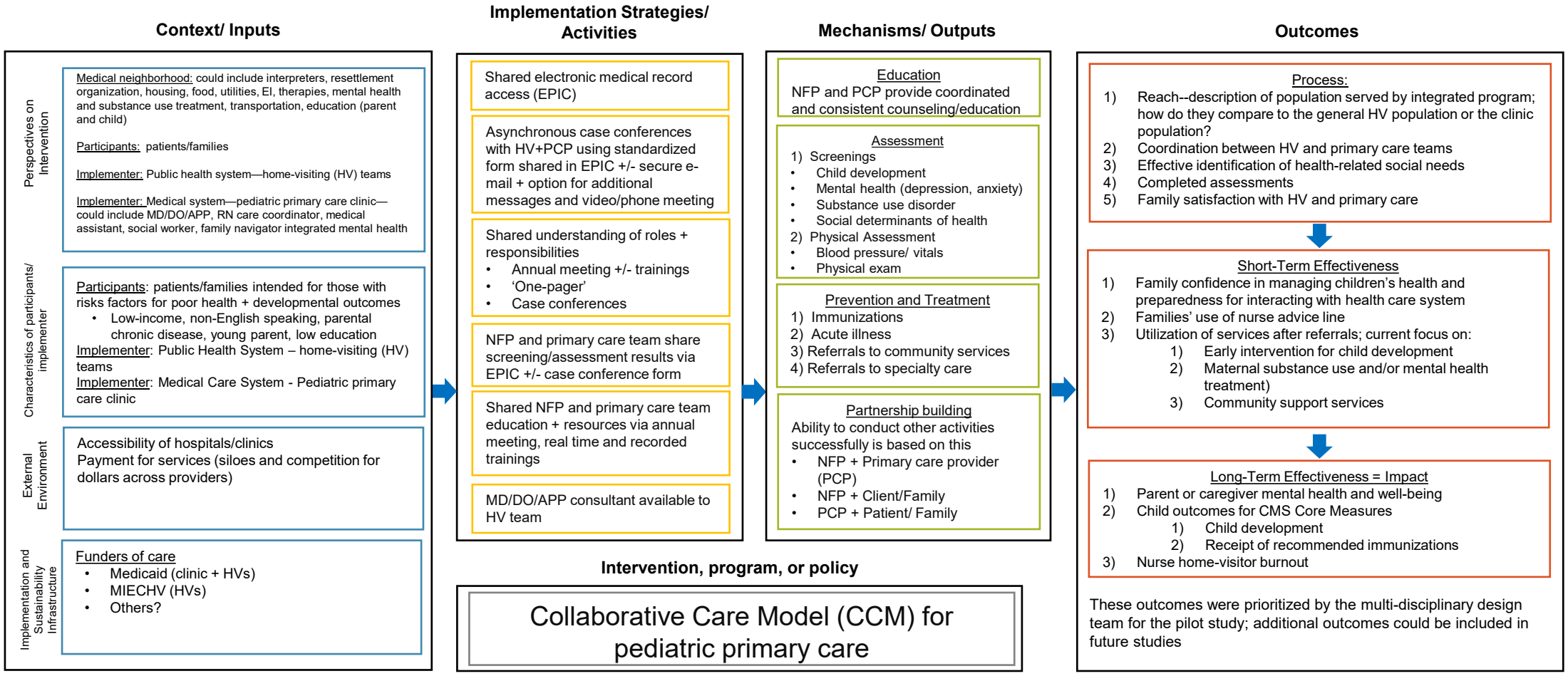
Context/ Inputs
Implementation Strategies/ Activities
Mechanisms/ Outputs
Outcomes
Perspectives on Intervention
Medical neighborhood: could include interpreters, resettlement organization, housing, food, utilities, EI, therapies, mental health and substance use treatment, transportation, education (parent and child)
Participants: patients/families
Implementer: Public health system—home-visiting (HV) teams
Implementer: Medical system—pediatric primary care clinic—could include MD/DO/APP, RN care coordinator, medical assistant, social worker, family navigator integrated mental health
Characteristics of participants/ implementer
Participants: patients/families intended for those with risks factors for poor health + developmental outcomes
Low-income, non-English speaking, parental chronic disease, young parent, low education
Implementer: Public Health System – home-visiting (HV) teams
Implementer: Medical Care System - Pediatric primary care clinic
External Environment
Accessibility of hospitals/clinics
Payment for services (siloes and competition for dollars across providers)
Implementation and Sustainability Infrastructure
Funders of care
Medicaid (clinic + HVs)
MIECHV (HVs)
Others?
Shared electronic medical record access (EPIC)
Asynchronous case conferences with HV+PCP using standardized form shared in EPIC +/- secure e-mail + option for additional messages and video/phone meeting
Shared understanding of roles + responsibilities
Annual meeting +/- trainings
'One-pager'
Case conferences
NFP and primary care team share screening/assessment results via EPIC +/- case conference form
Shared NFP and primary care team education + resources via annual meeting, real time and recorded trainings
MD/DO/APP consultant available to HV team
Education
NFP and PCP provide coordinated and consistent counseling/education
Assessment
1) Screenings
Child development
Mental health (depression, anxiety)
Substance use disorder
Social determinants of health
2) Physical Assessment
Blood pressure/ vitals
Physical exam
Prevention and Treatment
1) Immunizations
2) Acute illness
3) Referrals to community services
4) Referrals to specialty care
Partnership building
Ability to conduct other activities successfully is based on this
NFP + Primary care provider (PCP)
NFP + Client/Family
PCP + Patient/ Family
Process:
1) Reach--description of population served by integrated program; how do they compare to the general HV population or the clinic population?
2) Coordination between HV and primary care teams
3) Effective identification of health-related social needs
4) Completed assessments
5) Family satisfaction with HV and primary care
Short-Term Effectiveness
1) Family confidence in managing children's health and preparedness for interacting with health care system
2) Families' use of nurse advice line
3) Utilization of services after referrals; current focus on:
1) Early intervention for child development
2) Maternal substance use and/or mental health treatment)
3) Community support services
Long-Term Effectiveness = Impact
1) Parent or caregiver mental health and well-being
2) Child outcomes for CMS Core Measures
1) Child development
2) Receipt of recommended immunizations
3) Nurse home-visitor burnout
These outcomes were prioritized by the multi-disciplinary design team for the pilot study; additional outcomes could be included in future studies
Intervention, program, or policy
Collaborative Care Model (CCM) for pediatric primary care