MOVING THE NEEDLE

Expanding the Impact of EBHV Model Collaboration in Communities from Program to Population Impact

NATIONAL ALLIANCE
of home visiting models

A collaborative of national evidence-based home visiting models that started working together in 2012.

See https://www.nationalalliancehvmodels.org for more information

NATIONAL ALLIANCE

of home visiting models

The **collective mission of the National Alliance of Home Visiting Models** is to improve the health and well-being of pregnant women, young children and their parents by elevating and advancing the field of evidence-based home visiting through collaborative leadership.

https://www.nationalalliancehvmodels.org

Evidence Based Home Visiting Models

- **Early childhood home visiting is valuable**
  - it can make a measurable difference in the ability of many parents to care for their children and ensure optimal child development.
  - Evidence based models have proven their effectiveness and many have years of experience implementing their models in collaboration with communities
- **Different models offer different skills and approaches to a community**
  - A universal screening and referral program (Families Connect)
  - Registered nurses work with high-risk first time moms (Nurse Family Partnership)
  - A bridge between pediatric practices and the home (Healthy Steps)
  - A behavioral health intervention for trauma affected families (Child First)

NATIONAL ALLIANCE
of home visiting models

The Importance of Collaboration – Maximizing Community Impact

- **The power of collaboration AMONG home visiting models**
  - Today's presentation provides a powerful example of three models working together in Guilford, NC to improve parent & child health, focusing on children 0-3

- **Need to work closely with the wider community**
  - Home visiting programs, even when well implemented and staffed are not able to meet the needs of all families under all circumstances.
    - Efforts needed to improve the quality of housing, access to medical care, child care, and other primary supports to reduce parental stress and create new opportunities for parents beyond what a home visitor can provide

*"Early childhood home visiting is **a core component of a community's collective effort** to support parents of young children, enhance parental capacity, and promote positive child development."*

From January 2019 Alliance Brief "Lessons from the Field"

Today's Presenters

- Mary Peniston
  Chief Program Officer, | **Child First**
- Todd W. Dalrymple
  Program Officer, Special Initiatives | **The Duke Endowment**
- Krysta Gougler-Reeves
  Community Resource Specialist | **Family Connects International**
- Molly O'Fallon
  Executive Director of Quality and Compliance | **Nurse Family Partnership**

GET READY GUILFORD INITIATIVE

Todd W. Dalrymple

Program Officer, Special Initiatives | **The Duke Endowment**

GET READY GUILFORD INITIATIVE

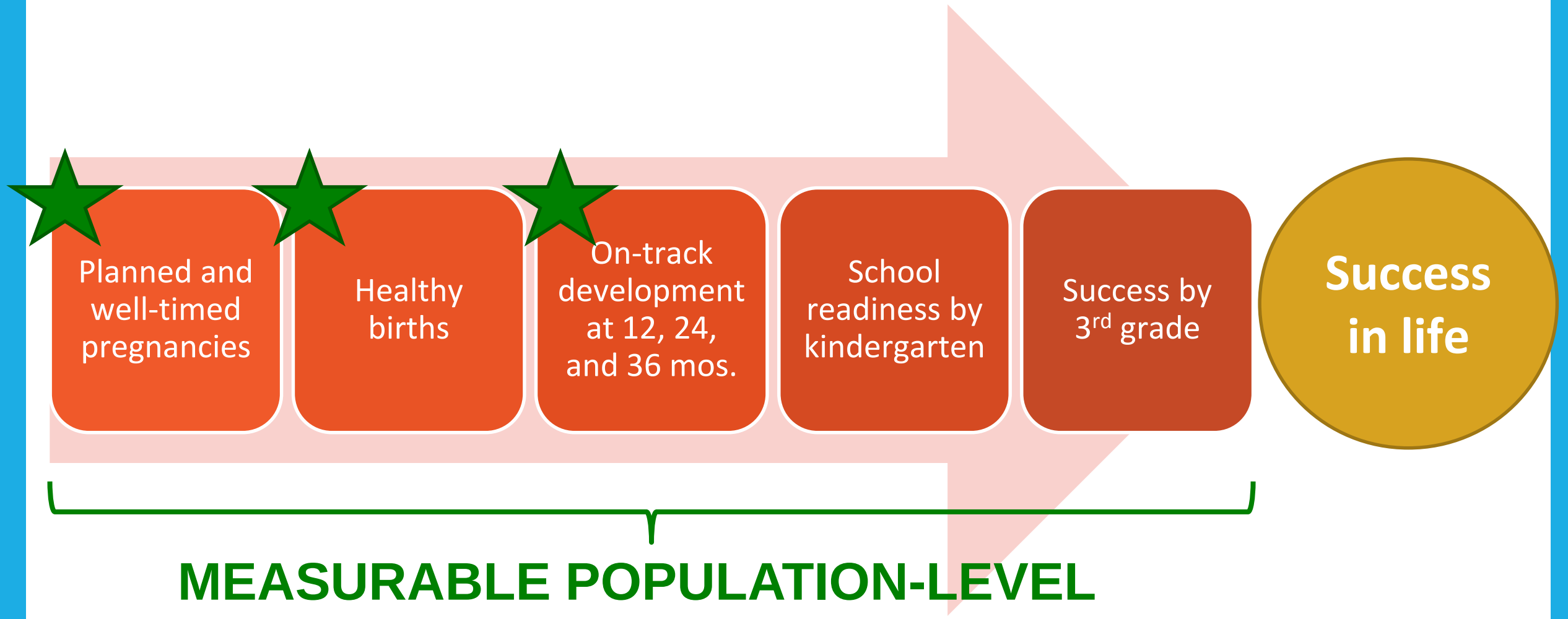
Collaborative strategy to achieve measurable, population-level change in preconception to age-8 outcomes in Guilford County, N.C.

THE
Cemala
FOUNDATION

THE
JOSEPH M. BRYAN
FOUNDATION

Children's Home Society
OF NORTH CAROLINA

GET READY GUILFORD INITIATIVE GOALS



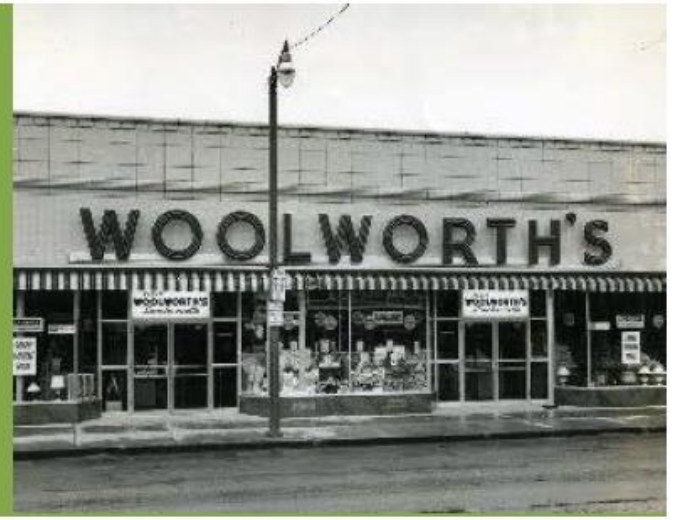
WHY GUILFORD COUNTY?

