Promise 1000:
Home Visiting for Kansas City

A Collective Impact Approach to Outcomes Focused Collaborations

PROMISE 1000

every day counts

Children's Mercy KANSAS CITY

United Way

United Way of Greater Kansas City

Health Forward FOUNDATION

Agenda Items

- Introductions
- Promise 1000 Overview
  - Early Development, Engagement, Strategic Planning & Structure
- Staffing
- Funding
- BREAK
- Centralized Referral & Intake System
- Shared Data, Outcomes, and Activities

Working Lunch 11:30-Noon

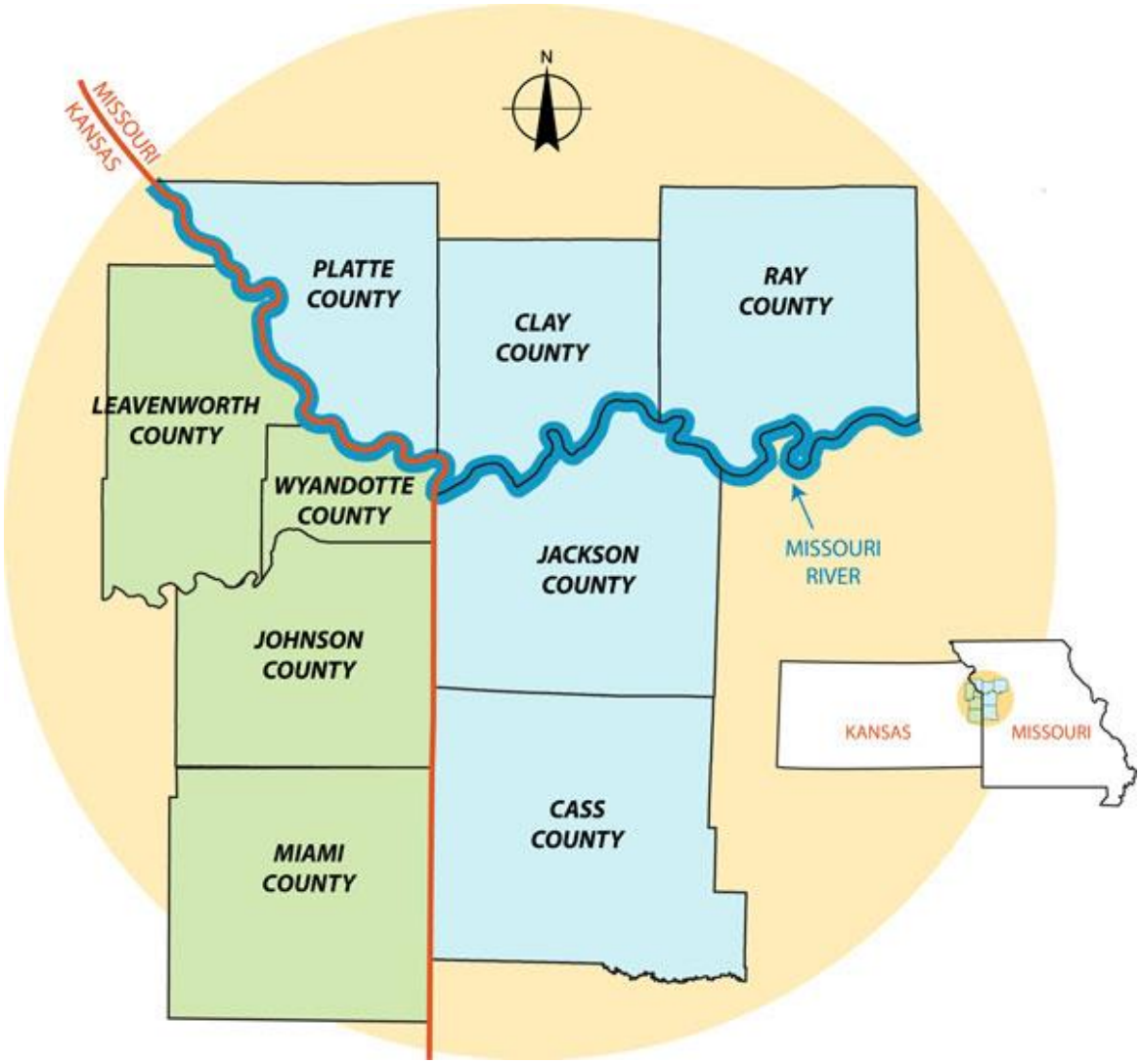
Promise 1000 – Who are We?

Promise 1000 – Home Visiting Collaborative connects the greater Kansas City region's most vulnerable families to in-home supports that optimize the beginning years of life for young children prenatal to three – the first 1,000 days of life. The mission of the Promise 1000 Collaborative is to provide an ***innovative, sustainable collaborative system*** of evidence-based home visiting services for pregnant women, young children and their families to:

(1) Improve maternal and child health & well-being
(2) Promote child development and school readiness, and
(3) Increase resilience and safety of participating families.

Vision:

Healthy Children, Healthy Families, Healthy Communities



Healthy Families America (HFA)
Child Abuse Prevention Association
Children's Mercy Hospital
Cornerstones of Care
Kansas Children's Service League
Great Circle

Parents as Teachers (PAT)
Kansas City, Kansas
Turner, Kansas
Front Porch Alliance

Early Head Start (EHS) & Head Start
Project Eagle
Front Porch Alliance

Additional Programs
Easter Seals Midwest, Nurturing Parenting Program
Children’s Mercy Hospital – Team for Infants Exposed to Substance Abuse (TIES)

Why Home Visiting?

*Proven by research to improve the lives of children and families**

- Improve health and development
- Prevent child injuries, child abuse, neglect, or maltreatment, and reduce emergency department visits
- Improve school readiness and achievement
- Reduce crime, including domestic violence
- Improve family economic self-sufficiency
- Improve the coordination and referrals for other community resources and supports

Common Agenda between Home Visiting & Providers
-Prevention & Improving the Lives of Children & Families-

https://www.promise1000.org/home-visiting-research.html

Promise 1000 – Early Engagement
How we began this effort

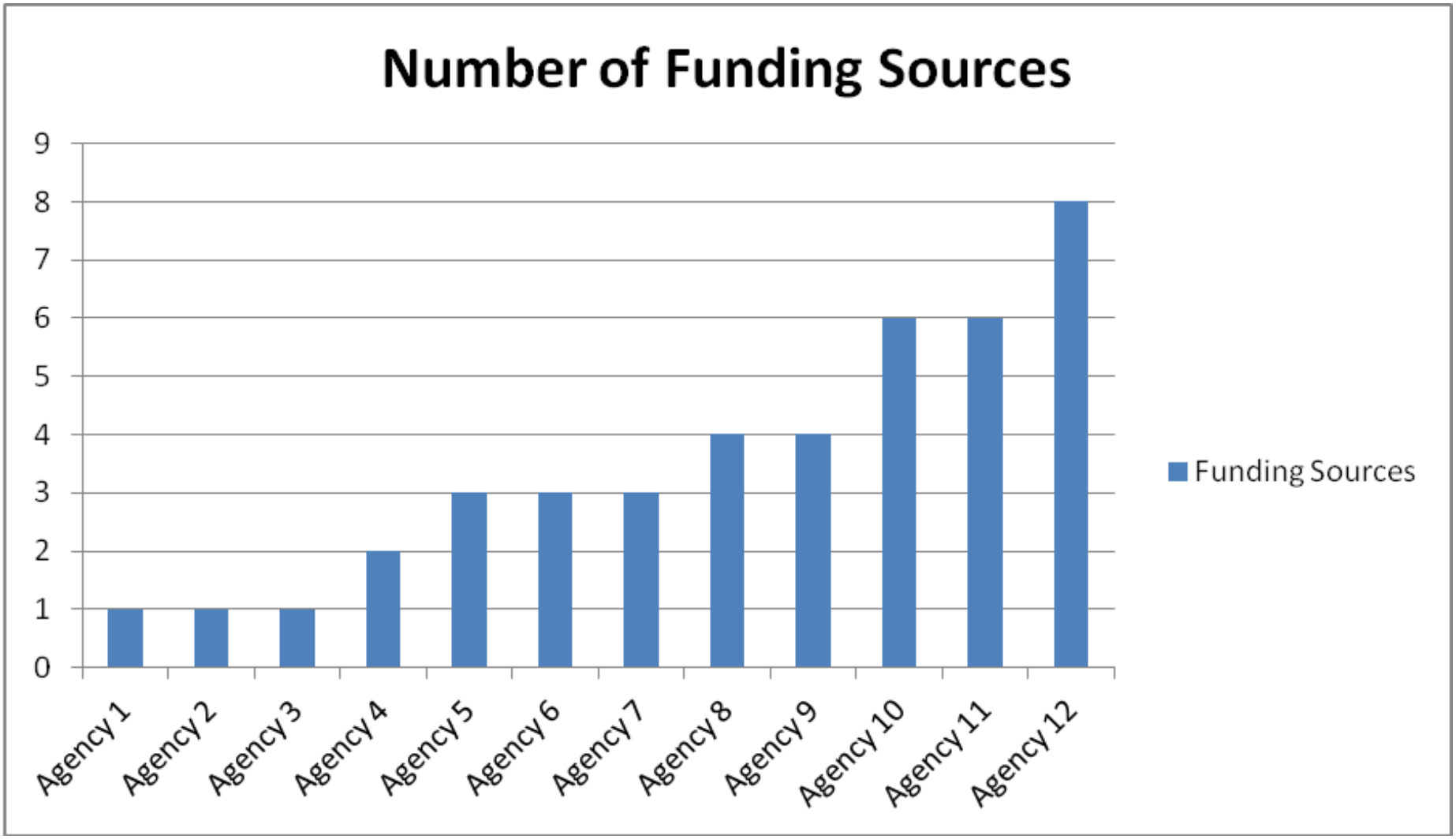
2013/2014 Stakeholder Engagement

Assessed current functioning of area home visiting services –strengths and challenges

- Survey
- Site visits/structured interview of Home Visiting Agencies (HVAs)
- Completed 1-year-long Strategic Planning Process

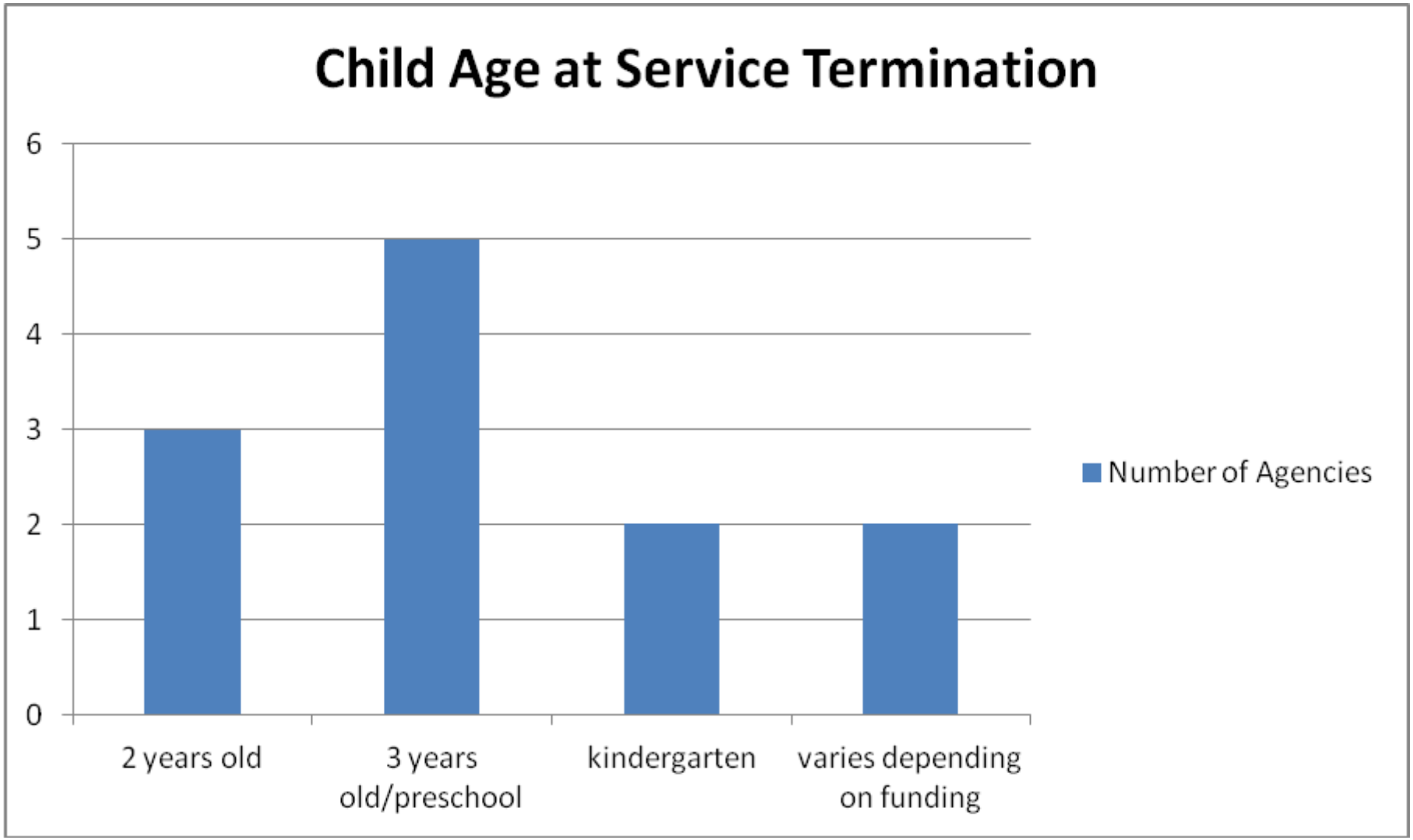
Promise 1000 – Early Engagement

Home Visiting-Kansas City



Promise 1000 – Early Engagement

Home Visiting-Kansas City



Promise 1000 – Early Engagement

Identifying Strengths & Addressing Barriers to Home Visiting

Strengths

- Several are Evidenced Based Programs
- Home visiting services are available to those in need throughout geographic area
- Most agencies offer flexibility in delivery of services
- Expertise in home visiting services

