
Preschool Pediatric Symptom Checklist (PPSC)	96127
Safe Environment for Every Kid (SEEK)	96160

Alignment: Our needs and the WVP

Family Engagement	Workflow (MA and provider engagement)	Content
• Pre-visit planning approach • Provide context to families about the screeners/questions asked • Opportunities to share & highlight strengths • Provide family results and personalized resources in a meaningful way • Available in English and Spanish • Intentional flow and presentation of screeners/questions	• Paperless and pre-visit approach • Automatic scoring and reporting in an efficient way to view the whole-child and family • Periodicity flexibility/customization • EHR integration	• Include required screeners by TX Medicaid, HealthySteps, and grants • Aligned with national standards (Bright Futures) • Includes at least 1 approved developmental screening tool • Strengths-based questions and positive health factors reported • Available in English and Spanish • One platform, easy to follow and navigate

PCC's WVP Implementation Timeline

Spring/summer 2023

Completed assessment of our screening process and shared results with staff

Late summer/ early fall 2023

Identified WVP as possible response

Compressed implementation process due to an impending EHR transition

- Convened a team that included operations, patient service representatives, MAs, early childhood team, and providers
- Registered and customized clinic-specific site
- Oriented and then piloted with 2, then 3, providers and their MAs for about a month
- Trained all providers and MAs

Mid-January 2024

Rolled out to all teams

February 2024

Switched EHRs

We created a customized WVP in just 15 minutes and began learning and engaging families immediately

Register & Customize

Provider creates an account and customizes their own WVP tool and website

Engage

Provider invites family to complete their WVP before the well-visit

Review

Provider receives a Clinical Summary report with WVP scores and results to review and prepare for the well-visit

Partner in Care

An enhanced encounter focused on family priorities, risks, and concerns, while anchoring to strengths and positive experiences

Well Visit Planner®

PEOPLE'S COMMUNITY CLINIC

Louis Appel

Logout

WVP Use Portal

Get Results: Your Data Dashboard

- Download a WVP data file

Engage Your Families

Implementation Roadmap: Create Your Plan

- Phase 1: Exploration
- Phase 2: Preparation
- Phase 3: Implementation
- Phase 4: Sustaining

Partner in Care

Keep Improving

Five Steps to implement the Well Visit Planner approach to care:

1. **Create Your Plan**
2. **Engage Your Families**
3. **Get Results**
4. **Partner in Care**
5. **Keep Improving**

Quick Links to update your WVP:

- Update your customized website
- Add additional questions and assessments
- Add or update special resource links

Your Portals:

- COE Dashboard
- PHDS Use Portal

Our Iterative process

Improving pre-visit completion rate

- Separate text from visit reminder text → combined text
- Determine how many days prior to visit to include the link to complete WVP
- Evolution of role of MAs in contacting family if WVP not completed

Optimize process when WVP is not completed pre-visit

Determine best ways for staff to support family in getting started and finishing the WVP

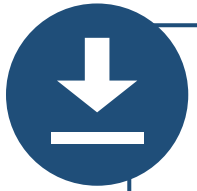
Having families complete as guest versus creating an account

Working with the CAHMI/WVP team

Get support to address issues as they arise

Follow up trainings for MAs and providers

Specifically centered on reviewing how to respond to certain areas of concern reported from the WVP



Child-level aggregate data available to integrate while working towards streamlined EHR integration

WVP Use at PCC: 12/13/2023- 8/30/2024

Total number of completed WVPs as of August 2024

~n=5650 (average of 700 per month)

Median completion time: 11 minutes; Completion rate prior to visits about 60%; 40% complete in office or visit room while waiting for provider. Rates expected to improve as we normalize WVP use.

Well Child Visit Age	%
1st week	6.3%
1 month (PCC 2 week visit)	2.2%
2 month visit	8.7%
4 month visit	10.6%
6 month visit	12.1%
9 month visit	9.7%
12 month visit	5.9%
15 month visit	4.5%
18 month visit	6.8%
2 year visit	7.7%
2 ½ year visit	5.6%
3 year visit	7.0%
4 year visit	6.8%
5 year visit	5.0%
6 year visit	1.1%

Clinical Summary of Well Visit Planner® Findings: 18 Month Well Visit

Date WVP Completed: 6/30/2024 • Birth Month & Year: 12/2022 • WVG ID: 30-40865Z630-409

Key: ☐ family response indicated no or low risk ☑ family response indicated some risk or concern ☒ family did not respond; nonresponse could indicate risk

Well Visit Planner®

Screening and Assessments Summary and Topics to Address: *Assess & Address*

Child Development

Developmental Surveillance and Screening

☑ **Developmental Screening SWYC milestones score[1]:** 8 (Results from 18 Month SWYC: did not meet age expectations, cutoff score of ≥ 9); score may or may not indicate a delay. Clinical review with family needed.