- Selected from 62 candidate communities
- Demonstrated community need
- Prior community mobilization by a backbone organization
- Existing presence of effective programs
- Potential to link to a promising K-12 initiative

GUILFORD'S CHILD POPULATION

Population ages 0-8: 62,000
Births annually: 6,000
By race/ethnicity:
- White: 45 percent
- Black/African-American: 38 percent
- Asian: 4 percent
- Hispanic or Latino: 12 percent

Children receiving free or reduced-price lunch: 59 percent



READY FOR SCHOOL, READY FOR LIFE

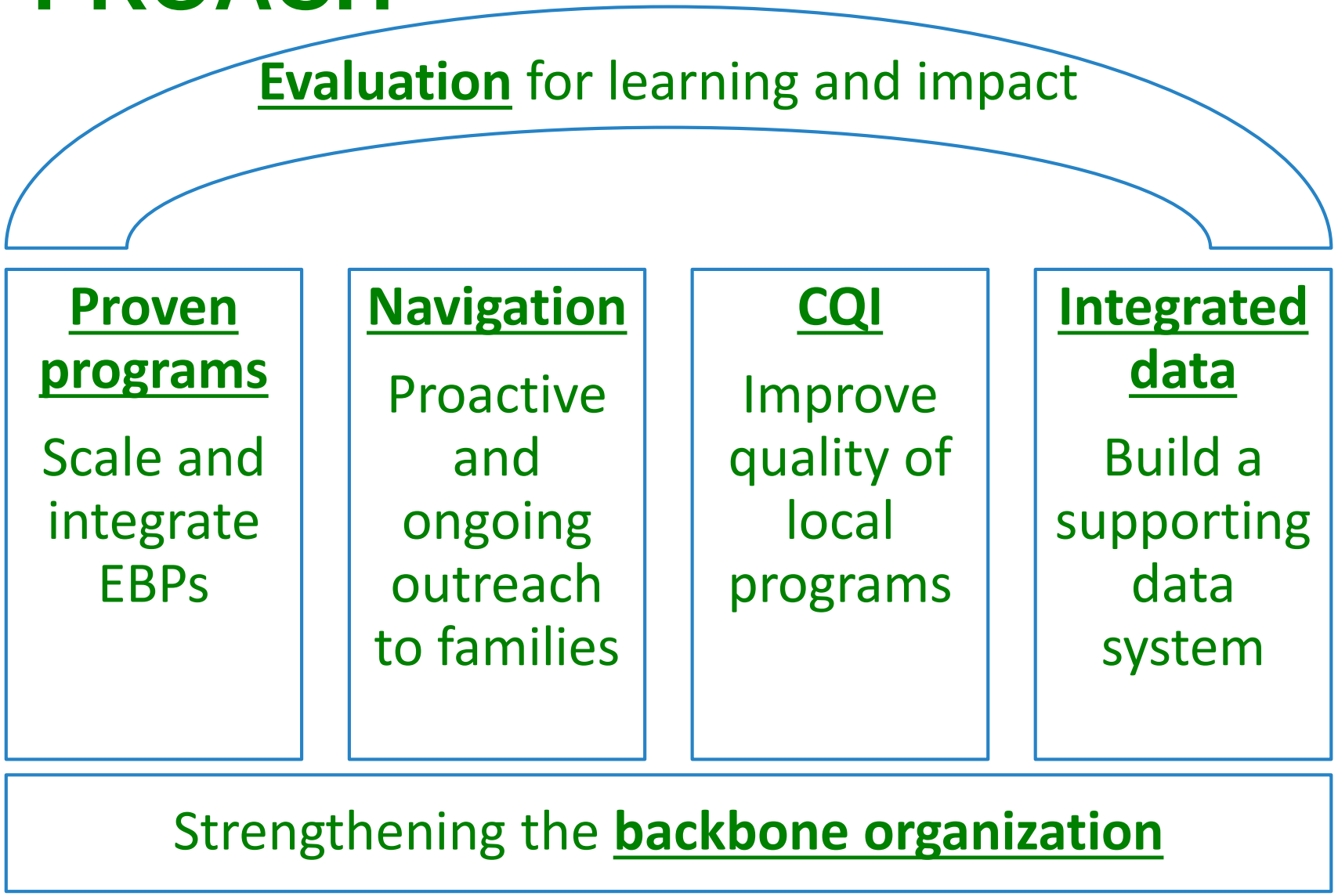
"Collaborative effort to build a connected, innovative system of care with and for Guilford County's youngest children and their families."

- Mobilizes the community around early childhood issues
- Leads the Get Ready Guilford Initiative and coordinates its partners

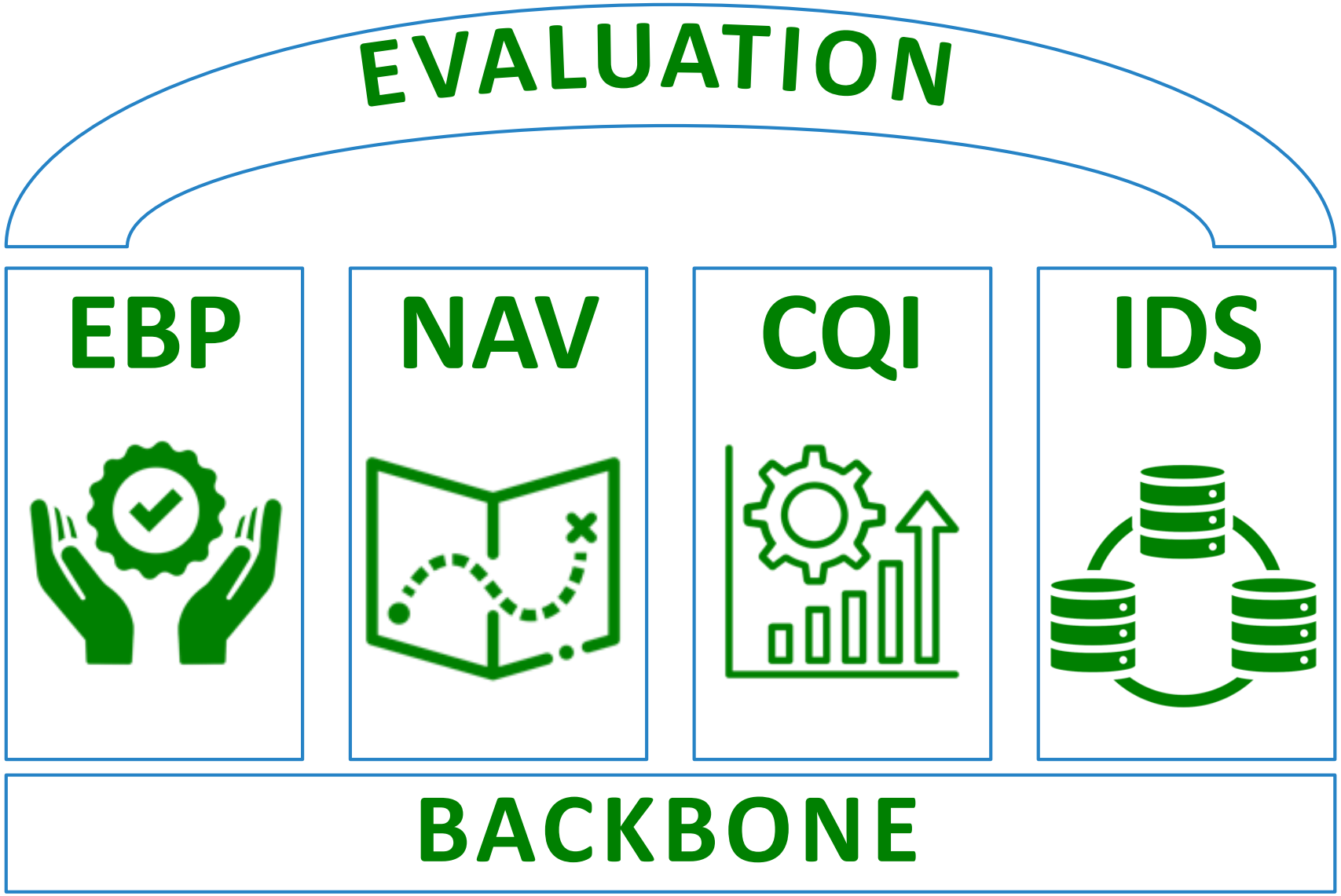
(Website: getreadyguilford.com)