Promise 1000 aimed to address multiple challenges that were identified by home visiting agencies during a year long strategic planning, including:

- Multiple funding sources with varied reporting requirements
- Lack of shared data collection, quality, and outcomes measures resulting in an inability to demonstrate population health impact
- Difficulties with recruiting referral sources, marketing, and expansion
- Varying eligibility requirements, services areas, and referral processes making referrals challenging
- Challenges in connecting Home Visiting and Health Care

Promise 1000 – Mutual Strategic Planning Goals

1. Continuous **funding** necessary to serve the families appropriate for home visiting services
2. A centralized recruitment, initial intake, and **referral system** to ensure eligible families are served by the most appropriate home visiting program to meet their identified needs
3. A **coordinated approach** with home visiting partners, health care, mental health, social service, and education systems in the delivery of home visiting services.
4. A **data system** for measurement of ongoing effectiveness of services provided and to identify areas for program improvement.
5. Home visiting agencies that operate according to federally-identified "evidence-based" models, or are in the process of becoming an "evidence based" model, with **standardized data collection on shared outcomes, standards, and quality measures.**
6. Home visiting agencies that are staffed by **highly-qualified and committed personnel** to provide centralized functions and services.
7. Home visiting services that are **culturally responsive** and meet the needs of the diverse, ever-changing populations represented in the defined geographical area.

Collective Impact

John Kania & Mark Kramer first wrote about collective impact in the Stanford Social Innovation Review in 2011 and identified five key elements:

1. All participants have a common agenda for change including a shared understanding of the problem and a joint approach to solving it through agreed upon actions.
2. Collecting data and measuring results consistently across all the participants ensures shared measurement for alignment and accountability.
3. A plan of action that outlines and coordinates mutually reinforcing activities for each participant.
4. Open and continuous communication is needed across the many players to build trust, assure mutual objectives, and create common motivation.
5. A backbone organisation(s) with staff and specific set of skills to serve the entire initiative and coordinate participating organisations and agencies.

"... we believe that there is no other way society will achieve large-scale progress against the urgent and complex problems of our time, unless a collective impact approach becomes the accepted way of doing business."

John Kania & Mark Kramer

Promise 1000 - Conditions for Collective Impact

Common Agenda

- Expanding Home Visiting in the KC Metro area to increase positive outcomes for children & families

Common Progress Measures

- Shared data system & standardized data collection on shared outcomes, standards, and quality measures
- Shared Centralized Referral & Intake System

Mutually Reinforcing Activities

- Structured & coordinated trainings for home visitors surrounding key outcomes
- Monthly Continuous Quality Improvement activities
- Advisory Work groups led by Home Visiting Supervisors
- Mutually beneficial marketing & outreach efforts
- Quarterly & bi-annual performance-based incentives
- Supportive funding & progress towards fiscal sustainability for home visiting

Continuous Communication

- Monthly CQI Supervisor & Promise 1000 meetings
- Quarterly Collaborative meetings
- Continuous updates and communication

Backbone Organization

- United Way of Greater Kansas City – Fiscal Agent
- Children's Mercy Hospital – Centralized Services
- Health Forward Foundation

Promise 1000 – What drives us?

- Data driven processes
- Community-based
- Population-based health approach
- Privately and state funded to date
- Fiscal incentives for performance
- Focused on Outcomes:
  - Improved health & well-being
  - Decreased health care spending
  - Increased child achievement
  - Reduced child maltreatment
  - Increased home safety & resiliency

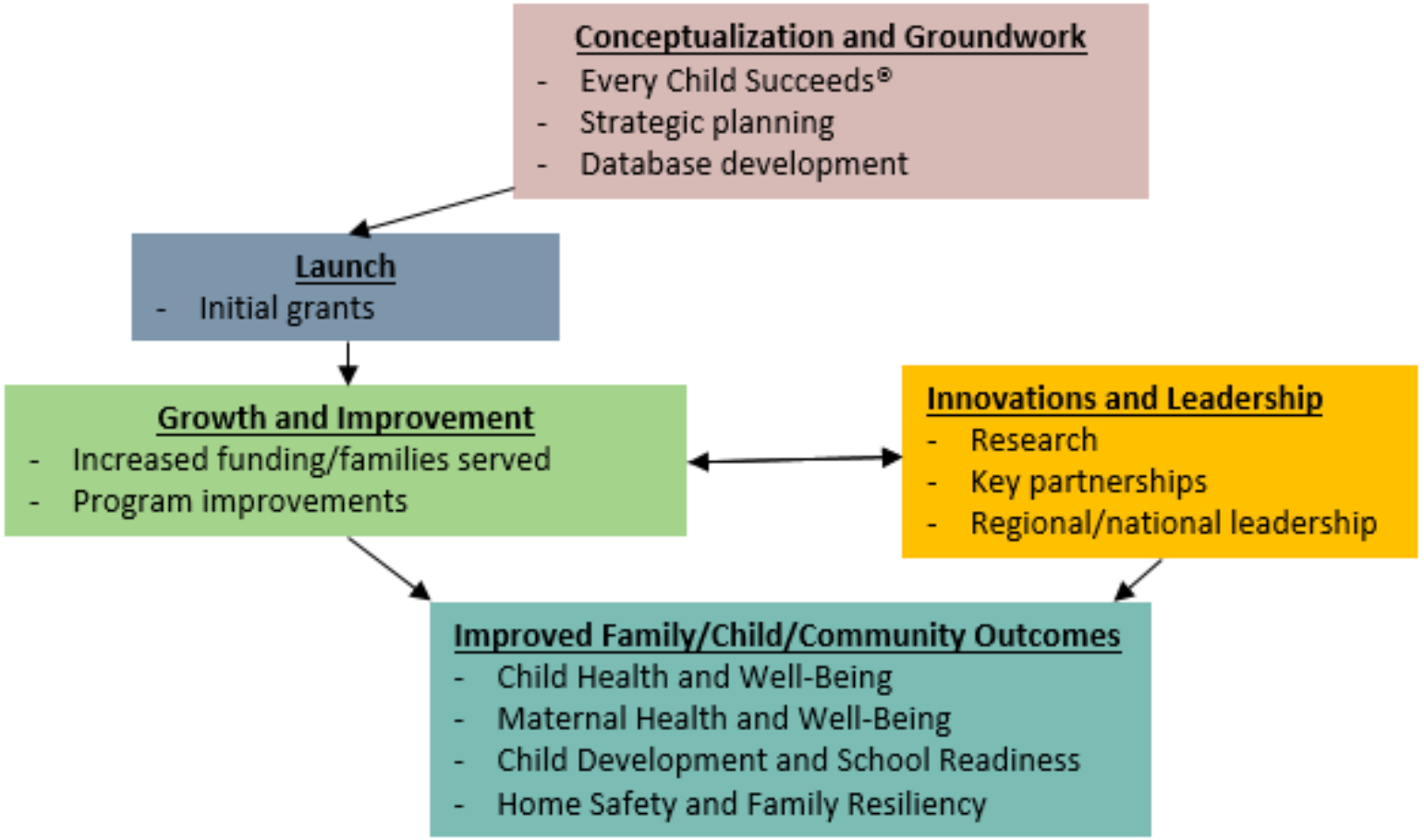
Eligibility:

- Poverty (185% of FPL)
- Pregnant or index child < 1 yr. old

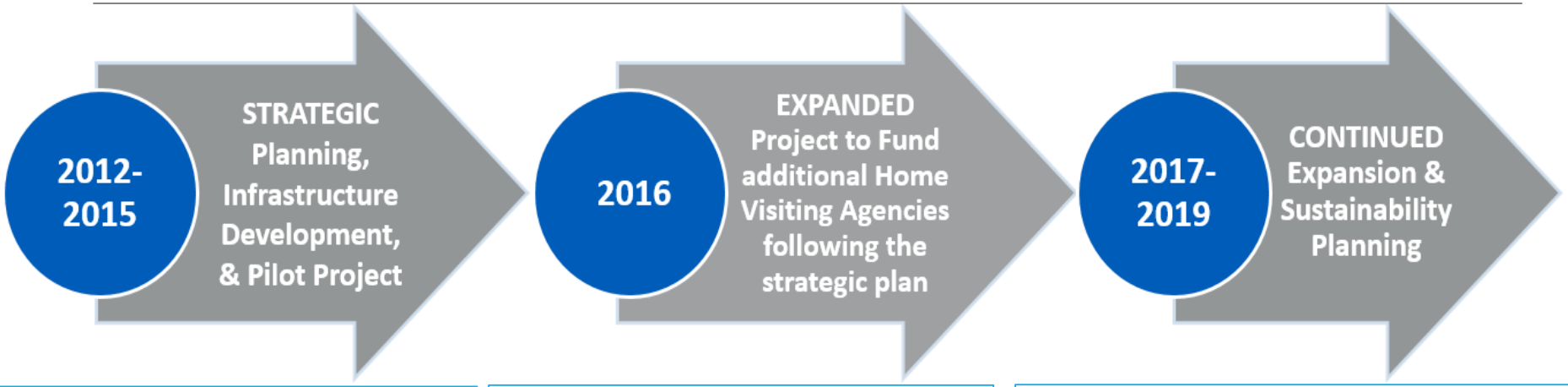
Risk Factors:

- Single
- Young
- Less than high school education
- Substance use/addiction
- Current or previous child maltreatment and/or domestic violence concerns
- Child/parent with other issues known to be a risk factor for poor health outcomes

Promise 1000 – Progress Framework



Promise 1000 – Development Timeline



2012-2014
-Engagement, Strategic Planning & Database Development (REDCap)
-Collaborative Agreements

2014-2016
-Piloted database with two HVAs
- Provided iPads with link to REDCap for data entry

-Constructed Centralized Referral Intake and Scheduling System (CRIS)
- On internet (website)
- Open access

-Identified all measures/metrics

2016-2017 Capacity Grant
-HVAs maintained their current funding streams and practices
-HVAs were paid additional funds for accomplishing Promise 1000 activities
-9 agencies funded
-Expectations: Database usage & Quality Improvement participation

2016-2017 RFP/MOU Incentivizes & Opportunities:
- Medical Home collaboration
- Standardized training
- Moving Beyond Depression

2017-2018 Fiscal Year (10 agencies)
-Increased Advertisement/Outreach
- Website Upgrades/Social Media/Pamphlets
- Obstetricians/Nurseries/Social Workers

Increased collaboration/connections
- Adolescent Medicine
- Fetal Health Center
- CMH Environmental Health
- Primary Care Providers
- CMH Health Equity & Diversity

2018-2019/2020 Fiscal Year (11 agencies)
-Added Performance Award Structure
-Partnered with ACT- Positive Parenting
-Began work on fiscal sustainability
**In addition to previous fiscal year activities!*

Promise 1000 – Shared Progress Measures

Child Health & Well-Being

- Breastfeeding frequency & duration
- Child healthcare goals
- Well-Child care visit attendance
- Home visitors attending well child visits

Maternal Health & Well-Being

- Maternal healthcare goals
- Depression screenings
- Home Visitor providing healthcare and contraception education

Child Development & School Readiness

- Developmental screenings
- Social-emotional developmental screenings
- Parent – Child Interaction screenings

Home Safety & Family Resilience

- Home safety screenings
- Protective factors screenings
- Domestic violence screenings
- Substance Use screenings

The "Big Picture" – Process Measures that lead to Outcomes!

Maternal/Child Health & Well-Being Examples…

MATERNAL HEALTH & WELL-BEING

Metric: Maternal Depression Screening/Referrals
Potential Outcomes: improved depression treatment rates, improved depression rates, improved child outcomes and relationships, etc.

Metric: Maternal Health-Related Goal
Potential Outcomes: improved maternal and fetal health, decrease in pre-term delivery, etc.

Metric: Family Planning Education/Guidance (contraception)
Potential Outcomes: increased birth spacing, decreased poverty, etc.

Metric: Guidance for Appropriate ED/UCC/PCP Attendance
Potential Outcomes: cost savings for Medicaid management, increased funding stream for home visiting services, etc.