Very Much
- Runs
- Uses words to ask for help

Somewhat
- Climbs up a ladder at the playground
- Kicks a ball
- Names at least 5 familiar objects - like ball or milk
- Walks up stairs with help

Not Yet
- Jumps off the ground with two feet
- Names at least 5 body parts - like nose, hand, or tummy
- Puts 2 or more words together - like "more water" or "go outside"
- Uses words like "me" or "mine"

☑ **Emotional/behavioral screening (PPSC Score 9)** At Risk; **See details on 2nd page.**

☑ **Autism spectrum disorder screen (M-CHAT R/F):** Moderate Risk

Administer M-CHAT Follow-Up for specific responses
1. If caregiver points at something, child does not look
2. Caregiver has wondered if child might be deaf
3. Child does not play pretend or make-believe
5. Child makes unusual finger movements near eyes

☐ **Caregiver's overall level of concern about child's development, learning, behavior**

☐ **Hearing concerns:** No

☐ **Speaking concerns:** No

☐ **Lazy or crossed eyes:** No

☐ **Bowel movements/urination concerns:** No

Health Behaviors

☑ **Smoking:** Child exposed to smoking

☐ **Flag for potential alcohol misuse**

☐ **Recreational/non-prescription drug use**

Relational Health Risks

☐ **Intimate partner violence risk[2]**
- Caregiver and partner work out arguments with some difficulty
- Some tension in relationship with partner

Social Factors/Determinants

☐ **Economic Hardship:** Rarely hard to cover costs of basic needs, like food or housing

Caregiver Emotional Health

☐ **Depression risk: PHQ-2[4] Score: 2:** Little interest or pleasure in doing things more than half the days over past 2 weeks

☐ **Caregiver social support**

☑ **Caregiver self care/hobbies:** Has not spent time in last 2 weeks doing things they enjoy

☐ **Caregiver coping:** Somewhat Well

Other assessments added by provider:

None

Additional caregiver/parent goals and/or concerns to address during the visit: Test specific goals/concerns comment

About This Child

Name: Test18month Testlastname
Special Keyword:
WVP completed by: Father
Gender: Male
Insurance coverage/type: Medicare

General Health and Updates

Child's Health and Health History

☐ **Child has ongoing health problem requiring above routine services (CSHCN screener[5])**

☐ **New medications**

☐ **Currently taking vitamins/herbal supplements**

☑ **Dentist:** Currently no dentist

☐ **Fluoride:** Unsure if fluoride in water source.

☐ **Lead exposure**

Family History and Updates

☑ **Recent family changes (e.g. move, job change, separation, divorce, death in the family):** Move

☐ **New medical problem in family**

☑ **Parent/grandparent had stroke or heart problem before age 55**

☑ **Parent has elevated blood cholesterol**

Lives with both parents: Yes

Strengths to Celebrate! *Connect & Celebrate*

Caregiver social support:

One thing that is going well for the caregiver as a caregiver:
enjoy reading at night with them

One thing the child can do that caregiver is excited about:
running at park

Anticipatory Guidance Priorities Selected by the Family: *Coach & Educate*

View educational materials for the 18 Month Well Visit here:
https://www.wellvisitplanner.org/Education/Topics.aspx?id=6

This child's parent/caregiver selected the following top 4 priorities across each of the 24 recommended Bright Futures anticipatory guidance topics for the 18 Month Well Visit. Click on the links below to access information and resources to share with families on these priorities. See page 2 for additional resources.

1. Your child's moods and emotions
2. Behaviors to expect in the next few months from your 18-month-old
3. Toilet training
4. What to do if your child swallows poison and when to call the poison control center

[1]SWYC Milestones: The developmental screening instrument of the Survey of Well-Being of Young Children (SWYC), which meets American Academy of Pediatrics' developmental screening guidelines [2]Intimate partner violence risk assessed using the Woman Abuse Screening Tool-Short (WAST-Short), a two-question abuse screening tool [3]The Pediatric ACEs and Related Life Events Screener (PEARLS) screens for a child's exposure to adverse childhood experiences (ACEs) and risk factors for toxic stress [4]Caregiver depression risk is assessed using the Patient Health Questionnaire-2 (PHQ-2) for the 9 month well visit and beyond [5]TThe Children with Special Health Care Needs (CSHCN) Screener is a validated 5-item screening tool identifying children with ongoing conditions and above routine service needs

Screening and Assessments Summary and Topics to Address: *Assess & Address*

Child Development

Developmental Surveillance and Screening

☑ **Developmental Screening SWYC milestones score[1]:** 8 (Results from 18 Month SWYC: did not meet age expectations, cutoff score of ≥ 9); score may or may not indicate a delay. Clinical review with family needed.