Ready for School Ready for Life

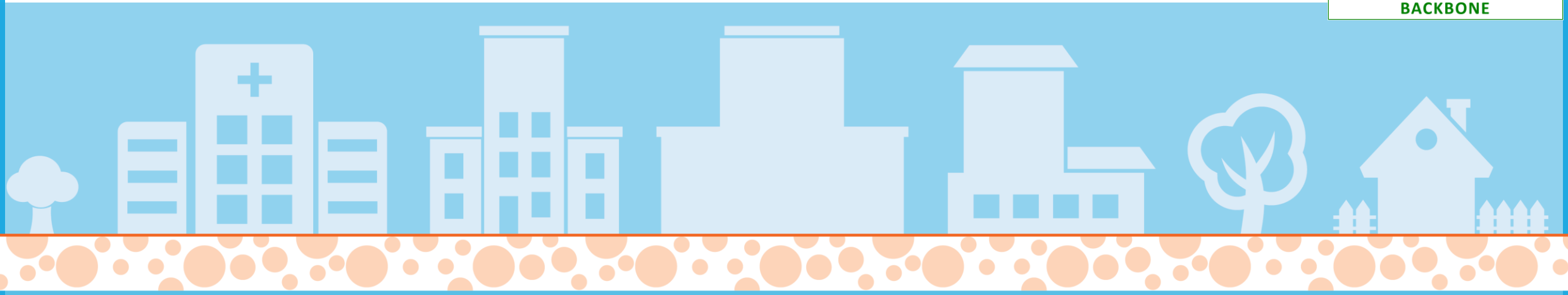
GET READY GUILFORD INITIATIVE APPROACH



OUR APPROACH



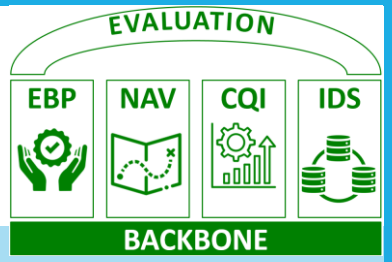
TODAY'S NON-SYSTEM



community services

700 nonprofit organizations

BACKBONE ORGANIZATION



Ready for School Ready for Life

PREGNANCY

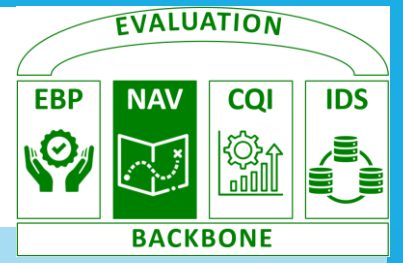
BIRTH

AGE 1

AGE 2

AGE 3

NAVIGATION: UNIVERSAL ASSESSMENT

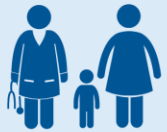


PREGNANCY ASSESSMENT

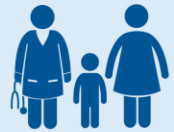
BIRTH ASSESSMENT

AGE 1 ASSESSMENT

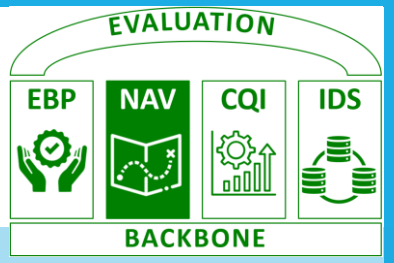
AGE 2 ASSESSMENT



AGE 3 ASSESSMENT