Metric: Maternal Postpartum Healthcare Attendance
Potential Outcomes: improved maternal health and mortality, reduced untreated postpartum Depression, improved maternal capacity to work and care for children, etc.

Metric: Tobacco Cessation/Substance Use Referrals
Potential Outcomes: improved maternal & child health, reduction of CA/N, improved bonding, improved parent-child interactions, etc..

Metric: Inter-Birth Spacing
Potential Outcomes (combo): improved pre-term birth rates, improved infant mortality, improved bonding, improved parent-child interactions, improved maternal health and stress, etc.

CHILD HEALTH & WELL-BEING

Metric: Breastfeeding Rates (frequency & duration)
Potential Outcomes: improved bonding, improved infant health, improved maternal health, etc.

Metric: Well Child Care Visits
Potential Outcomes: reduced preventative health conditions, improved caretaking by parent, reduced hospitalizations, etc.

Metric: Child Health-Related Goal (similar outcomes to well child care visits), etc.

Metric: Preterm Birth Rates
Potential Outcomes: improved infant health, cost savings for healthcare, etc.

Metric: Child Behavioral Concerns
Potential Outcomes: improved school-readiness, decreased CA/N, improved usage of mental health Services, etc.

Metric: Insurance Coverage (mother & child)
Potential Outcomes: improved health, reduced preventative health conditions, reduced hospitalizations, etc..

Metric: Prenatal Enrollment
Potential Outcomes: improved pre-term birth rates, improved birth weights, improved infant health, improved maternal health, etc.

The "Big Picture" – Process Measures that lead to Outcomes!

Child Development, Early Learning, Home and Child Safety Examples…

HOME AND CHILD SAFETY

Metric: Protective Factors Screening
Potential Outcomes: reduced risk factors associated with CA/N, increased protective factors that help to prevent CA/N including: family functioning and parental resilience, positive social supports, concrete supports, parental nurturing and attachment, parental knowledge of positive parenting practices and child development, etc.

Metric: Intimate Partner Violence Screening/Referrals
Potential Outcomes: reduced domestic violence rates, increased empowerment and healthy relationships, improved parental health and mortality, and decreased CA/N, etc.

Metric: Home Safety Screening/Education
Potential Outcomes: improved home environment safety and safe sleep practices, reduced childhood injury, decreased neglect, and increased medical cost savings, etc.

Metric: Safe Infant Sleep Practices
Potential Outcomes: improved infant mortality, improved maternal quality of sleep/health, etc.

Metric: Child Maltreatment Screening
Potential Outcomes: reduced substantiated CA/N

CHILD DEVELOPMENT/EARLY LEARNING

Metric: Parent-Child Interactions
Potential Outcomes: improved bonding and attachment, improved affection, improved parental responsiveness and encouragement, and improved child learning/development

Metric: Early Language & Literacy Activities
Potential Outcomes: improved reading and learning, improved bonding and attachment, increased parental engagement, improved school achievement, and increased educated workforce, etc.

Metric: Developmental Screening/Referrals (covers fine/gross motor, receptive/expressive language, cognition, etc.)
Potential Outcomes: improved child development, improved parental knowledge/understanding of appropriate child development, increased appropriate expectations of children, increased usage of developmental services, improved school-readiness, etc.

Metric: Caregiver Education
Potential Outcomes: improved economic stability, decreased parental stress, increased engagement of child in early learning activities, etc.

Promise 1000 – Staffing Structure

Centralized Promise 1000 Team

- Fiscal Agent
- Director(s)/Developers
- Program Manager
- Data Manager/Analyst
- I.T./Technical Support
- Project Coordinator

Questions about Staffing?

Promise 1000 – Training Structure

Kickoff/Home Visitor Orientation, REDCap & Processes Structure, Manager Orientation/Training & MBD Trainings

IN-PERSON CORE TRAININGS (INCENTIVIZED)

-Required for new home visitors/supervisors or home visiting agencies new to P1000 funding. Available to home visitors that have attended past P1000 CORE In-Person trainings, but may elect to do modular trainings instead. *We suggest ALL attending the new in-person trainings to participate in valuable networking experiences with home visitors, experience new expanded training topics by expert presenters, and have the opportunity to ask questions and get answers that benefit the whole group-*

ONLINE TRAININGS (NOT INCENTIVIZED) – Institute for the Advancement of Family Support Professionals https://institutefsp.org/modules

-*All* modular trainings will be available to *all* home visitors/supervisors at no cost. Home Visitors that have attended past P1000 CORE In-Person trainings may elect to take online modular trainings instead, but are also welcome to attend in-person trainings if they want. Although all the modular trainings will be available to home visitors, the elective ones below will be required if the modular option is selected.-

VETERAN TRAINING OPTIONS (Circle either the in-person OR the modular training option for each *"bucket"* focus area (not just the individual training topics). You can pick all in-person or all modular, or have a combination of both. For example, you will either pick the CORE training for Maternal Health & Well-Being OR the Modular Training for Maternal Health & Well-Being – See *examples* in red below)

CORE TRAININGS:

#1 MATERNAL HEALTH & WELL-BEING (4 hours)

- Pregnancy through the Stages & Prenatal Care Access
- Postpartum care & Maternal Health
- The Intersection of Breastfeeding & Safe Infant Sleep
- Families with Disabilities – Service Provider Q&A

#2 CHILD HEALTH & WELL-BEING/CHILD DEVELOPMENT & SCHOOL READINESS (4 hours)

- Supporting Families with WCC
- Infant Health & Wellness – Fact vs. Myth
- Pediatrician Panel
- Tying Early Brain Development to Behavior

#3 HOME SAFETY & FAMILY RESILIENCE (4 hours)

- Home & Visitor Safety
- Potty Training Challenges & Discipline
- Substance Use
- Diverse Populations – Lived Experiences of Parenting

ONLINE MODULAR TRAINING ELECTIVES (DUE 12/31/19)

#1 MATERNAL HEALTH & WELL-BEING

- Prenatal Basics (45 min)
- Reproductive Health (45 min)
- Breastfeeding 1, 2 & 3
  - (1) Helping mothers choose breastfeeding (45 min)
  - (2) Helping mothers initiate breastfeeding (45 min)
  - (3) Helping mothers continue breastfeeding (30 min)

#2 CHILD HEALTH & WELL-BEING/CHILD DEVELOPMENT & SCHOOL READINESS

- Bright Futures: Working with a Medical Home (45 min)
- Growing Healthy Children 1, 2 & 3 (1 hour, 30 min total)
- Child Development: Secrets of Baby Behavior (30 min)

#3 HOME SAFETY & FAMILY RESILIENCE

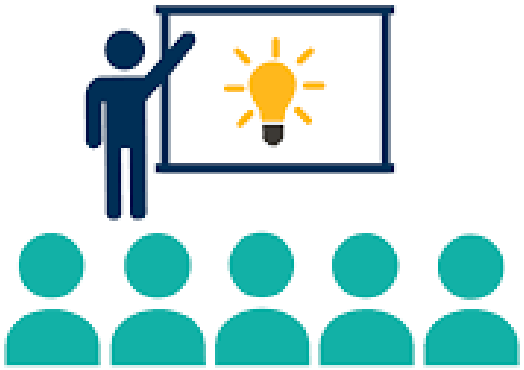
- Staying Safe while Supporting Families (1 hour)
- Promoting Safe & Healthy Homes (45 min)
- Early Intervention: Impact of Perinatal Substance Use of Infants (45 min)
- Collaborative Care: Developing & Implementing Plans of Safe Care for Substance Exposed Infants (45 min)
- Cultural Humility: Part 1 & Part 2
  - (1) Supporting Immigrant Families, a Culturally Humble Approach
  - (2) Supporting Dual Language Learners

Promise 1000 – Training Structure

2020-2021 Training Structure/Outline

- Kick-Off (all staff)
- REDCap Training (staff that need refresher/new staff)
- Core Training (New Staff only) – Online Module Development
  - Focused on ALL Process Measures & Outcomes
  - Could be taken at any point (so if hired later on, can still take them)
  - Since modular, can be taken at their own pace (although will have a completion deadline that is considerate of their start date)
- In-Person Professional Development Trainings (2) - Optional
  - Focused on Specific Process Measures & Outcomes
  - Informed by Pre-Assessment/Surveying (that would be required by all home visitors)
- Online Module Trainings
  - Pre-Assessment above (All HV) housed here
  - Additional Modules/HV Certificate Completion for Professional Development (Optional)

Questions about Shared Trainings?



Promise 1000 – Funding

- Catchment Area? Available Funding Sources?
- Fiscal Agent?
- Fiscal Planning/Structure
- Beginning Funding & Initiating Services
- Development of RFPs/MOUs/Data Sharing Agreements/Consent Forms

Collaboration Challenges

- Not everyone will accept a collective impact model (sometimes its difficult to try something new, or to share control)
- Established systems may take a while to adapt to changes
- Sharing data or funding has its challenges
- Different levels of support
- Meeting the needs of the many
- Staying focused on the “big picture”, we all want the same thing!
- Fiscal Sustainability

Components for Successful Collaboration

Bringing together a collective of diverse people/agencies/models to focus on shared procedures and outcomes can present unique challenges, as each has their own existing structure and focus areas. Essential components for successful collaboration include:

- Open communication
- Continuous quality improvement (CQI)
- Recognition of expertise & flexible programming
- Collaborative Buy-In
- Remembering the “big picture” or common agenda to create focused efforts that are both purposeful and meaningful
- Funding/Expertise/Decision making tightly tied together
- Low Overhead


TAKING
A
BREAK
15 Minutes

CRIS (Centralized Referral Intake System)

- Development of Basic Elements of the CRIS questionnaire
  - What does each agency need at intake/enrollment?
  - Collapsing questions down to one form
  - Identifying minimal necessary information for outward facing referral form & for eligibility criteria for algorithm logic
  - Identifying other information needed at intake/enrollment
  - Developing consent language for form (if needed)
  - Agreement on final CRIS form
    - Collaborative Agreements for evidence-based HVAs to be a part of CRIS regardless of funding

*See Example……

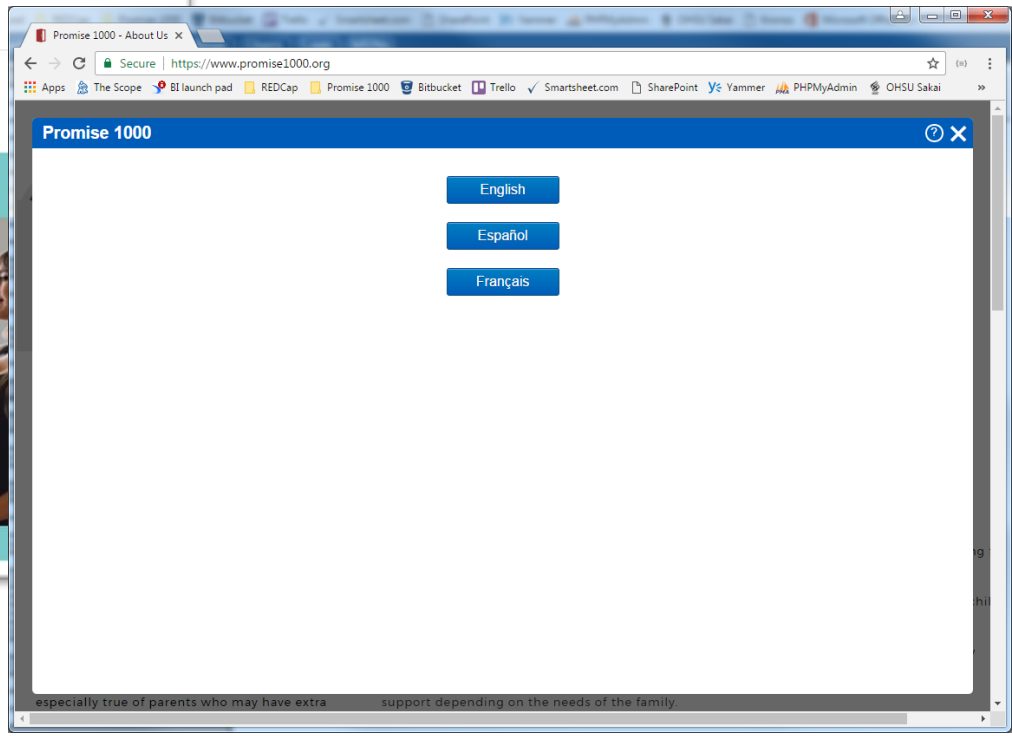
CRIS (Centralized Referral Intake System)

Round robin queue system that assigns referrals based on an agency's criteria (i.e. pregnant at enrollment, zip code/county, etc…)

Efficiently manages referrals and gets them reassigned appropriately when agencies and families don't match

Couple ways for referrals to get into CRIS

1) The Promise 1000 Website (promise1000.org)