Very Much
- Runs
- Uses words to ask for help

Somewhat
- Climbs up a ladder at the playground
- Kicks a ball
- Names at least 5 familiar objects - like ball or milk
- Walks up stairs with help

Not Yet
- Jumps off the ground with two feet
- Names at least 5 body parts - like nose, hand, or tummy
- Puts 2 or more words together - like "more water" or "go outside"
- Uses words like "me" or "mine"

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Other assessments added by provider:

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Additional caregiver/parent goals and/or concerns to address during the visit: Test specific goals/concerns comment

Strengths to Celebrate! *Connect & Celebrate*

Caregiver social support:

One thing that is going well for the caregiver as a caregiver:
enjoy reading at night with them

One thing the child can do that caregiver is excited about:
running at park

Successes 1

Supporting a relational health approach	
Providers	
Feature	**Metrics of success and benefits**
Strength-based/positive questions	Conveys things that are going well which can be used by providers to connect positively with caregivers Aligns with work we have done to improve providers' skills at connecting with families during the visit.
Screening information and family-identified interests prior to visits	Providers are more efficiently able to address concerns and family-selected priorities
Families	
Ability to complete screenings at home	Families are less stressed due to fewer questions during the visit
Explanations of questions	Families have a better idea of why specific questions are being asked

Successes 2

Providing families with access to resources linked to their specific areas of interest	
Feature	**Metric of success and benefits**
Well Visit Guide	Families receive the Well Visit Guide, which provides them with detailed information on topics they expressed interest in Families can choose their level of engagement in terms of how much they use the resources offered by the WVP platform

Meeting screening requirements we have for HealthySteps, Texas Medicaid, and specific grants	
Feature	**Metric of success and benefits**
Comprehensive screening by the Well Visit Planner	Staff **do not** need to keep track of a complicated periodicity Staff and families **do not** need to navigate multiple paper screening tools

Successes 3

Increasing efficiency and using screenings to inform visits	
Feature	**Metric of success and benefits**
WVP Clinical Summary	Provides a beautifully concise and easy to quickly review summary of all the information shared by the family, and takes only moments for the provider to assess areas needing attention
Ability to complete the WVP pre-visit	As we increase the proportion of families completing the WVP pre-visit, we are seeing important gains in efficiency of the visit for intake and for recognizing and addressing concerns
Comprehensive screening and resource sharing capabilities	HealthySteps screenings are meant to help us support families and connect them to resources when needed With the WVP, we are doing a better job of identifying needs and referring to resources, including related to maternal behavioral health and child social-emotional development

Successes 4

Supporting team-based care	
Team unit	**Contribution to care**
Operations team	Ensures families are being sent the link prior to the visit
MAs	Contact families if WVP not completed at time of the chart prep
Platform	Handles the scoring and highlights areas needing attention
Providers	Use the results to refer to early childhood intervention, to social work for caregiver behavioral health support Call for or refer to our early childhood team, especially around specific social-emotional needs identified

Provider feedback 1

> *"I really **love the 'strengths to celebrate'** section when it's filled out. I find it's a good way to start the visit when the well visit planner is done ahead of time.*
>
> *I usually go in and while EPIC is loading, I'll bring up 'thanks for filling that planner out ahead of time, I see (whatever the positive item was the parent shared),' and it usually **gets parents pretty excited** and they'll go on about other milestones that they're excited about."*

Provider feedback 2

> *"The thing that has stood out most to me is the **depression screener for the moms**.*
>
> *"I have had so many conversations with moms about how they are feeling since starting the WVP, and I think they **feel more comfortable opening up** in this platform. I have been able to provide support through just listening in some cases or referring to Social Work for more help."*
>
> *"It's been **impressive to me how many moms are sharing this feedback via the Well Visit Planner** and I am grateful for that."*

Provider feedback 3

> *"It's a **nice summary of multiple domains**. It's especially useful having the SDOH and maternal depression screening built in. I also like the questions about recent changes in the family (separation, death in the family, etc) as parents don't always volunteer this information."*