NAVIGATION: TARGETED REFERRAL



Ready for School Ready for Life

PREGNANCY ASSESSMENT

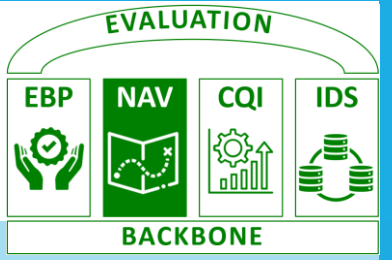
BIRTH ASSESSMENT

AGE 1 ASSESSMENT

AGE 2 ASSESSMENT

AGE 3 ASSESSMENT

NAVIGATION: ONGOING SUPPORT



PREGNANCY ASSESSMENT

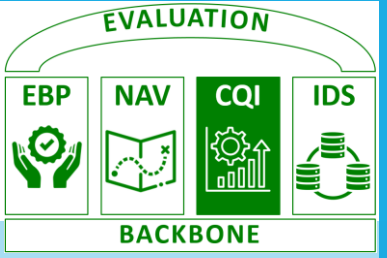
BIRTH ASSESSMENT

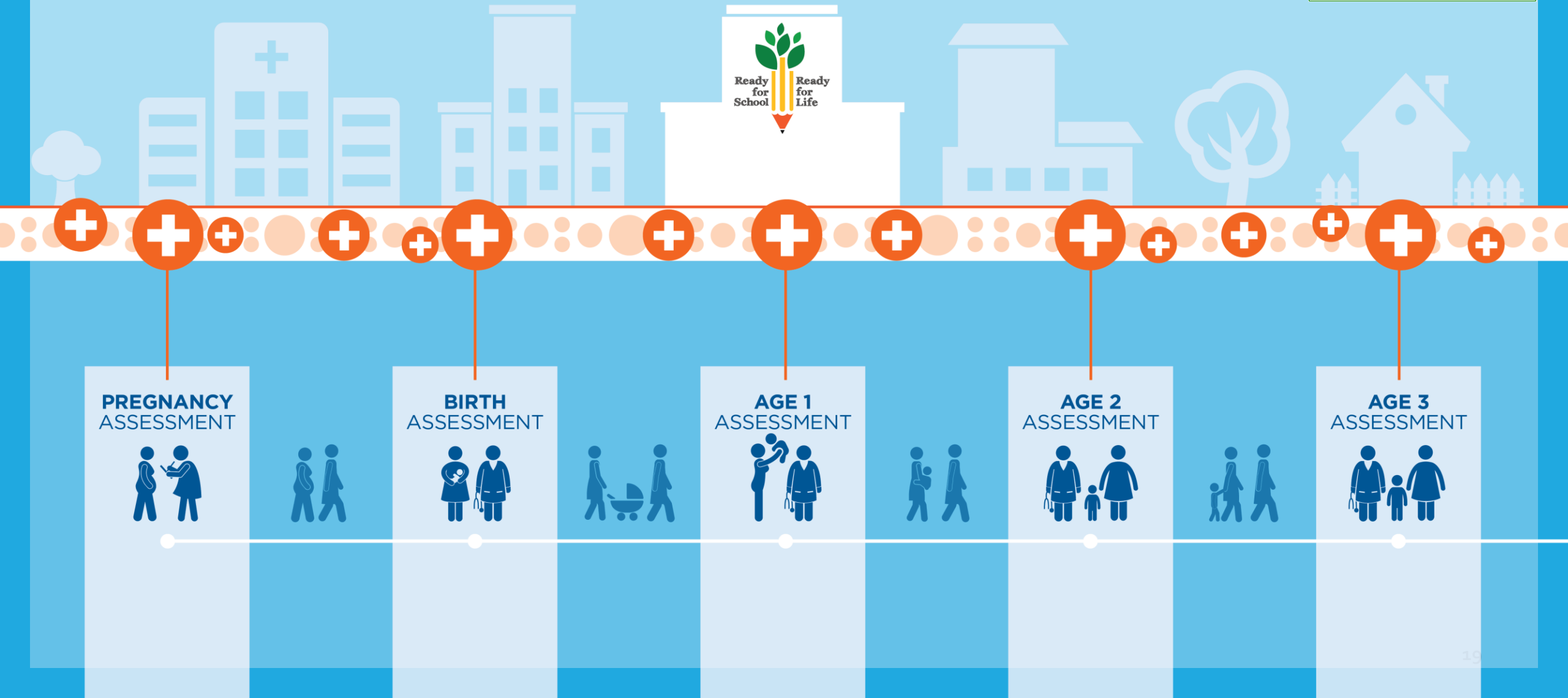
AGE 1 ASSESSMENT

AGE 2 ASSESSMENT

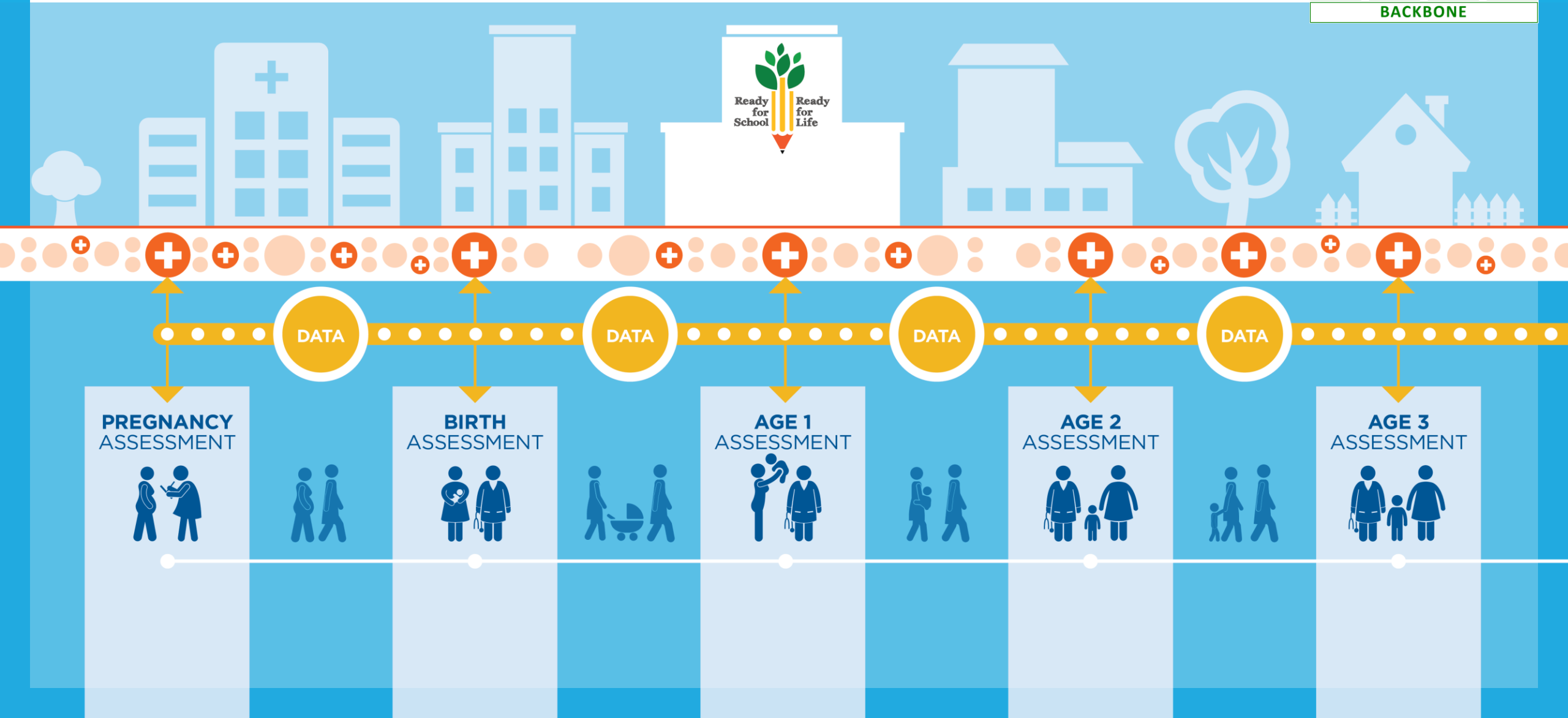
AGE 3 ASSESSMENT

CONTINUOUS QUALITY IMPROVEMENT

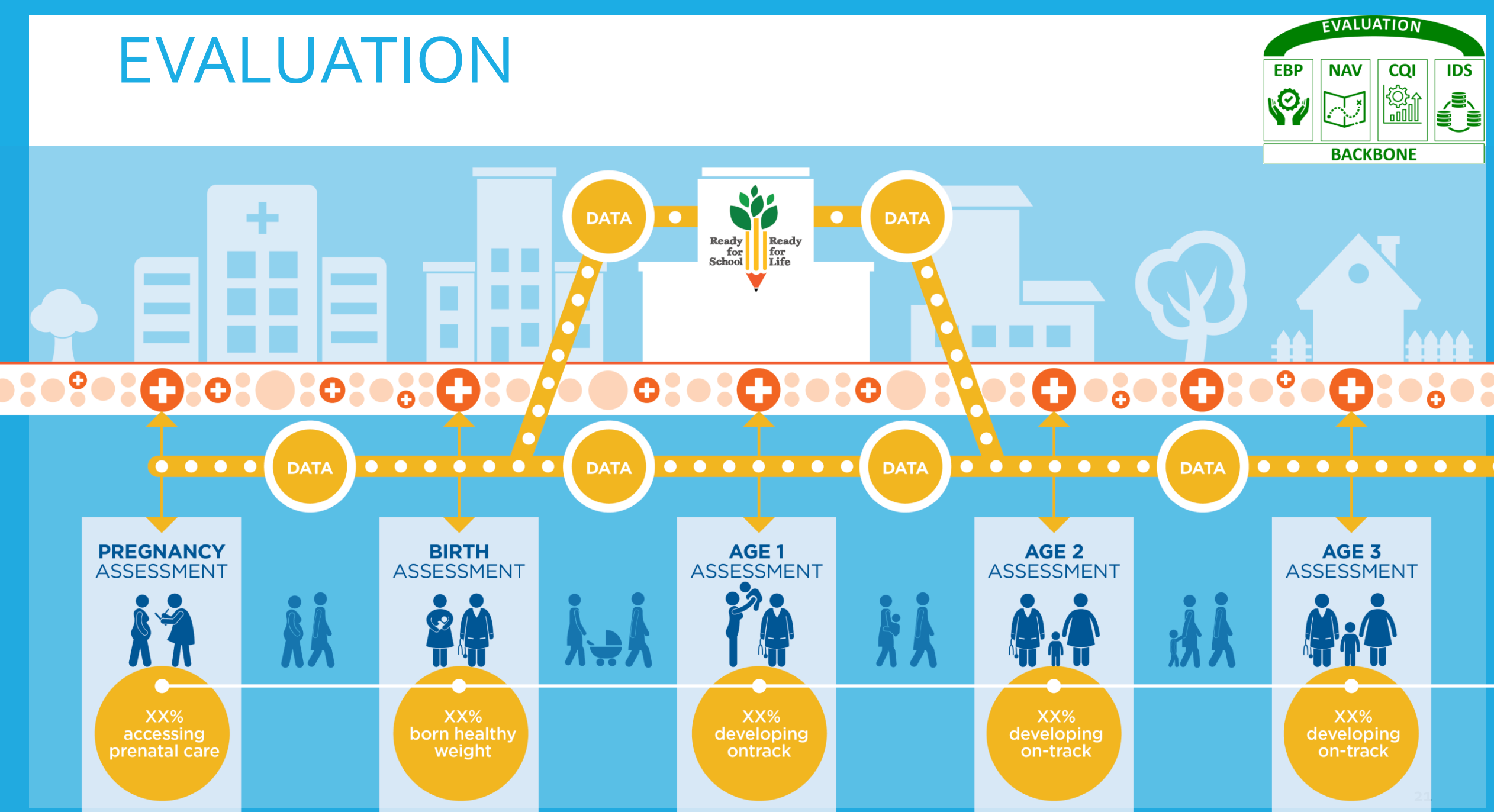




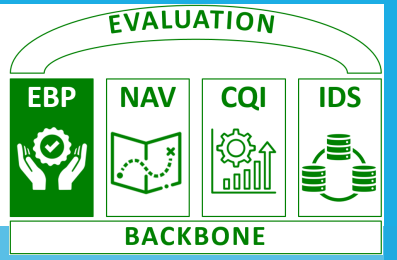
SHARED DATA


EVALUATION
EBP
NAV
CQI
IDS
BACKBONE
Ready for School
Ready for Life
DATA
DATA