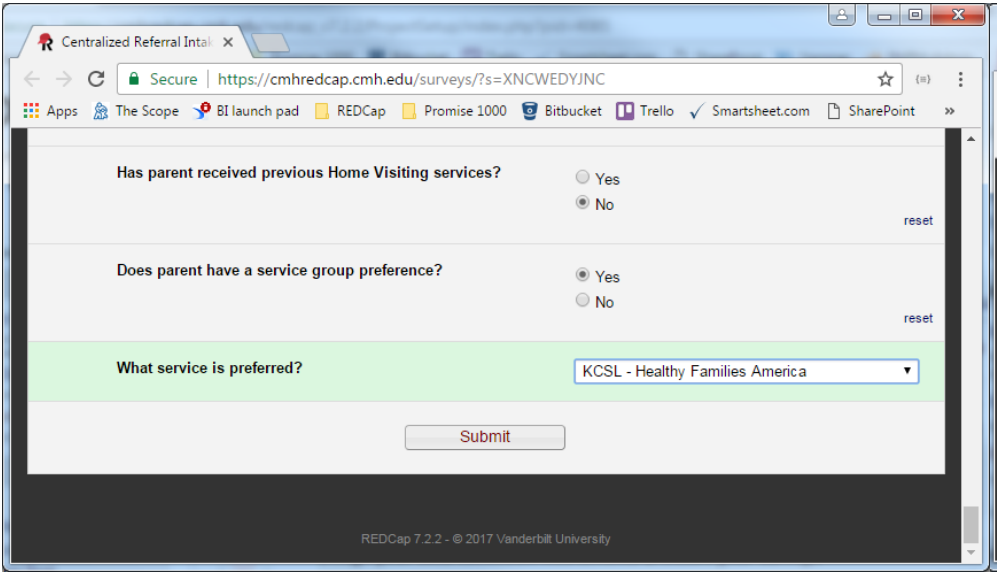


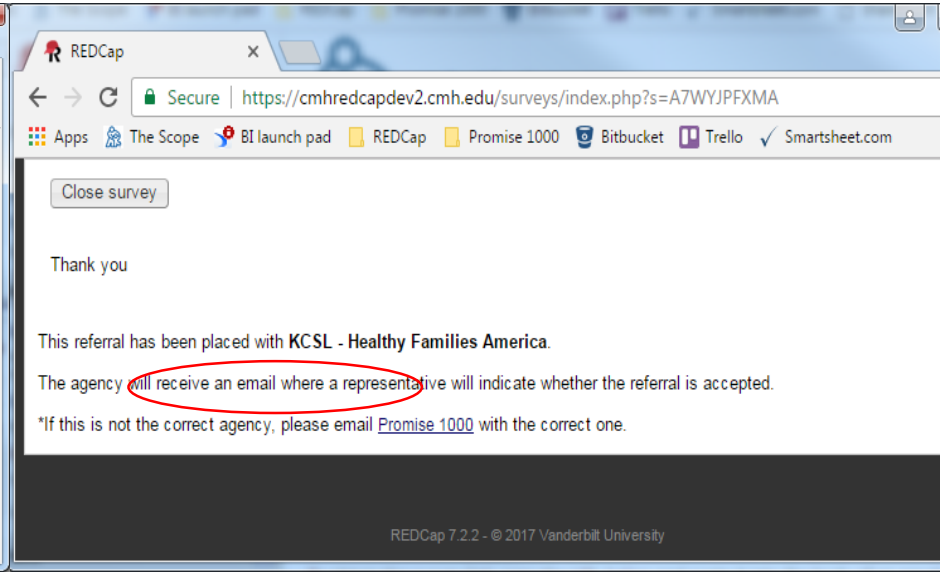
2) United Way (2-1-1)

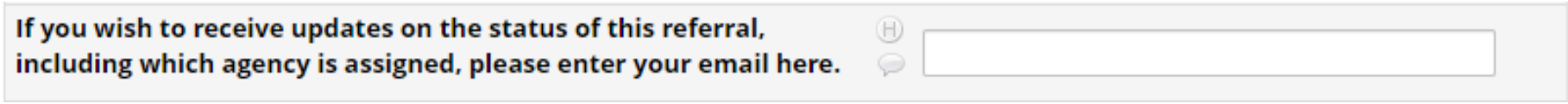
- United Way representatives have guidance on what might qualify for home visiting
- A designated United Way representative monitors the call center, and is the “go-to” person for potential home visiting referrals
- Phone calls can be more personal

Placement Depends on the Agency's Criteria

- If a referral is entered that does not match the criteria, the agency will not receive the referral
  - Example: You only serve families living in Jackson County and there is a referral from Clay County, the referral will go to another agency.
- There is an option to select a specific Agency on the form (last 3 questions)
- There is a way to track progress of the referrals/receive email updates





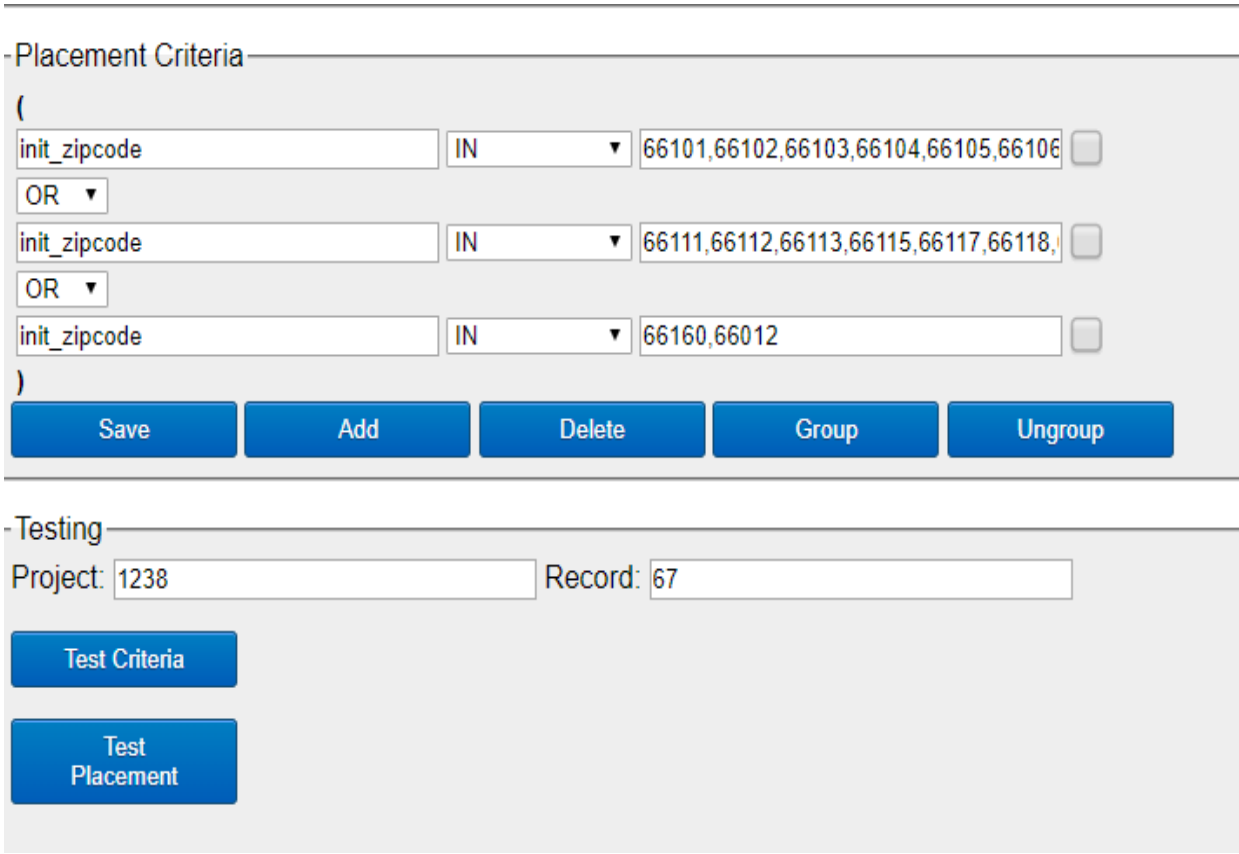


Background Logic, Assigning by:

- Zip Code
- Pregnancy Status
- Date of Birth
- Etc…

➢ Pulls answers and assigns based on set placement criteria for each agency

➢ Can “test” if a family would qualify for each agency



Referral Emails

Other adults living in the home are employed	Yes
Income covers needs	Yes
Family and/or Friends for Support	Yes
Mother's Education Level	High School/GED
Father's Education	High School/GED
Moves Last 6 Months	2
Serivce for Mental Health	No
Depressed	No
Substance Abuse before knowledge of Pregnancy	Yes
Drugs and/or alcohol creating a problem now or in the past	No
TANF	No
WIC	Yes
SNAP (Food Stamps)	No
Medicaid	Yes
Housing Benefits	No
Disability	No
No Benefits	No
init_homesurvyes	0

Accept | Decline

Follow Up Email-(Every 7 days until accepted/declined)

Employment	Unemployed
Other adults living in the home are employed	Yes
Income covers needs	Yes
Family and/or Friends for Support	Yes
Mother's Education Level	High School/GED
Father's Education	High School/GED
Moves Last 6 Months	2
Serivce for Mental Health	No
Depressed	No
Substance Abuse before knowledge of Pregnancy	Yes
Drugs and/or alcohol creating a problem now or in the past	No
TANF	No
WIC	Yes
SNAP (Food Stamps)	No
Medicaid	Yes
Housing Benefits	No
Disability	No
No Benefits	No
init_homesurvyes	0

Accept | Decline | In Progress

**NOTE: These graphics do not represent all the questions asked on the referral form, but agencies receive all of the questions/answers.*

CRIS Dashboard (Queue) Example

Record ID: 488 2019-09-12 14:43:58, 53 day(s) OVERDUE **(13th notice)**	Jackson MO 1 yrs, 10 mo old	Parents As Teachers MO	GO	Accept / Decline / In Progress
Record ID: 562 2019-10-08 10:51:41, 28 day(s) OVERDUE **(4th notice)**	Clay MO 36 weeks Pregnant	Cornerstones of Care	GO	Accept / Decline / In Progress
Record ID: 570 2019-10-23 13:47:30, 13 day(s) Waiting for placement confirmation	Jackson MO 23 weeks Pregnant	CMH HFA	GO	Accept / Decline / In Progress
Record ID: 573 2019-10-23 17:52:16, 12 day(s) Waiting for placement confirmation	Jackson MO 38 weeks Pregnant	CAPA	GO	Accept / Decline / In Progress
Record ID: 577 2019-10-29 13:59:57, 7 day(s) Waiting for placement confirmation	Jackson MO 16 days old	Front Porch Alliance	GO	Accept / Decline / In Progress
Record ID: 484 2019-11-01 15:15:30, 3 day(s) Waiting for placement confirmation	Jackson MO 3 mo, 14 days old	Cornerstones of Care	GO	Accept / Decline / In Progress
Record ID: 582 2019-11-01 15:27:08, 3 day(s) Waiting for placement confirmation	Jackson MO 14 days old	Cornerstones of Care	GO	Accept / Decline / In Progress
Record ID: 584 2019-11-04 09:28:49, 1 day(s) Waiting for placement confirmation	Wyandotte KS 18 weeks Pregnant	Project Eagle	GO	Accept / Decline / In Progress
Record ID: 586 2019-11-05 13:01:54, 1 hr(s) and 11 min(s) Waiting for placement confirmation	Clay MO 6 mo, 29 days old Drug Use	Easter Seals	GO	Accept / Decline / In Progress

*Agencies can only see their individual dashboards/remains confidential

*Can click on the record ID# in the dashboard to see full referral form and progress notes

Details

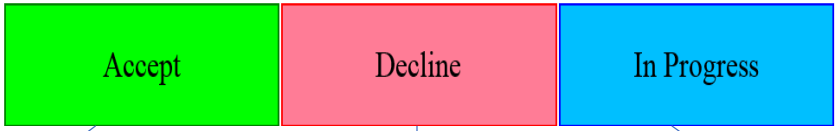
Record ID	186
Date	2017-12-22
County	Douglas KS
Zipcode	66210
Filled out By	Dad
Parent's Name	TEST - Please IGNORE
Currently Pregnant	Yes
Gestational Age (weeks)	4
Prenatal Care	Yes
Attended(s) All Prenatal Appointments	No
First Time Parent	Yes
Mother's Age	4
Gross Income	0
Housing	Other
Race	Caucasian
English	Yes
Spanish	No
Chinese	No
German	No
French	No
Vietnamese	No
Arabic	No
Somali	No
Other	No
Mother's Insurance	Public
Child's Insurance	Public
Single	Yes
Married	No
Divorced	No
Unmarried Partners	No
Widowed	No
Single Parent	Yes
Smokes	Yes
Employment	Employed Part Time
Return to work after birth of the baby?	Yes - Full Time

History

Location	Status	Date
Douglas County HFA	Unable to Place	2017-12-22 11:53:49
Promise 1000	Initial email sent to jpreston@ldchealth.org	2017-12-22 11:51:05
Douglas County HFA	Waiting for placement confirmation	2017-12-22 11:51:05

Referral Email Workflow

If they get a referral from the website or from the United Way, before they accept it, they sure the family is a fit with their Agency. They don't hit the accept button right away. They wait until they know the family is going to be a part of the program!



Hit "Accept" if the family is going to be a part of the program!