Provider feedback 4

> *"I like to read about the **good things that parents are noticing about their kids**. I really like that question.*
>
> *When [the WVP] is filled out before the visit, it certainly **allows for more time to hone in and discuss a particular concern**….it really makes for a smoother and more productive visit if I can focus on the parent/patient….*
>
> *I like the break up of sections on the WVP (Clinical Summary)…it allows me to **easily get a quick glance at development/family/environment (issues) and any major concerns**."*

WVP Data Download Feature

Logout

WVP Use Portal

Get Results: Your Data Dashboard

Download a WVP data file

Engage Your Families

Implementation Roadmap: Create Your Plan

- Phase 1: Exploration
- Phase 2: Preparation
- Phase 3: Implementation
- Phase 4: Sustaining

Partner in Care

Keep Improving

Your WVP Family Website

- Update your customized website
- Add additional questions and assessments
- Update links to additional assessments
- Update links to additional resources
- Update notifications and ways to receive family data

COE Dashboard

Download a WVP data file

To download your WVP data file:

1. Select a start date and end date below for the data collected on your customized WVP. Then click **Add Request.**
2. Click on "Request a code to download the data file".
3. After submitting your request, check your email used to register for this account and enter the code to download the data file.

Start date 1/1/2023 End date 7/26/2024 Add Request

WVP Data files: You will need to request a code every time you download the data file.

Creation Date	Start Date	End Date		
7/26/2024	1/1/2023	7/26/2024	Request a code to download the data file	Delete
7/19/2024	1/1/2024	6/30/2024	Request a code to download the data file	Delete
7/2/2024	1/1/2023	7/2/2024	Request a code to download the data file	Delete
6/3/2024	1/1/2023	6/3/2024	Request a code to download the data file	Delete
5/21/2024	1/1/2023	5/21/2024	Request a code to download the data file	Delete

A	C	F	G	J	P	Q
articipar	VisitGuide	FirstName	LastName	DOB	AgeGroup	surveyStartDate
36374	2-36374B8	Test	CAHMItest	2/1/2021	3 Year Wel	2/2/2024 5:
36782	22-36782V	EPDStest2n	Test	12/30/2023	2 Month W	2/22/2024 7:
36810	23-36810V	EPDStest	Test	10/21/2023	4 Month W	2/23/2024 5:
36811	23-36811V	EPDStest	CAHMItest	12/20/2023	2 Month W	2/23/2024 5:
37282	14-37282N	Test1montl	CAHMItest	2/15/2024	1 Month W	3/14/2024 21:
37283	14-37283N	Test2montl	CAHMItest	1/15/2024	2 Month W	3/14/2024 21:
37311	16-37311P	Test4montl	CAHMItest	12/16/2023	4 Month W	3/16/2024 6:
37316		Test6montl	CAHMItest	9/20/2023	6 Month W	3/17/2024 17:
37317	17-37317C	Test6montl	CAHMItest		6 Month W	3/17/2024 17:

I	FirstName	LastName	DOB	AgeGroup	surveyStartDate	surveyEndDate	S1D_DepInterest	S1D_DepEmot	PHQ2Score	PHQRiskFlaggedCS
35194	CAHMItest			1 Month W	1/22/2024 13:51		90	90	90	
36273	CAHMItest	Test	4/3/2023	9 Month W	1/29/2024 17:27	1/29/2024 17:38	1	2	3	Yes
36275	CAHMItest	Test	1/29/2023	12 Month	1/29/2024 17:44	1/29/2024 17:55	1	2	3	Yes
36276	CAHMItest	Test	########	15 Month	1/29/2024 17:58	1/29/2024 18:08	3	3	6	Yes
36277	CAHMItest	Test	7/20/2022	18 Month	1/29/2024 18:10	1/29/2024 18:19	1	1	2	No
36278	CAHMItest	Test	1/1/2022	2 Year Wel	1/29/2024 18:20	1/29/2024 18:26	0	0	0	No
36288	CAHMItest	CAHMItest	7/1/2020	3 Year Wel	1/30/2024 6:22		99	99	99	Caregiver did not resp
36290	CAHMItest	CAHMItest	7/1/2020	3 Year Wel	1/30/2024 6:41	1/30/2024 7:03	0	1	1	No
36292	CAHMItest	CAHMItest	9/13/2021	2 1/2 Year	1/30/2024 7:05	1/30/2024 7:20	1	0	1	No
36294	CAHMItest	CAHMItest	9/9/2019	4 Year Wel	1/30/2024 7:26	1/30/2024 7:35	1	1	2	No
36295	CAHMItest	CAHMItest		5 Year Wel	1/30/2024 7:36	1/30/2024 7:44	99	99	99	Caregiver did not resp