DATA
DATA
PREGNANCY ASSESSMENT
BIRTH ASSESSMENT
AGE 1 ASSESSMENT
AGE 2 ASSESSMENT
AGE 3 ASSESSMENT

EVALUATION


EVALUATION
EBP
NAV
CQI
IDS
BACKBONE
DATA
DATA
Ready for School
Ready for Life
DATA
DATA
DATA
DATA
PREGNANCY ASSESSMENT
XX% accessing prenatal care
BIRTH ASSESSMENT
XX% born healthy weight
AGE 1 ASSESSMENT
XX% developing ontrack
AGE 2 ASSESSMENT
XX% developing on-track
AGE 3 ASSESSMENT
XX% developing on-track

PHASE 1 EVIDENCE-BASED PROGRAMS



FAMILY CONNECTS
NURSE HOME VISITS

FC

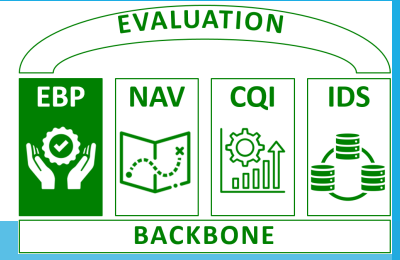
NFP

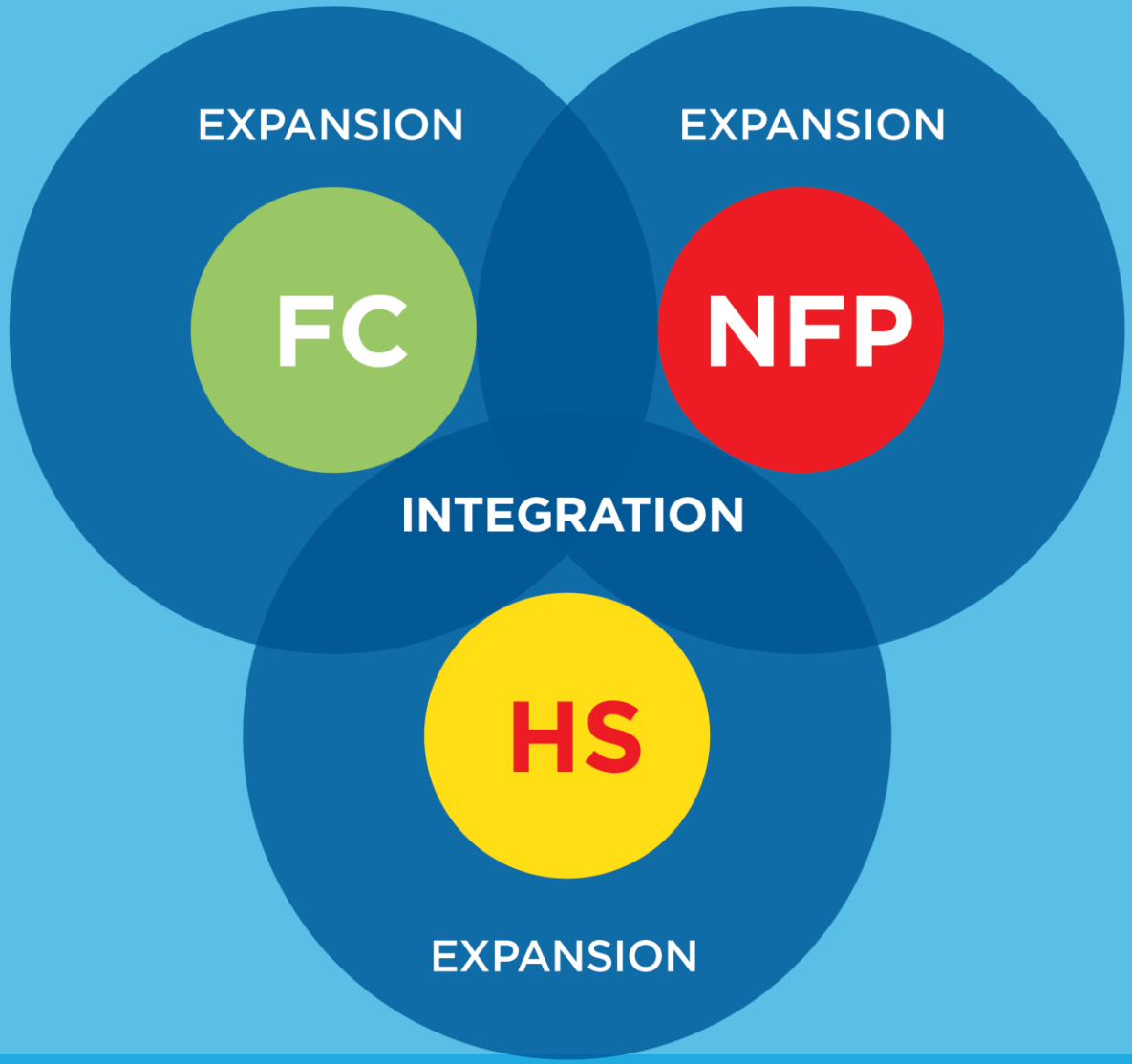
Nurse-Family Partnership
Helping First-Time Parents Succeed®