- CRIS Adds this family to the agencies records in REDCap

Hit "Decline" if:

- The family does not qualify for their agency
- They are full or at capacity

*These cases will be reassigned to another agency in CRIS

- Family not wanting home visiting
- Not being able to reach the family after multiple attempts

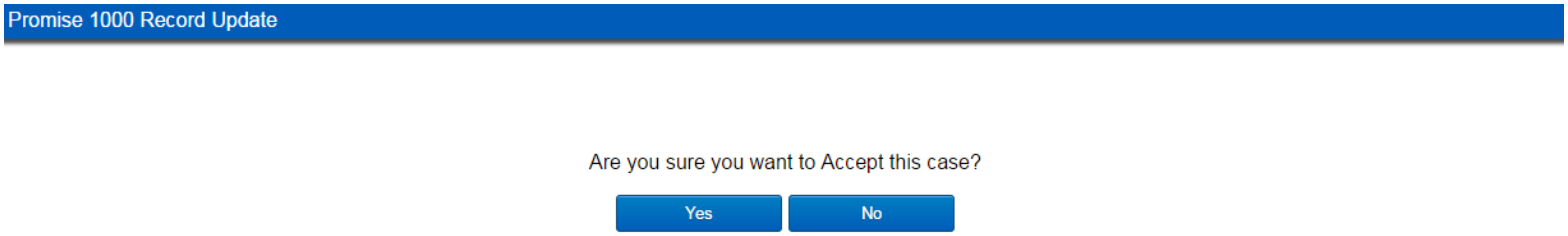
*These cases will not go back into the queue for another agency.

- **Can hit decline now and what reason you put determines where it goes!**

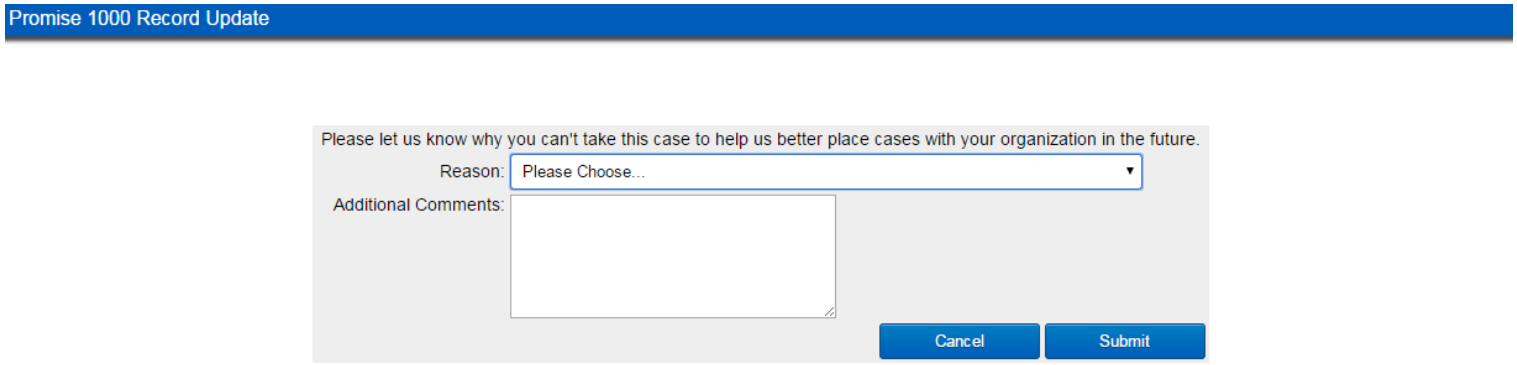
Hit "In Progress" if they are still trying to reach the family!

- Enter the reason it is in progress via the "In Progress Button" and see the narrative by click on the ID# in the dashboard

Accepting/ Declining



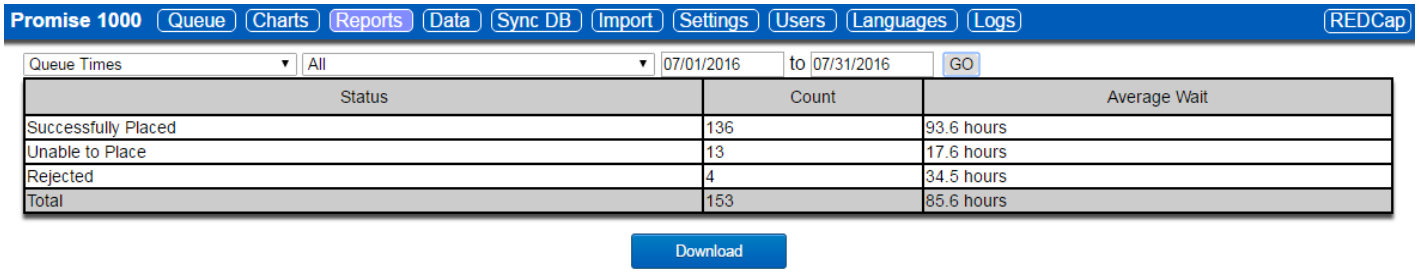
Children's Mercy



Children's Mercy

CRIS Reporting

- Transparency
  - Statistics
  - Percentages
  - Queue Times

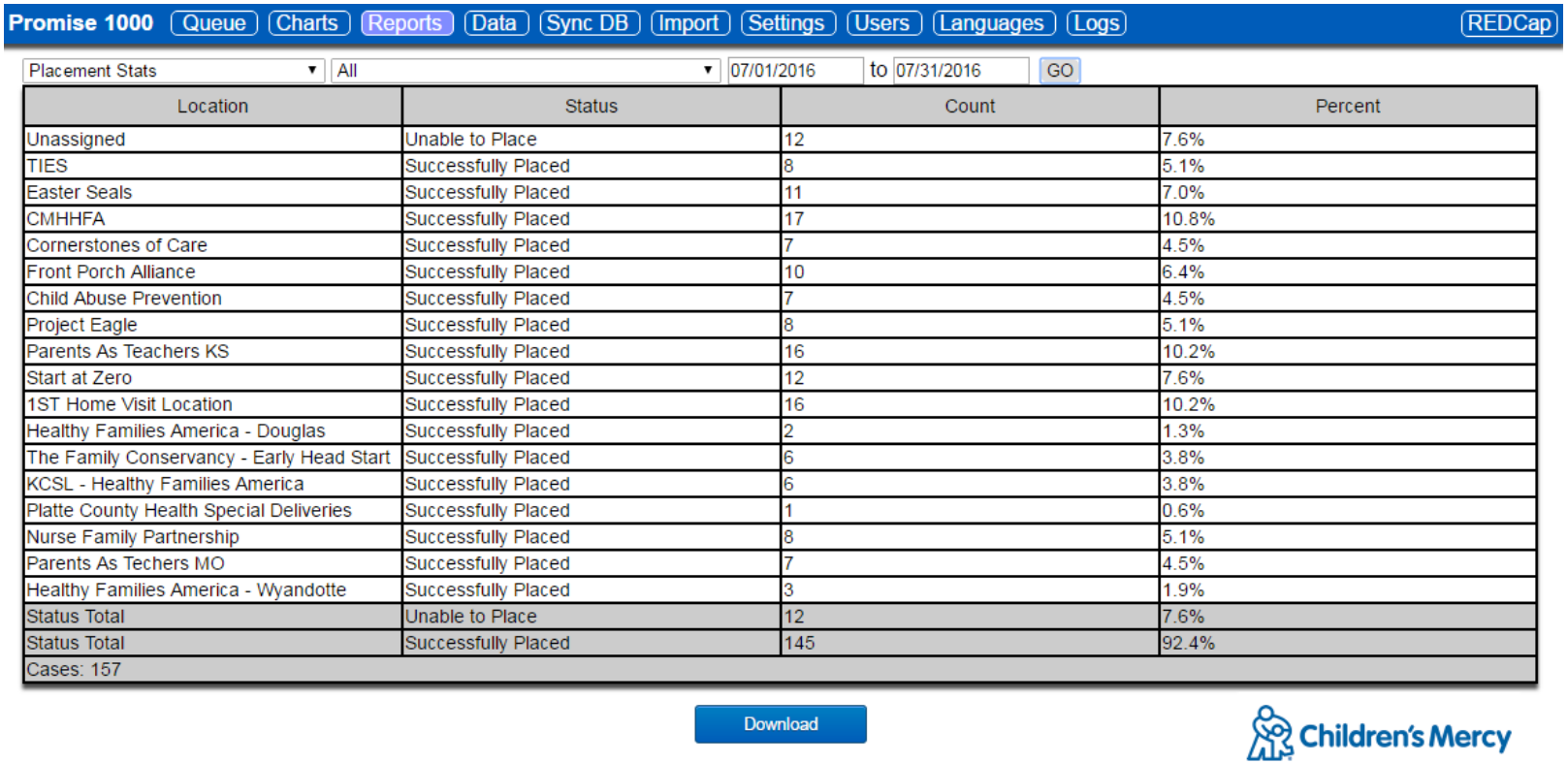


Promise 1000 | Queue | Charts | Reports | Data | Sync DB | Import | Settings | Users | Languages | Logs | REDCap

Queue Times | All | 07/01/2016 to 07/31/2016 | GO

Status	Count	Average Wait
Successfully Placed	136	93.6 hours
Unable to Place	13	17.6 hours
Rejected	4	34.5 hours
Total	153	85.6 hours

Download



Promise 1000 | Queue | Charts | Reports | Data | Sync DB | Import | Settings | Users | Languages | Logs | REDCap

Placement Stats | All | 07/01/2016 to 07/31/2016 | GO

Location	Status	Count	Percent
Unassigned	Unable to Place	12	7.6%
TIES	Successfully Placed	8	5.1%
Easter Seals	Successfully Placed	11	7.0%
CMHHFA	Successfully Placed	17	10.8%
Cornerstones of Care	Successfully Placed	7	4.5%
Front Porch Alliance	Successfully Placed	10	6.4%
Child Abuse Prevention	Successfully Placed	7	4.5%
Project Eagle	Successfully Placed	8	5.1%
Parents As Teachers KS	Successfully Placed	16	10.2%
Start at Zero	Successfully Placed	12	7.6%
1ST Home Visit Location	Successfully Placed	16	10.2%
Healthy Families America - Douglas	Successfully Placed	2	1.3%
The Family Conservancy - Early Head Start	Successfully Placed	6	3.8%
KCSL - Healthy Families America	Successfully Placed	6	3.8%
Platte County Health Special Deliveries	Successfully Placed	1	0.6%
Nurse Family Partnership	Successfully Placed	8	5.1%
Parents As Techers MO	Successfully Placed	7	4.5%
Healthy Families America - Wyandotte	Successfully Placed	3	1.9%
Status Total	Unable to Place	12	7.6%
Status Total	Successfully Placed	145	92.4%
Cases: 157			

Download

Children's Mercy

Promise 1000 Database – REDCap Features & Content

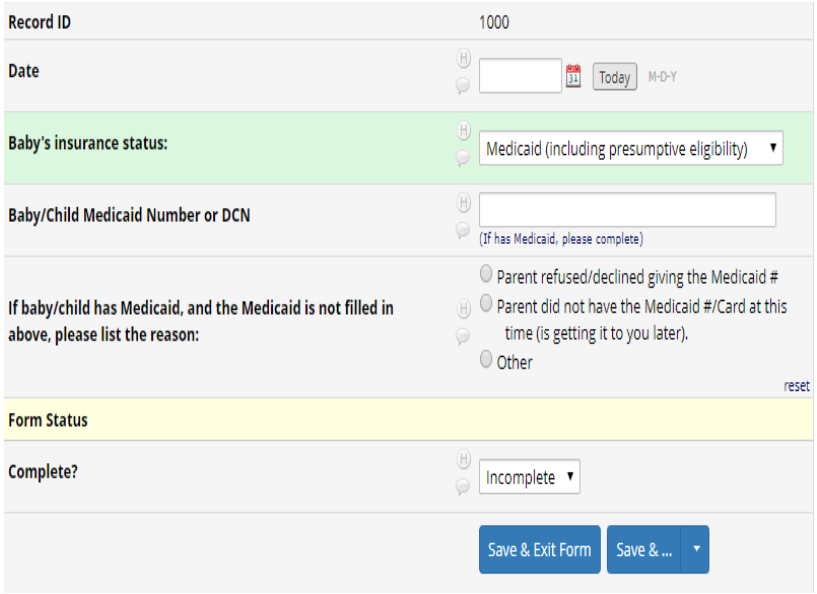
Promise 1000 – Shared Screening Tools

- Ages & Stages Questionnaire-3 (ASQ-3) – child development
- Ages & Stages Questionnaire-Social Emotional (ASQ-SE)– child social emotional development
- Edinburgh Postnatal Depression Scale – maternal depression
- Women's Experience With Battering Scale (WEB) – IPV
- Protective Factors Survey – family functioning and strengths tool for measuring improvements
- Home Safety Inventory – environmental safety in the home
- Parent Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO) – parent-child interaction tool
- UNCOPE – Substance Use Screen

*See Screening Schedule……

Promise 1000 - Shared Evaluation/Information Forms

- Short Forms to feed reporting, identified benchmarks, goals and process measures
- Some forms may be agency specific and only turned on for agencies that need them for their specific model