Example Population Data We Get:
SWYC, IPV, EPDS and PHQ Screening Results

SWYC age-appropriate developmental expectations	%
Met age expectations	52.4%
Did not meet age expectations	47.6%
Not scored (all items missing)	0.8%

Patient Health Questionnaire – 2 PHQ Risks (9 month – 6 year visits)	%
Yes	2.1%
No Risk	95.8%
No Risk (some items missing)	2.0%
Not Scored (all items missing)	2.0%

Edinburgh Postnatal Depression Scale (EPDS) Risks (1-6 month visits)	%
High Risk	3.9%
At Risk	5.5%
Low/No Risk	83.9%
Low/No Risk (some items missing)	6.7%
Not scored (all items missing)	1.7%

Intimate Partner Violence Screening	%
Yes	9.3%
No Risk	88.7%
No Risk (1 item missing)	1.9%
Not Scored (missing data)	2.5%

Example Population Based Data We Get:
M-CHAT, BPSC, PPSC

M-CHAT Risks (18 month, 2 year, 2 ½ year visits)	%
High Risk	1.9%
Moderate Risk	7.6%
Low Risk	67.8%
Low Risk (some items missing)	22.6%
Not scored (all items missing)	1.1%

Baby Pediatric Symptom Checklist Risks (1 m – 17 months, 31 days old)	%
At Risk	36.8%
Low/No Risk	56.7%
Low Risk (some items missing)	6.5%
Not scored (all items missing)	1.3%

Preschool Pediatric Symptom Checklist Risks (18 – 66 months old)	%
At Risk	21.2%
Low/No Risk	65.2%
Low/No Risk (some items missing)	13.6%
Not scored (all items missing)	1.2%

Example Population Based Data We Get Family Strengths to Celebrate

Do you have at least one person whom you trust and to whom you can go with personal difficulties?

- Yes: 86%

How many times in the last 2 weeks have you gone out socially or spent time doing hobbies, self-care or spare-time activities you enjoy?

- None: 40.9%
- 1-2 times: 43.0%
- 3-5 times: 12.8%
- >5 times: 3.3%

In general, how well do you feel you are coping with the day to day demands of parenthood?

- Very well: 51.9%
- Well: 35.9%
- Somewhat well: 10.2%
- Not very well/Not well at all: 2.0%

Lessons and Tips

Implementation logistics

- Time to prepare and coach families on the WVP
- A small percentage of families require more support to learn WVP account management, password, and technology --but influence staff impressions disproportionately
- EHR integration process is mostly difficult due to EHR side, but hopeful!

Improving efficiency

- Pre-clinic completion makes a big difference
- Improving the pre-clinic completion rate has required an iterative quality improvement approach - work in progress
- WVP completion during intake can slow clinic flow
  - Yet, paper screeners were at least as time consuming and not as extensive or integrated like in the WVP

Family feedback

- Families like learning and getting results and knowing what to expect
- Families like partnering around their stated goals and priorities
- Some families find select questions confusing or interpret questions differently than intended
- A small number of families object to a few of the questions (e.g. alcohol use by a family member)—yet, they do not have to complete ANY items they do not wish to complete or share

Next steps

EHR Integration

- Data, interpretation/clinical summary, family-identified topics, family-shared positive reports, family-directed resources
- EHRs need to understand families and clinical staff need more than just screening questions in an electronic format

WVP data flowing into EHRs allows the tools HealthySteps has developed to automate a lot of reporting and tracking required by HealthySteps

Promoting Healthy Development Survey

- Aggregate reporting of results back to the clinic to provide family feedback on their experience

Aim to use the PHDS to obtain feedback from families based on their experiences

Use feedback to improve our care and support value-based contracting with managed care organizations

Screening completion data

Will be used to support value-based contracting with managed care organizations

Resources for providers

Providers can use WVP links to provider-centric resources to gain familiarity with the tool and increase the value of their services