HS

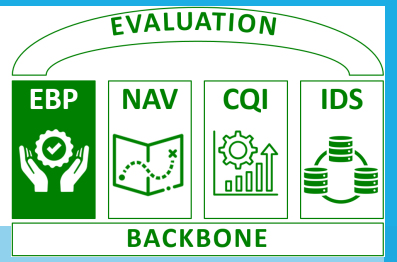
HealthySteps

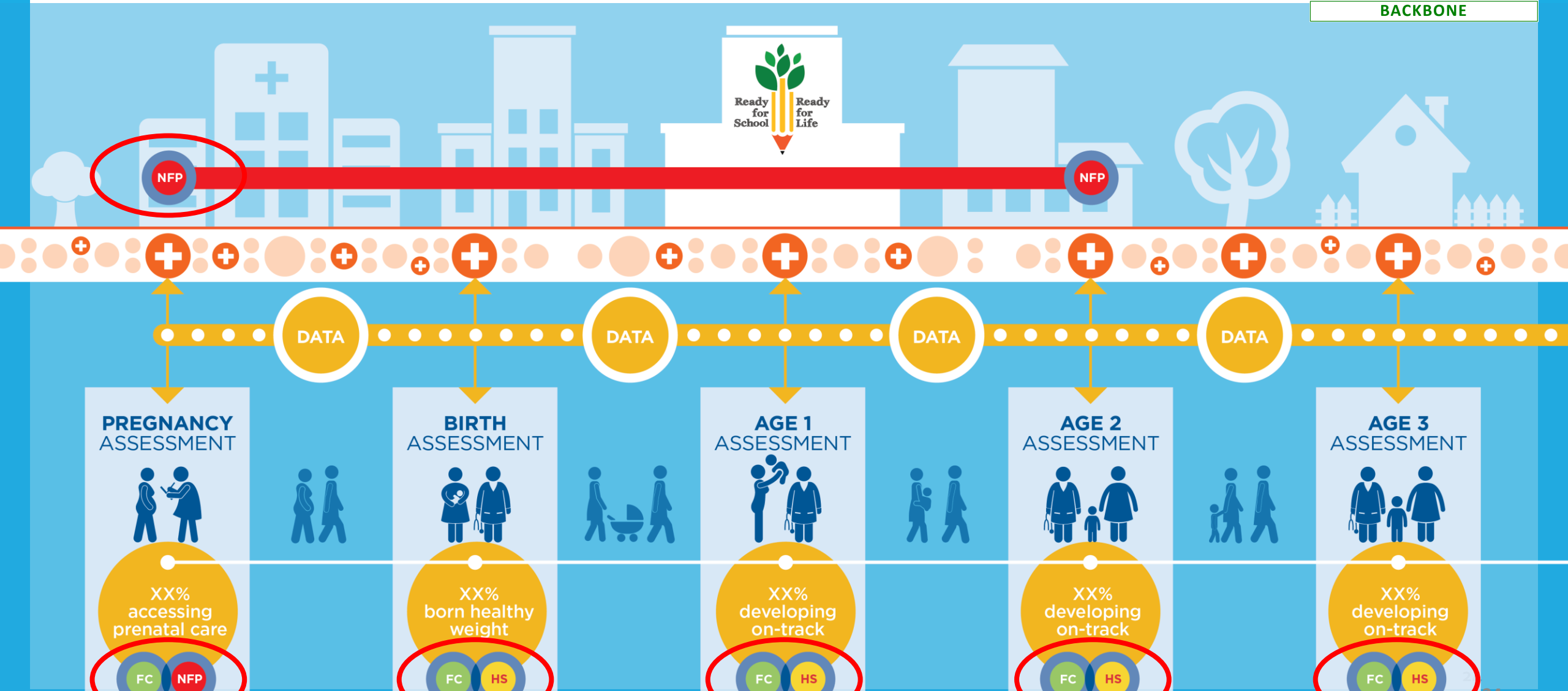
PHASE 1 EVIDENCE-BASED PROGRAMS





ROLE OF EVIDENCE-BASED PROGRAMS





COMMUNITY ALIGNMENT

Krysta Gougler-Reeves

Community Resource Specialist | **Family Connects International**

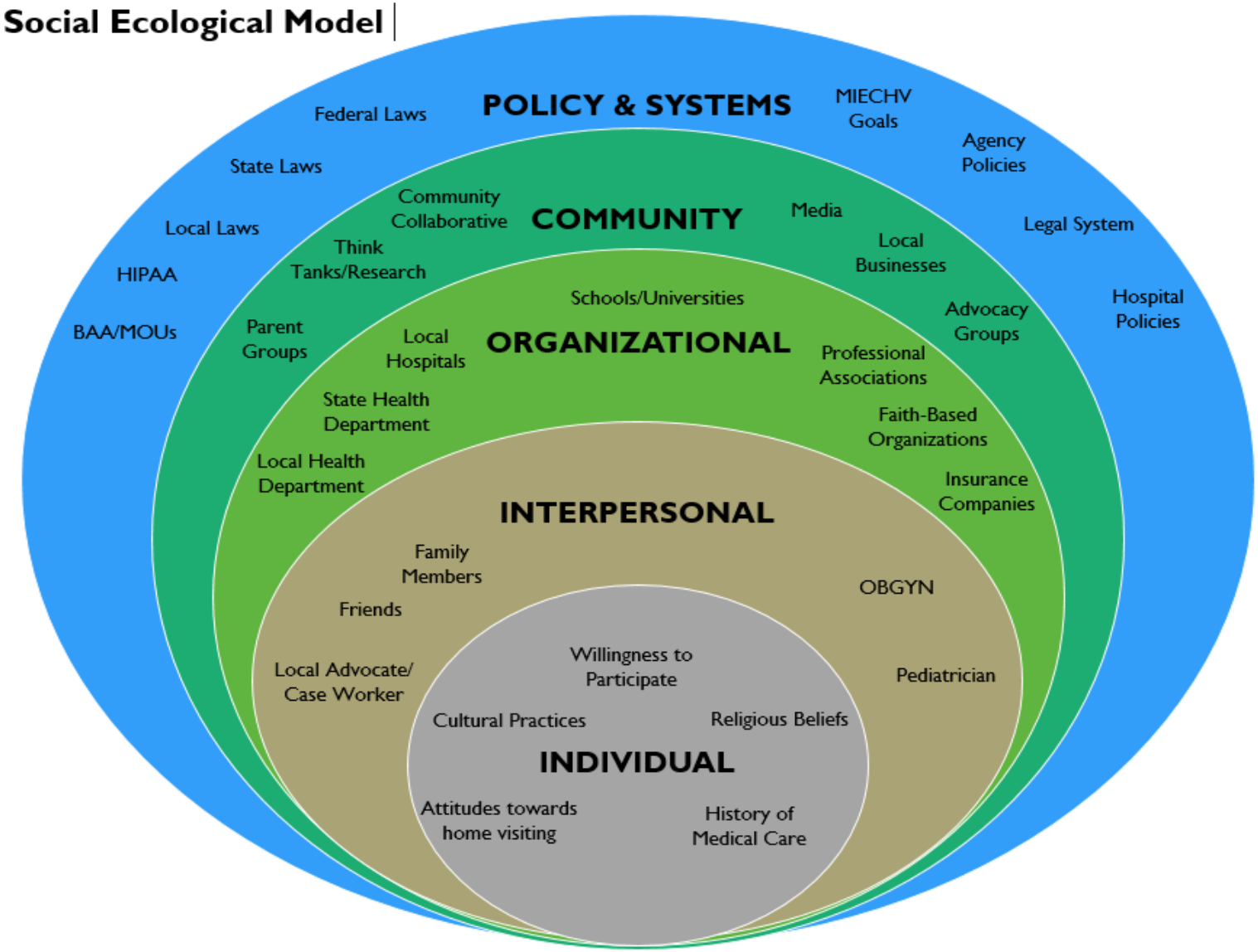
Community Alignment Philosophy

If you are trying to impact community system level change, it's imperative that you remember and promote the message that you are working **WITH** the community and not **ON** the community

Community Context

- What is the history of this community?
- What precipitated the call for action?
- Where has this community been and where do you want to go?

Social Ecological Model



Community Alignment Approach

Harnessing Relationships as a Catalyst for Change

Why is Community Alignment Important?