PROMISE 1000 FORMS SCHEDULE		
Form	**How Often**	**Due Dates**
STATIC FORMS (Done Only Once)		
Centralized Intake & Referral Form	Once	Intake/Start
Agency & Eligibility Form	Once	Intake/Start
Program Consent Form	Once	Intake/Start
Baby.Child Information Form	Once (possibly more if more than once child)	Intake and/or Child's birth
Breastfeeding Form	Once	Date Stopped Breastfeeding
Case Closure Form	Once	Closure
ONGOING & AS NEEDED FORMS		
Lost to Follow Up Status	As needed	When LFU starts/ends
Prenatal Healthcare Visits	as occur	When healthcare visits occur
Prenatal Visits Form	Everytime mom is pregnant, every visit	As prenatal visits occur
Postnatal Visits Form	Everytime mom is postnatal, every visit	As postnatal visits occur
Referrals Form	As needed	As Referrals Happen
Baby.Child Health Insurance	As needed	Intake/Start & As Changes/Updates
Primary Care Physician Child	As needed	Intake/Start & As Changes/Updates
Primary Parent Health Insurance	As needed	Intake/Start & As Changes/Updates
Demographic Updates	Quarterly	Quarterly/Every 6 months from enrollment-see popup
Maternal Health Goals	As needed	Intake/As goals get created and completed (should always have a goal)
Child Health Goals	As needed	Intake/As goals get created and completed (should always have a goal)
Immunizations	As needed	Same timeframes at well-child visits (as they occur)
Child ER/UCC Visits	As needed	As ER/UCC visits happen
Parent ER/UCC Visits	As needed	As ER/UCC visits happen
Child Abuse or Neglect Form	As needed-Postnatal	If Child Abuse/Neglect is reported
AGENCY SPECIFIC FORMS (Only see if required by your agency)		
Family Goals	Ongoing-As needed	See Supervisor
Groups, Graduation, Other	Ongoing-As needed	See Supervisor
Attempted Visit Documentation	Prenatal & Postnatal	See Supervisor
Phoneletter Documentation	Prenatal & Postnatal	See Supervisor
Visit Documentation	Prenatal & Postnatal	See Supervisor

Developing Shared Data, Outcomes & Activities

MIECHV Benchmarks

- Measure 01: Preterm Birth
- Measure 02: Breastfeeding
- Measure 03: Depression Screening
- Measure 04: Well-Child Visits
- Measure 05: Postpartum Care
- Measure 06: Tobacco Cessation Referrals
- Measure 07: Safe Sleep
- Measure 08: Child Injury
- Measure 10: Parent-Child Interaction
- Measure 11: Early Language and Literacy Activities
- Measure 12: Developmental Screening
- Measure 13: Behavioral Concerns
- Measure 14: Intimate Partner Violence Screening
- Measure 15: Primary Caregiver Education
- Measure 16: Continuity of Insurance Coverage
- Measure 17: Completed Depression Referrals
- Measure 18: Completed Developmental Referrals
- Measure 19: Intimate Partner Violence Referrals

Demographics
Total number of PCGs served
Total number of children served
Total number of home visits provided
PCGs by age
Children by age
PCGs by race
Children by race
PCGs by ethnicity
Children by ethnicity
PCGs by marital status
PCGs by employment status
PCGs by housing status
Primary language spoken at home

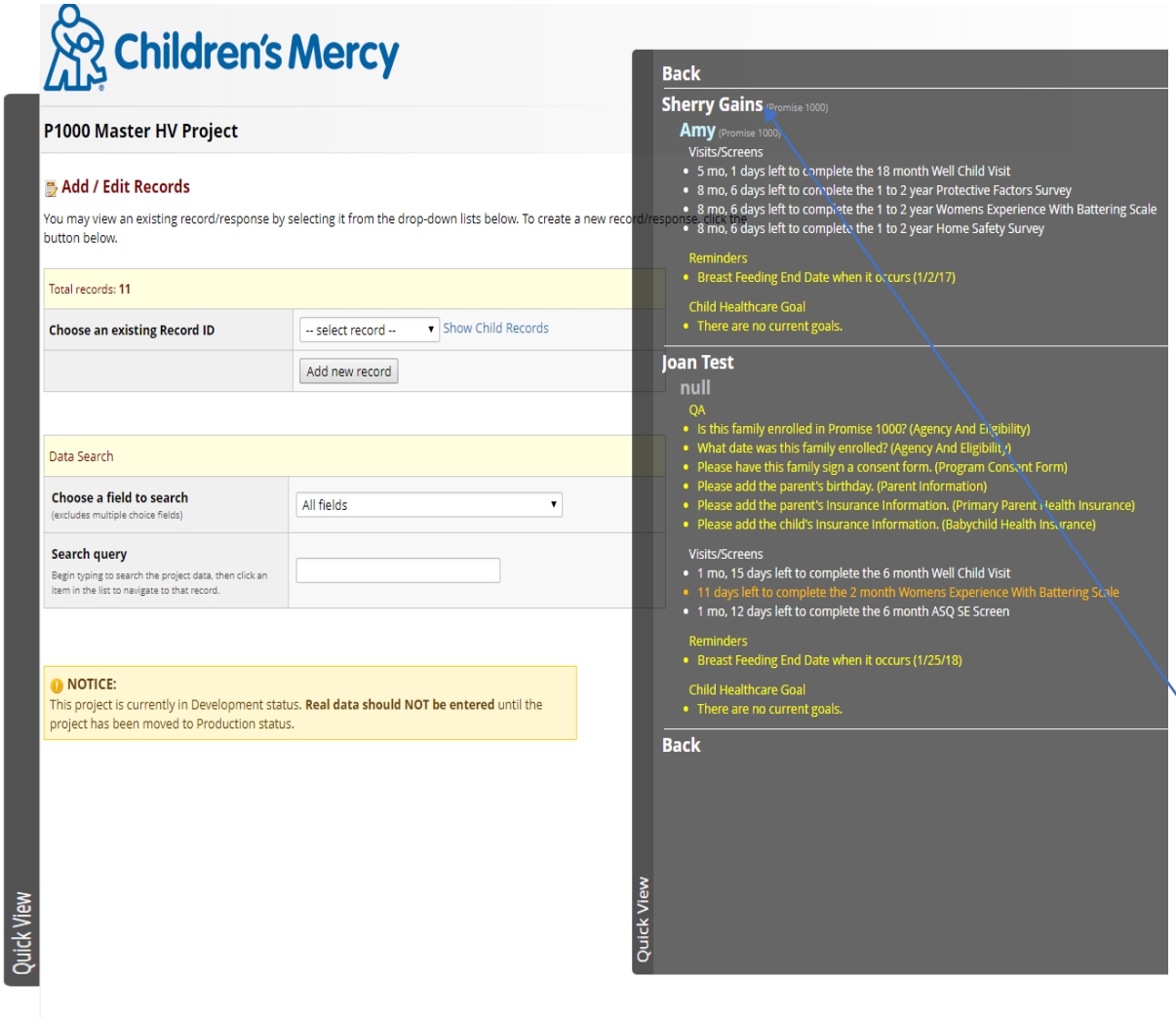
*See MIECHV Decipher Key

Developing Shared Data, Outcomes & Activities

Promise 1000 – REDCap Database

Promise 1000 Centralized Referral Intake System	637	126	3 forms 2 surveys	■	☑
P1000 Master HV Project	32	1,461	46 forms 1 survey		
Promise 1000-AGENCIES (11)					
CMHHFA HV Database 2019-20	163	1,461	47 forms		☑
Easter Seals Midwest HV Database 2019-20	1,223	1,461	47 forms		☑
Cornerstones of Care HV Database 2019-20	716	1,461	47 forms		☑
Front Porch Alliance HV Database 2019-20	80	1,461	47 forms		☑
Child Abuse Prevention Association HV Database 2019-20	113	1,461	47 forms		☑
Project Eagle HV Database 2019-20	55	1,461	47 forms		☑
Parents As Teachers KCK HV Database 2019-20	118	1,461	47 forms		☑
Parents As Teachers Turner KS HV Database 2019-20	47	1,461	47 forms		☑
TIES HV Database 2019-20	156	1,461	47 forms		☑
KCSL HV Database 2019-20	86	1,461	47 forms		☑
Great Circle HV Database 2019-20	137	1,461	46 forms 1 survey		☑

Seeing your caseload in REDCap™



In Add/Edit Record Page:

- Click on Quick View tab (gray bar)on the far right of the screen

Quick View Shows:

- Individual home visitor caseloads
- Tools/items that are due or are missing Quality assurance items that need addressed

Record Status Dashboard:

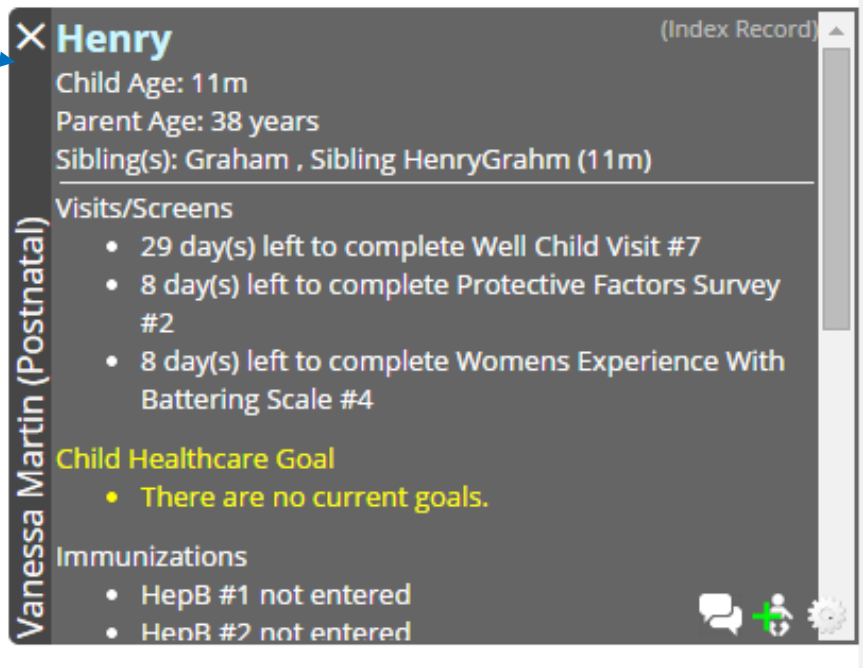
- Additional way to see your overall caseload and what has been completed (on left side of main screen)

Click on the name to go to that persons record directly

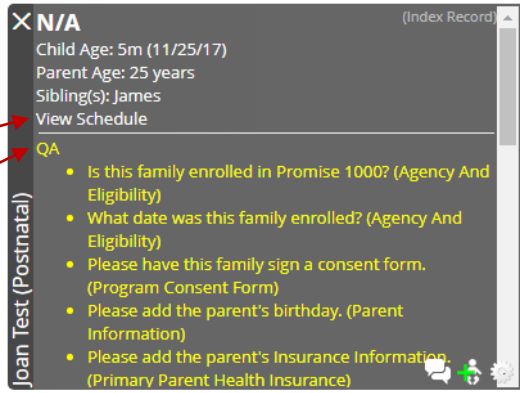
Individual Mom/Child Pop-Up Window

Follow your Reminder Window!