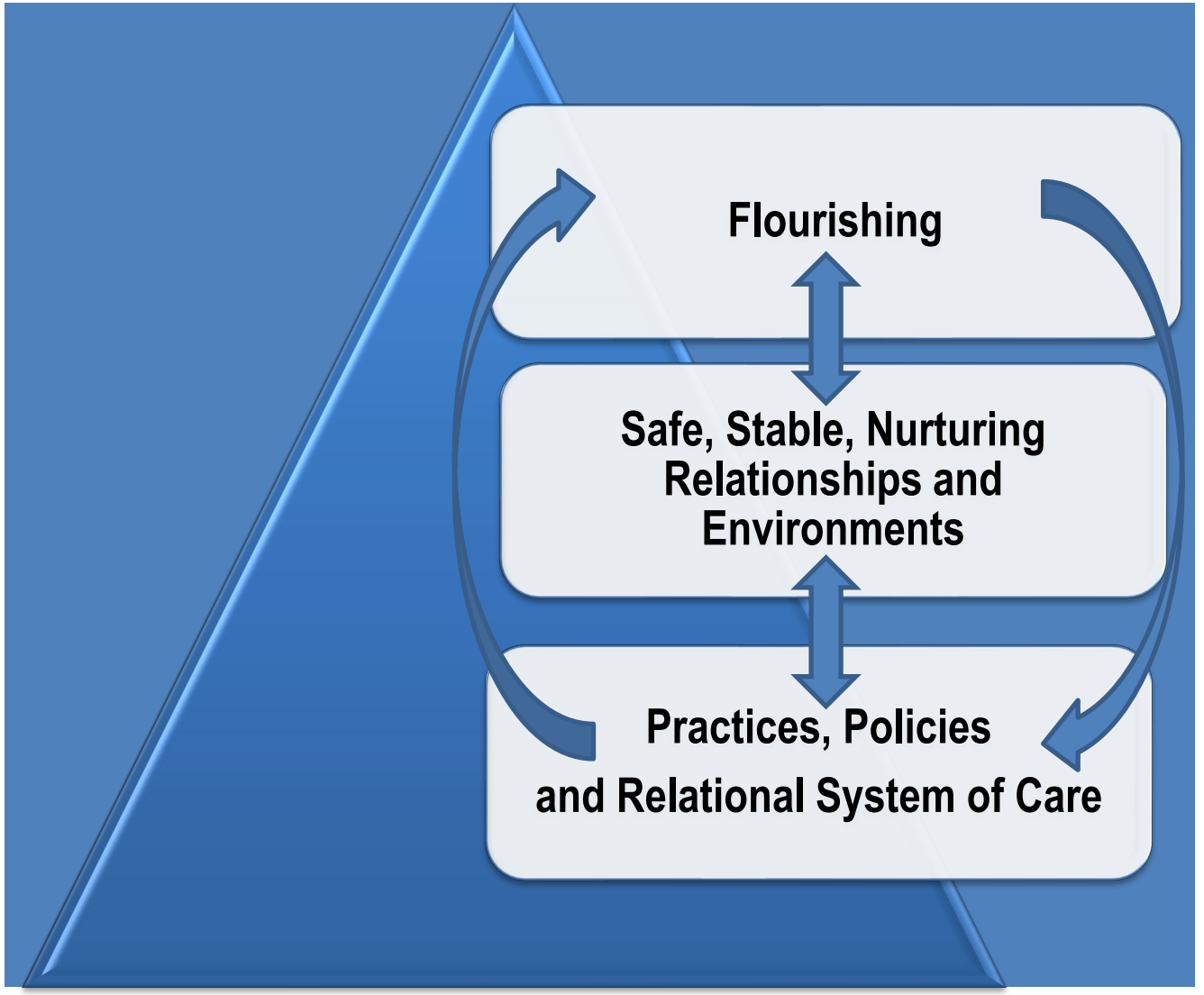
Future Well Child Check (WCC)

We are looking to create a Well Child Check that provides space for promoting early relational health.

Guided by ongoing staff training, improvements in workflow, WVP integration, and further implementation of anticipatory guidance videos, the WCC aims to:

- Allow the team to discuss information and help caregivers grow their skills for nurturing, responsive relationships with their children
- Focus on family-identified areas of interest
- Help families feel connected to the clinic, heard, and engaged in their child's health and healthcare
- Help the clinic team feel effective and engaged in the care they are providing

Start Where We Want to End Up



Imagine

a world where…

-every child and family can flourish despite experiencing adversity

-every child, from the time they're born, has equitable access to high-quality care regardless of social factors

-every physician has the tools to adequately support their families and experience joy in their practice

-every community and care team collaborates effectively with health systems for the well-being of their families

-every child health and family support service available is optimized and leveraged

Promoting positive health and flourishing of children, youth and families is our greatest public health need and opportunity! Trusting relationships, personalized care, reliable and comprehensive data and ongoing engagement of families and communities is required. This is the goal of the CAHMI's Cycle of Engagement model and tools.