- The community impacts every level of the program/intervention
- Helps with the transition from being outsider to being an insider
- Assists in garnering buy-in from all levels and all stakeholders
- Some situations, can serve as a catalysts on "activating" your community

PILOTING PRENATAL SCREENING, NAVIGATION AND REFERRAL

Molly O'Fallon
Executive Director of Quality and Compliance | **Nurse Family Partnership**

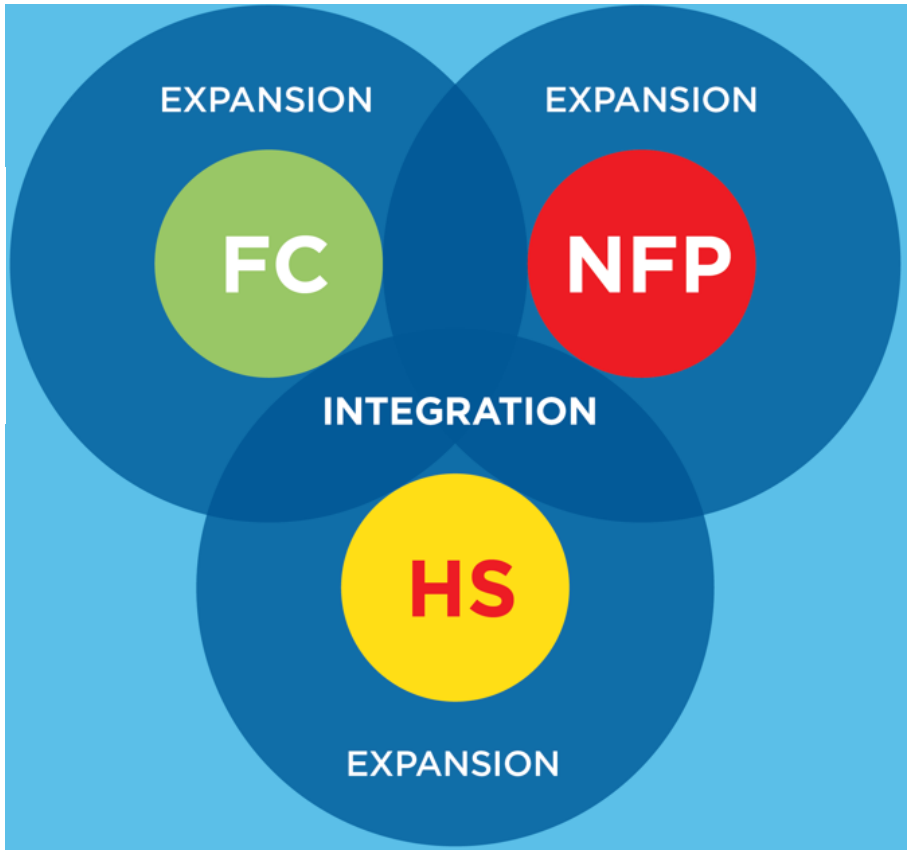
Get Ready Guilford Initiative (GRGI)

The Duke Endowment approached three Evidence Based Home Visiting models to participate in this initiative.

The models:

Duke FAMILY CONNECTS INTERNATIONAL

HealthySteps



Nurse-Family Partnership
Helping First-Time Parents Succeed®

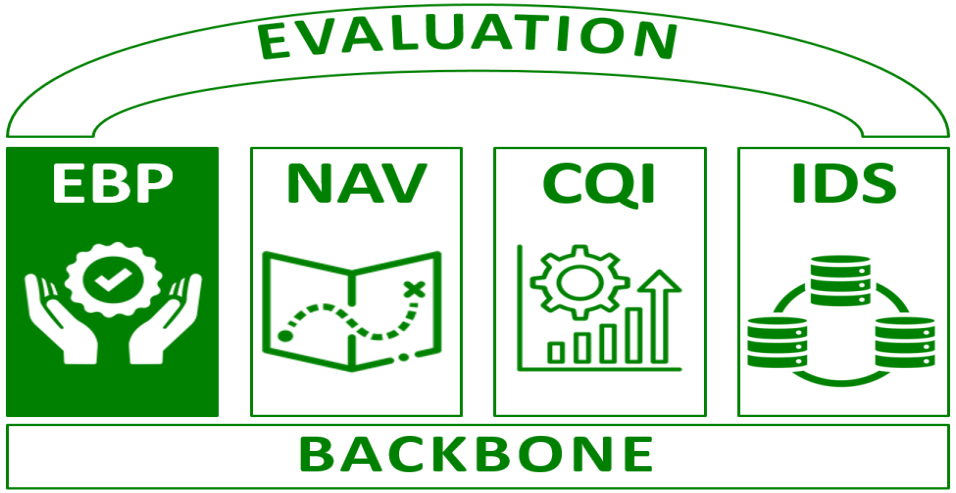
Model Agreements:

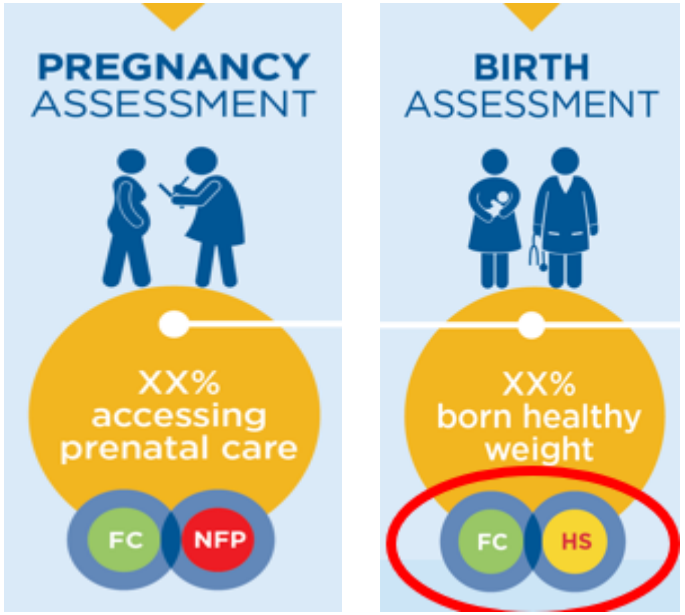
The need for healthy parents, children, and the family system to support the child's readiness for school.

To innovate, as needed, to meet the needs of the community AND to work together -so- the sum is greater than the parts.

- *Participate in a community navigation program to ensure delivery of the right program, to the right family at the right time*
- *Collect and provide data for a integrated data system*
- *Utilize the periodic screening/assessment of the child and family*
- *Deliver individual EBHV program as designed where appropriate*
- *Continue to learn*

Early Program Development





Prenatal screening, referral and navigation

Three Outcomes:

Accessing Prenatal Care

Healthy Birth Outcomes

Address Family Needs (Health, Psychological, Environmental)

Prenatal: Family Connects and NFP

- Review of each other's processes and impacts.
- Determine goals related to the overall GRIG with the long term goal improved population health and readiness for school.
- GRGI is Universal.

  - *Women can and do access prenatal care early in pregnancy.*
  - *Women continue to access prenatal care during pregnancy.*
  - *Women obtain necessary services to support a healthy pregnancy.*
    - *General – nutrition, safety, transportation, education*
    - *Targeted – more intense interventions to support vulnerable and high risk families*
  - *Families are directed to necessary services during the pregnancy period.*
  - *Families are ready for the birth of the child and transition to post-natal programs that are appropriate for the family – including health care of the mom and infant.*

Involve the community: Resources & Support

Community Members

- Ready Ready provided introduction to their existing community focus group- Family Action Learning Team

Other Community Groups

- Involvement of the local health department and state department of health –
  - State and local prenatal program – OB Care Management
  - Clinics
  - Physician offices – OB
- Collaboration with other programs in the community

Guilford County Coalition On Infant Mortality

"Creating Futures, One Baby At A Time"

List of Programs/organizations in Community Action for Healthy Babies

- Adopt-a-Mom
- Pregnancy Care Management (OBCM)
- Nurse Family Partnership
- Guilford Family Connects
- HealthySteps
- WIC
- Parents as Teachers
- YWCA Greensboro
- YWCA High Point
- Partnership for Community Care
- Healthy Start
- Care Coordination for Children
- Family Support Network of Central Carolina
- Guilford County Partnership for Children
- Center for New North Carolinians
- March of Dimes
- Community Care Network of NC
- Cone Health
- Wake Forest Health
- Ready for School, Ready for Life
- Triad Baby Love Plus
- Children's Home Society
- United Way of Greater Greensboro
- OB Providers/Midwives

Prenatal Screening Tool

- Development of a screening tool based on domains of health and social determinants

- Yes and No Questions
  - If the mom answers yes to any question, the navigator will follow up.
  - Each question is mapped to programs in the community for the mom/family.
  - Several resources on the agency finder were contacted by GRGI navigator regarding participation.