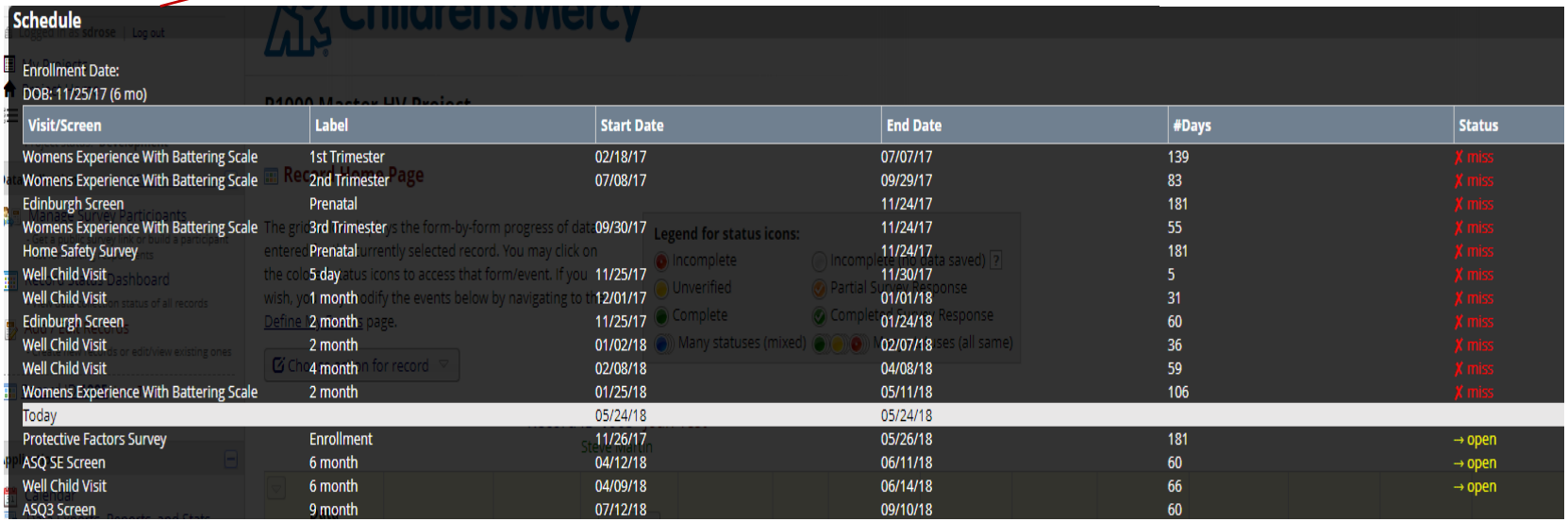
- Overdue/missing data appears in **YELLOW** – correct immediately
- Coming due in less than 30 days in **ORANGE**
- "To-Do" list with timeline appears in **WHITE**



Seeing the screening schedule in REDCap™



Quality Assurance Reminders



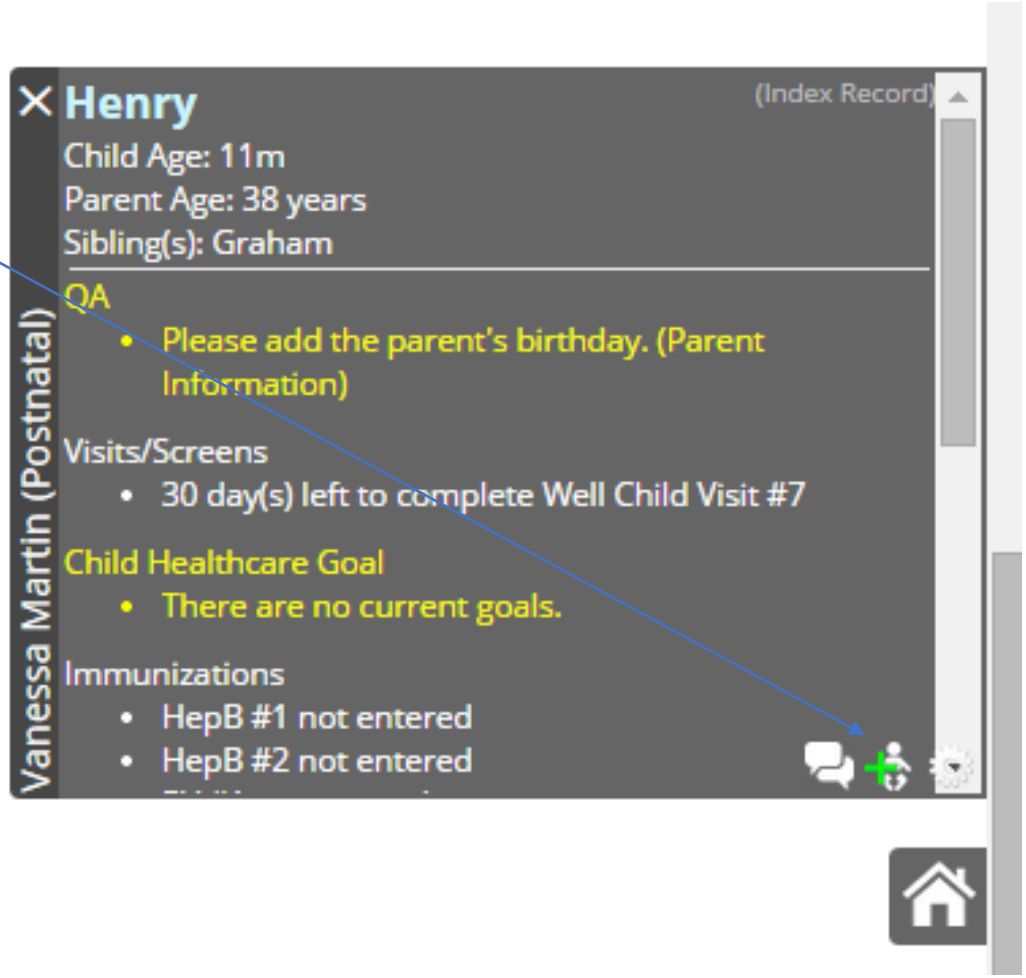
Schedule

Enrollment Date:
DOB: 11/25/17 (6 mo)

Visit/Screen	Label	Start Date	End Date	#Days	Status
Womens Experience With Battering Scale	1st Trimester	02/18/17	07/07/17	139	✗ miss
Womens Experience With Battering Scale	2nd Trimester	07/08/17	09/29/17	83	✗ miss
Edinburgh Screen	Prenatal		11/24/17	181	✗ miss
Womens Experience With Battering Scale	3rd Trimester	09/30/17	11/24/17	55	✗ miss
Home Safety Survey	Prenatal		11/24/17	181	✗ miss
Well Child Visit	5 day	11/25/17	11/30/17	5	✗ miss
Well Child Visit	1 month	12/01/17	01/01/18	31	✗ miss
Edinburgh Screen	2 month	11/25/17	01/24/18	60	✗ miss
Well Child Visit	2 month	01/02/18	02/07/18	36	✗ miss
Well Child Visit	4 month	02/08/18	04/08/18	59	✗ miss
Womens Experience With Battering Scale	2 month	01/25/18	05/11/18	106	✗ miss
Today		05/24/18	05/24/18		
Protective Factors Survey	Enrollment	11/26/17	05/26/18	181	→ open
ASQ SE Screen	6 month	04/12/18	06/11/18	60	→ open
Well Child Visit	6 month	04/09/18	06/14/18	66	→ open
ASQ3 Screen	9 month	07/12/18	09/10/18	60	

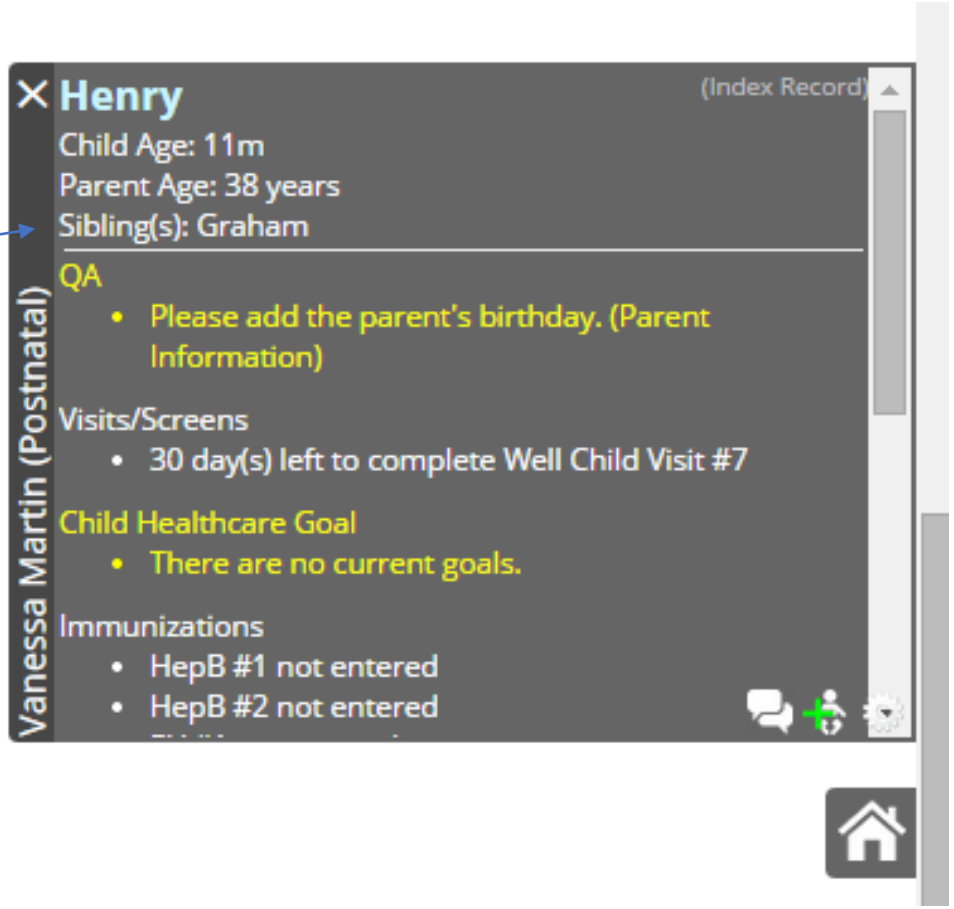
Add Sibling/Additional Child Record

- Click green + in bottom right of reminder window
- Enter required information
- New record opens without duplication of parent info



Sibling/Additional Child Record

- You can toggle between child records in a family here
  - Sibling(s) in reminder window
- Index Record = mom/baby#1 record
  - Mom's name will also be at the top of the record
- Child Record = Baby #2, 3, etc…



Data Collection Instrument	Static Information	Ongoing Events	Prenatal Visit	Postnatal Visit
Centralized Referral Intake (survey)	●			
Agency And Eligibility	●			
Lost To Follow Up Status		●		
Program Consent Form	●			
Kempe Assessment	●			
Parent Information		●		
Baby.Child Information	●			
Prenatal Visit			●	
Postnatal Visit				●
Visit Documentation			●	●
Referrals		●		
Breastfeeding	●			
Baby.Child Health Insurance		●		
Primary Care Physician Child		●		
Primary Parent Health Insurance		●		
Maternal Health Goals		●		
Child Healthcare Goals		●		
Family Goals		●		
Well Child Visit		●		
Immunizations		●		
Child ER UCC Visits		●		
Parent ER UCC Visits		●		
ASQ3,ASQSE2				●
ASQ-3		●		
Edinburgh			●	●
Womens Experience With Battering Scale			●	●
Protective Factors Survey			●	●
Home Safety			●	●
Attempted Visit Documentation			●	●
Phoneletter Documentation			●	●
Groups, Graduation, Other		●		
Child Abuse or Neglect				●
Case Closure	●			

Records in REDCap™

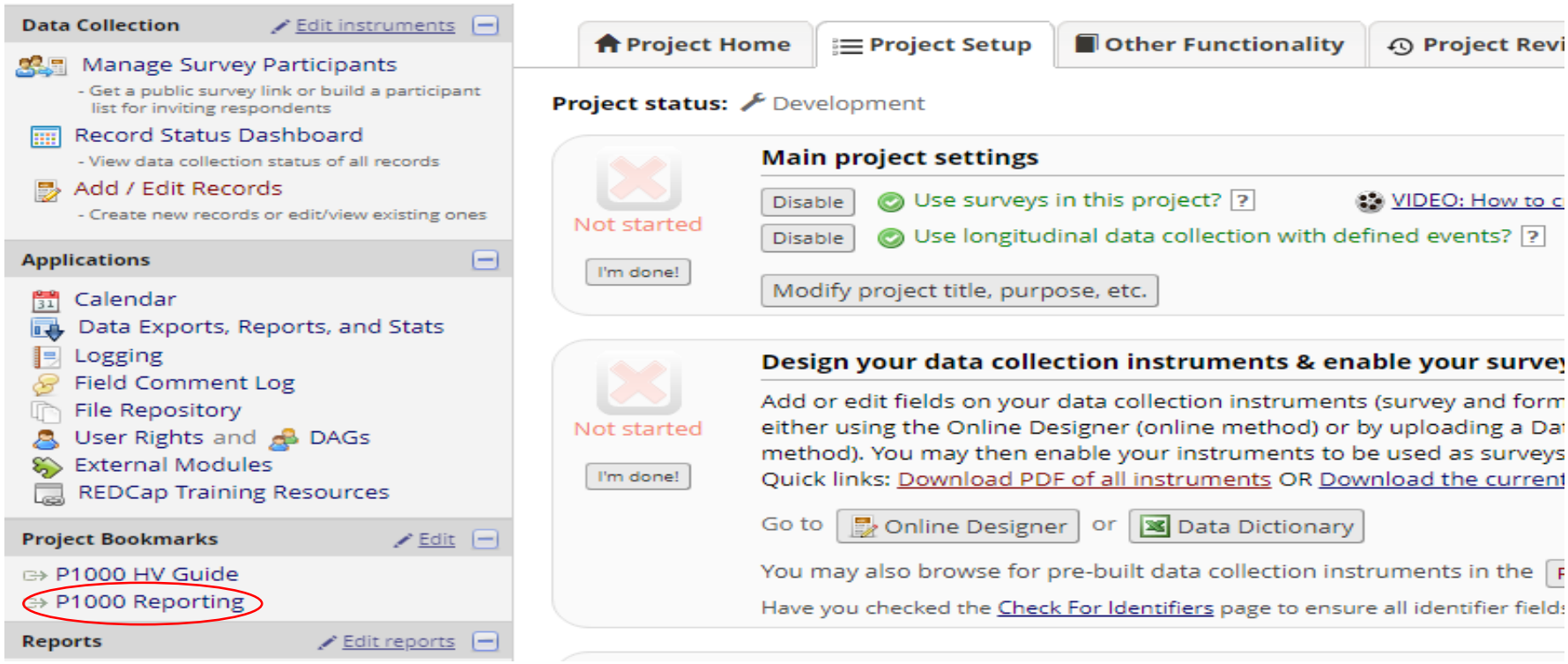
-Layout of Forms

Static Information-Events/data that should only occur once for a case (i.e. Enrollment, etc…)
Ongoing Events- Events that are repeatable, but are not necessarily tied to a visit (i.e. well child checks, insurance, etc…)
Prenatal Visit- Completed when mom is pregnant
Postnatal Visit- Completed when mom is not pregnant

Things to know!