What Would It Take? Developmental Screening

Current Rate of Developmental Screening for Children Under 3 in the US	33.7% Range Across States: 24.5-49.1%
Current Rate of Developmental Screening for Publicly Insured Children Under 3 in the US	28.7% Range Across States: 8%-54.6%

How many publicly insured children would we need to screen to improve current rates?

- By 5 points to 33.7% n=146,476
- By 20 points to 48.7% n=585,905
- By 30 points to 58.7% n=878,857
- By 60 points to 88.7%% n=1,757,714

What Would It Take? Well Visit Rates (CMS Data)*

Proportion of publicly insured children **under 15 months** of age that had at least **6 of 9** recommended well visits

2022: 55.7%
Range Across States: 28.2%-77.5%
(1/2rd visits occur)

Proportion of publicly insured children **15-30 months** of age that had at least **2 of 4** recommended well visits

2022: 64.9%
Range Across States: 36.5%-84.4%
(2/3 visits occur)

How many publicly insured children would we need to ensure had well visits to improve current rates?

Age 0-15 months by 20 points to 75.7% ~n=321,000

Age 0-15 months by 45.3 points to 100% ~n=715,000

Age 15-~30 months by 20 points to 85% ~n=307,000

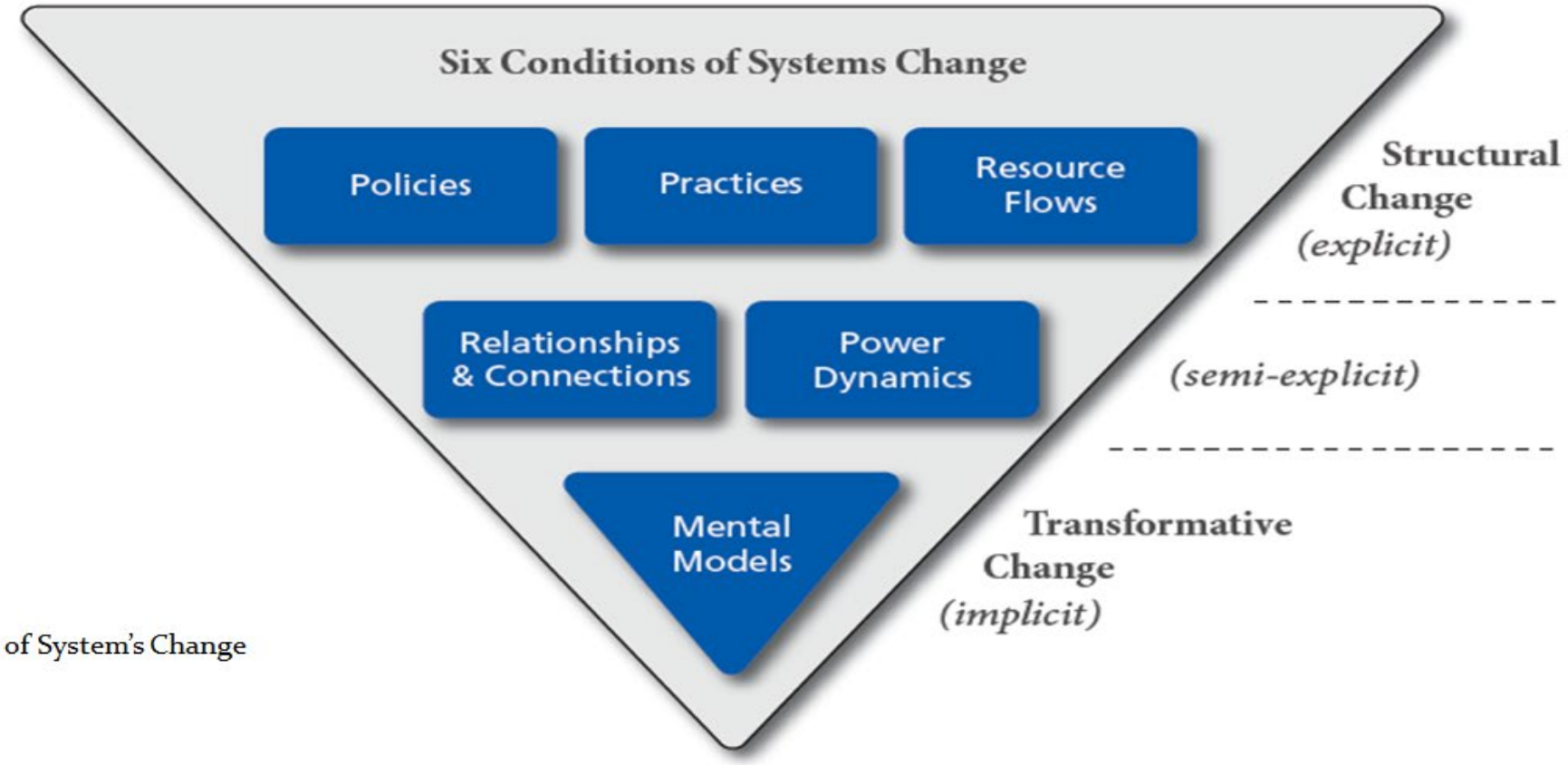
Age 15-30 months by 35 points to 100% ~n=538,000