GRGI Pregnancy Screener: Sample Questions

Health Care Access

- *Do you have health care?*

Adjustment to Pregnancy

- *Is the baby's father involved with you at this time?*
  - If yes worries about how the new baby will fit into your relationship with the baby's father?
- *Some feelings of being overwhelmed, sad, or anxious can happen before and after having a baby. This is not uncommon. At least 1 of 7 women experience stressful moods during this time.*
  - Has this happened in prior pregnancies (if applicable)?

Household Need

- *Do you or anyone in your family want help with finding job(s) or having job training?*

Prenatal Screening Tool and Pilot

- Together with Ready Ready, the local and state health department and Coalition for Healthy Babies, the tool was reviewed and development of a resource/ referral document with local programs was completed.

- Some modifications were made to the GRGI tool to accommodate the state requirements for Medicaid clients.

- Tool was piloted at 3 local OB-GYN offices
  - Screening tool
  - Navigation
  - Community Referral
  - Interest- staff and participants

Results- Conducted Over a 4 Week Period

- 142 clients were identified as "new OB clients" in the three clinics.
- 78 "new OB clients" were asked to complete a GRGI/OBCM screening tool.
- 45 of 78 clients (57.69%) who received a screener at the OB clinic consented to complete the screener and be contacted by a GRGI Navigator.
- Among the 45 consenting clients, the GRGI Navigator
  - Had a conversation with 22;
  - Left messages for 7;
  - Did not reach 3 ; and
  - 13 were not eligible to participate or had incomplete assessments.

Navigator Discussion and Referrals based on Response to GRGI Screener

Health Care

• Referred to OB	7
• Referred to Health Department for Medicaid	5
• Referred to Pediatrician	4
• Referred to NFP	6

Adjustment to Pregnancy (not first time birth)

• Parents as Teachers	1

Maternal Well-Being

• Child birth classes	3
• Mental health referrals	1
• To OB for health issues	1
• Discussion about Baby Blues	6

Household Need

WIC	9
Work First	6
Food stamps	2
Housing	1
Car seat info and installation	3
Food Panty	1

Personal Safety

• Provided information about Family Justice Center	1

Lessons Learned & *Open Questions*

- The prenatal screener was an effective tool in settings where women had an OB
  - *Need to expand the outreach to meet population goals*
  - *How do we screen pregnant women in the community who have not accessed care to fully address population health?*

- Women participating were open to the screening questions & process
  - *Evaluate the need for additional pilots and address any duplication*

- Women identified as candidates for NFP were referred and enrolled
  - *Plan to expand services to meet the additional need in the Guilford community*

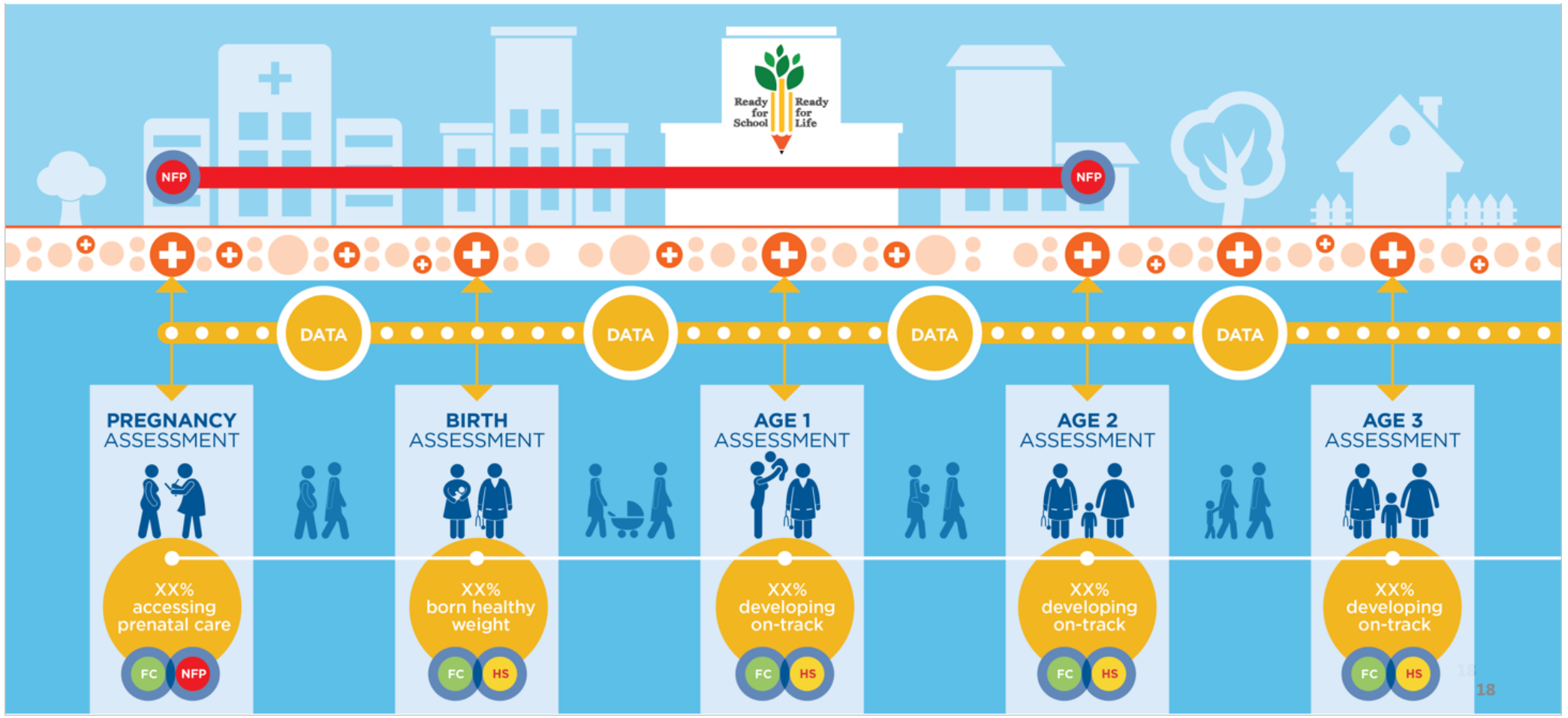
Lessons Learned & *Open Questions*

- Women referred to community programs received the services
  - *Determine ways formalize agreements between GRGI and referral programs, as appropriate*
- There may be gaps in services for families involved in GRGI
  - *Need to develop plan to assess gaps and provide additional services*
- Participating provider offices were supportive of the project
  - *Determine ways to refine the process to decrease confusion*
  - *Plan to expand to other offices and clinics; possibly additional pilots*

Lessons Learned & *Open Questions*

- Initial navigation process was successful
  - *Successful integration of navigation across all aspects of GRGI*
  - *How can the navigation system work most effectively with the three evidence-based programs and other programs in the community?*
  - *At what agency will the navigation system be housed, administered and monitored? Who can the mother call between screening opportunities and if the family is in crisis, and where is the responsibility?*
  - *Should the system have an independent navigator at all times, or could the EBP or county serve as navigator at some time points?*

Next steps in implementing GRGI



Marketing & Framing for the Community

- Universal outreach is a paradigm shift.
- Service providers are not duplicating or competing with other service providers or systems but creating a community context for collective impact.
- Putting families and agencies in best position to be successful.

Questions?