- Must complete the Agency & Eligibility Form at enrollment & complete intake form, if necessary
- Click on any corresponding dot to add that form
- If repeated form, click on + sign to add additional forms
- Click on multiple circles to see all forms entered thus far
- REDCap automatically turns the dots green for “completed” and red for “Incomplete”. Agencies can determine if/how they use the colored dots for case management purposes, but they do not impact Promise 1000 reporting.

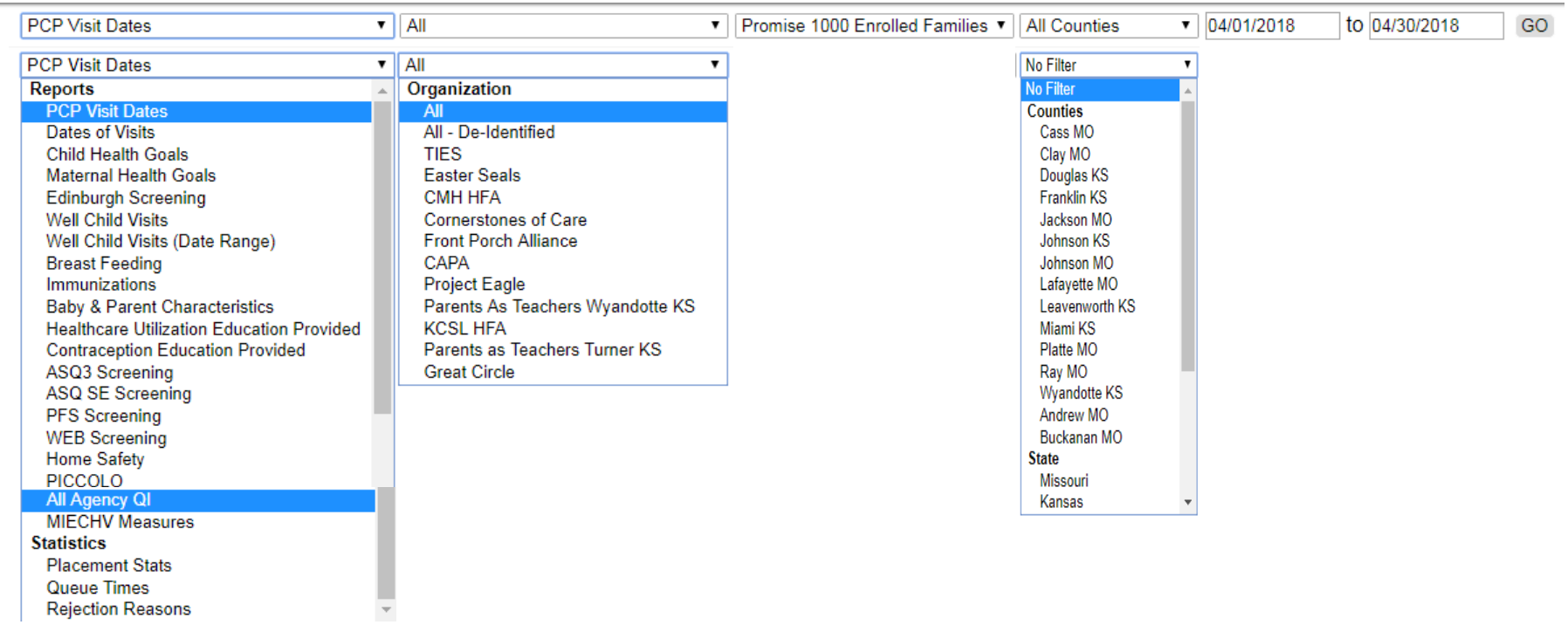
Viewing Reports (Created internally)



Note: Additional reporting built for anything not captured in this feature – “tailor it yourself” option.

Reporting

- Select the report, any other filters, and time frame from drop downs – Select Go!
- If you click on “Edit” you can go directly to the participant record (on the right hand side)
- Clicking on the record ID# takes you to the participant time line chart
- Can copy and export into Excel/SPSS



Reports: Example Edinburgh Screening

Location	Case Worker	ID	DOB	Prenatal	2 month	9 month	21 month	33 month	Date Range %	Other Screen Dates	
[redacted]	[redacted]	[redacted]	[redacted]								
		1167-66				06/17/19			100%		EDIT
		1175-117					07/29/19		100%		EDIT
Easter Seals	Closed Cases	1175-23						07/09/19	100%		EDIT
Easter Seals	WaitList - Victoria Campos	1175-106					06/17/19		100%		EDIT
Easter Seals	Closed Cases	1175-20						03/18/19	100%		EDIT
Easter Seals	Closed Cases	1175-105		02/25/19					50%		EDIT
Easter Seals	Closed Cases	642-14						07/29/19	100%	03/07/19	EDIT
Easter Seals	Closed Cases	1167-23						08/01/19	100%		EDIT
Easter Seals	Closed Cases	1166-33				12/18/18			100%		EDIT
Easter Seals	Toni Reynolds	1174-75	08/01/18			04/09/19			100%		EDIT
Easter Seals	Closed Cases	1166-95	08/22/18			05/31/19			100%	04/18/19	EDIT
				100%	75.86%	79.63%	69.05%	72.73%	76.28%		
Screening Windows Closed in Date Range:		156									
Screens Completed for Closed Windows:		119									

MBD	On Schedule	Off Schedule
# of Screens	119	59
Scored 10+	32	16
Action		
Referral FAXED/SENT to Moving Beyond Depression (MBD)	9	10
Referral FAXED/SENT to other community mental health agency	2	0
Other reason no referral faxed or mental health program not presented (previously "no referral")	5	0
MBD Program Presented/Discussed-NO REFERRAL FAXED	10	3
Other community mental health agency presented/discussed-NO REFERRAL FAXED	6	3
No Referral Reason		
Declined MBD	0	0
Declined any treatment for depression	2	1
Mother already receiving treatment	5	2
Mother is on a waitlist for services	10	0
MBD not presented to mother	6	0
Referred to another agency	0	0
Score does not indicate a need for a referral	0	0
Mother ineligible due to language barrier	0	0
Mother ineligible due to age (under 16 years old)	0	0
Other	0	3
MBD Presented, mom will follow up later	0	0

Guidelines
1. Prenatal - any time prenatally, we encourage home visitors to screen moms in the first month enrolled.
2. Birth – home visitors have 60 days after birth to administer the screen.
3. 9 months postpartum – home visitor can screen 30 before or 30 days after.
4. 21 months postpartum - home visitor can screen 30 before or 30 days after.
5. 33 months - home visitor can screen 30 before or 30 days after.

De-identified here, but shows up if you select the agency or ALL, or can select de-identify and it will just say “home visitor” or “agency”

Blue = Due & Completed “On Time”
Yellow = Missed
Other Screen Dates = Completed “Not on time”

Measure	Agency #1	Agency #2	Agency #3	Agency #4	Agency #5	Agency #6	Agency #7	Agency #8	Agency #9	Agency #10	All
September 2018					**Child Health & Well-Being Indicators**						
Breast Feeding Avg	6 mo, 10 days	7 mo, 11 days	5 mo, 20 days	1 yrs, 11 mo	8 mo, 7 days	9 mo, 7 days	12 mo, 4 days	8 mo, 24 days	10 mo, 26 days	5 mo, 22 days	8 mo, 15 days
Breast Feeding % (Goal: 50%)	82.14%	39.26%	66.67%	60%	85.71%	68.18%	73.08%	72.73%	31.48%	83.33%	57.51%
Child Healthcare Goal (Goal: 75%)	98.21%	85.93%	66.67%	20%	80.95%	100%	100%	81.82%	70.37%	62.5%	85.23%
September 2018											
Well Child Visits (Goal: 50%)	46.43%	48.15%	0%	0%	52.38%	40.91%	65.38%	18.18%	37.04%	45.83%	46.11%
Home Visitor Attendance (Goal: 50%)	26.79%	5.19%	16.67%	0%	23.81%	54.55%	26.92%	9.09%	57.41%	37.5%	24.61%
					Maternal Health & Well-Being Indicators						
Maternal Healthcare Goal (Goal: 70%)	92.98%	79.65%	66.67%	0%	84%	95.45%	93.75%	54.55%	73.33%	53.57%	79.1%
Edinburgh Screens (Goal: 70%)	100%	85%	100%	0%	N/A	33.33%	66.67%	0%	14.29%	33.33%	61.9%
HV Healthcare Education (Goal: 70%)	96.23%	82.02%	75%	75%	78.95%	100%	72.09%	50%	58.33%	13.33%	76.9%
HV Contraception Education (Goal: 60%)	94.55%	81.82%	80%	60%	90%	100%	83.72%	14.29%	63.04%	30%	77.99%
					Child Development/School Readiness Indicators						
ASQ 3 Screen Rate (Goal: 50%)	80%	80%	N/A	0%	N/A	100%	88.89%	50%	37.5%	75%	72.55%
ASQ SE Screen Rate (Goal: 50%)	80%	86.67%	N/A	0%	N/A	100%	88.89%	50%	33.33%	50%	71.15%
					Home Safety & Family Resilience Indicators						
Home Safety Screen Rate (Goal: 70%)	85.71%	80%	100%	N/A	100%	100%	80%	N/A	50%	100%	80.56%
PFS Screen Rate (Goal: 70%)	100%	90.91%	100%	N/A	100%	100%	70%	100%	14.29%	100%	78.26%
WEB Screen Rate (Goal: 70%)	83.33%	82.35%	100%	N/A	75%	100%	83.33%	N/A	28.57%	100%	78.18%

QI Measure Comparisons over the last 3 Years

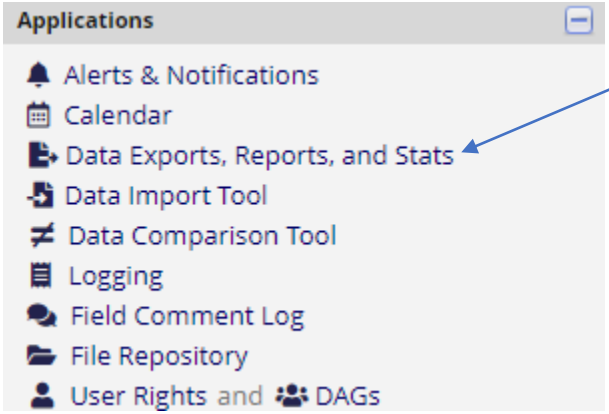
	5/1/16-4/30/17	5/1/17-4/30/18	5/1/18-4/30/19
Breast Feeding Avg (Goal: 6mo, 0 days)	7 mo, 1 days	9 mo, 11 days	9 mo, 11 days
Breast Feeding % (Goal: 50%)	51.71%	56.6%	58.71%
Child Healthcare Goal (Goal: 75%)	56.59%	89.38%	90.29%
Maternal Healthcare Goal (Goal: 70%)	4%	55.83%	76.71%
Well Child Visits (Goal: 50%)	30.73%	27.92%	41.14%
Home Visitor Attendance (Goal: 50%)	19.51%	20.64%	18.95%
Edinburgh Screens (Goal: 70%)	29.31%	54.93%	70.05%
HV Healthcare Education* (Goal: 70%)	N/A	72.83%	83.94%
HV Contraception Education* (Goal: 60%)	N/A	60.91%	83.21%
ASQ 3 Screen Rate* (Goal: 50%)	N/A	25.49%	64.75%
ASQ SE Screen Rate* (Goal: 50%)	N/A	39.85%	67.44%
Home Safety Screens (Goal: 70%)**	N/A	40.34%	70.92%
Protective Factors (Goal: 70%)**	N/A	39.06%	68.69%
WEB Screens (Goal: 70%)**	N/A	35.51%	64.06%

71% of our indicators were meeting the criteria for our goals in the 2018-2019 fiscal year!!!

Highlights

(comparing 17/18 to 18/19)

- Breastfeeding Average: same
- Breastfeeding Percentage: increase by 2.11%
- Child Healthcare Goal: increase by .91%
- **Maternal Health Care Goal: increase by 20.88%**
- Well Child Visits: increase by 13.22%
- Home Visitor Attendance: decrease of 1.69%
- Edinburgh Screens: increase by 15.12%
- HV Healthcare Education: increase by 11.11%
- **HV Contraception Education: increase by 22.3%**
- **ASQ 3 Screen Rate: increase by 39.26%**
- **ASQ SE Screen Rate: increase by 27.59%**
- **Home Safety Screens: increase by 30.58%**
- **Protective Factors Screens: increase by 29.63%**
- **WEB (IPV) Screens: increase by 28.55%**



Outcomes /Raw Data Analysis

If you have questions or need further clarification following this presentation, please contact Sommer Rose at sdrose@cmh.edu or (816) 234-3732