*https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html

Key Conditions of Systems Change

A fish is swimming along one day when another fish comes up and says "Hey, how's the water?"
The first fish stares back blankly at the second fish and then says "What's water?"

FIGURE 1. SHIFTING THE CONDITIONS THAT HOLD THE PROBLEM IN PLACE



Source: Waters of System's Change

Early Childhood National Centers

RESOURCE & REFERRAL CENTER

PEDIATRIC PRIMARY CARE

HOME VISITING

Help me grow

EARLY CARE AND EDUCATION

PEDIATRIC PRIMARY CARE

IDEA INFANT & TODDLER COORDINATORS ASSOCIATION

EARLY INTERVENTION

Faith for Family Health

FAITH BASED HEALTH PROGRAM

PEDIATRIC PRIMARY CARE

Safe Babies
A Program of ZERO TO THREE

INFANT TODDLER COURT

Head Start

COMMUNITY-BASED RESOURCES

PEDIATRIC PRIMARY CARE

WIC

COMMUNITY-BASED SUPPORTS

THE POSSIBILITIES TO ENGAGE AND ENSURE FAMILIES RECEIVE QUALITY PREVENTIVE SERVICES AND SUPPORTS ARE ENDLESS–BUT INTEROPERABLE FAMILY ENGAGEMENT AND WHOLE CHILD ASSESSMENT APPROACHES AND LINKAGES ARE ESSENTIAL!

Multiple Entry Points for Catalyzing Positive System Change

https://cahmi.org/our-work-in-action/engagement-in-action/EnAct!Framework

One Big Doable Thing! Elevating Comprehensive Developmental Promotion and Preventive Services With the Family-Engaged Well-Visit Planner Approach

(September 10, 2024)

Quick Links to Key CAHMI Resources

The Cycle of Engagement Well Visit Planner Approach to Care (COE WVP)

- Videos
  - COE WVP Overview: Cycle of Engagement Well Visit Planner
  - Well Visit Planner Introduction for Families: English and Spanish
  - Get a Demo on the Cycle of Engagement Account System and Key Features
- Family Engagement Models and Tools
  - COE WVP Approach Overview: Clinical Focus
  - COE WVP Approach Overview: Community Partner Focus
  - Summary of Content and Benefits of the COE WVP
  - The Engagement In Action (EnAct!) Framework Summary
  - Family Outreach Flyer (example of many family resources)

Explore Data Findings from the National Survey of Children's Health (NSCH) from Your State!

- Data Resource Center Interactive Data Query

Additional Resources

- Key Research Publications related child flourishing, school readiness, and ACEs/PCEs
- Quick Links to Priority Technical Assistance Resources on Early Childhood Systems Transformation

Access all resources in our **Google Drive Folder**

Resources

Poll #3. What next step(s) will you consider after participating in this webinar? Select all that apply.

Together We Can Achieve
One Big Doable Thing!

Questions

How Did We Do?

- Please take a moment to complete a brief survey to support the Evidence to Impact Center in improving its trainings and technical assistance offerings and assessing program outcomes over time.

- The survey is anonymous, voluntary, and should take **no longer than 5 to 10 minutes** to complete.

To complete the survey, please click on the link in the chat or scan the QR code below on a mobile device.

CEUs

- Go to the “Contents” tab on the event page.
- Select “CEU Survey.”
- Enter the verification code provided at the end of the survey. (Code is case sensitive.)
- Complete the quiz.
- Once all items are completed the certificate will become available for download.
- You have 30 days to return to the event page and complete items for CEU credit.

Event page link: https://elearn.zerotothree.org/p/ECDHS-WellVisitPlannerApproach#tab-product_tab_contents__5

Thank you again for joining us!

Please scan the QR code to complete our feedback survey.

Early Childhood Developmental Health Systems | EVIDENCE TO IMPACT CENTER