Recommendations For the Expansion of Help Me Grow 2016

The purpose of the recommendations is to inform the development of an implementation plan to expand Minnesota's Help Me Grow (HMG) system. These final recommendations are a reflection of the work conducted by the four Minnesota Help Me Grow work groups (Centralized Access, Health Care Provider Outreach, Community and Family Outreach, and Data), the leadership team, tribal consultation, and the national Help Me Grow technical assistance center. For any background information regarding these recommendations please contact Kelly Monson, Children's Cabinet Program Manager at Kelly.monson@state.mn.us or call 651-201-3405.

Centralized Access

Who is served by the Centralized Access Point (CAP)?

A1. All families of children prenatal to 8 years of age in Minnesota.

A2. All professionals, paraprofessionals, etc. serving those families.

A3. Minnesota will use a Targeted Universalism[1] approach: While the HMG system in Minnesota will provide universal access to the populations listed above, it will also be designed to serve the most vulnerable, in-risk and at-risk families with young children who may need extra support connecting to services.

Access

A4. Families and providers will have *multiple ways to connect* with the CAP: web, phone, mobile/app-based, text and chat, in-person (local connections). The CAP will partner with existing community agencies and providers to optimize outreach and in-person linkages.

A5. Use the existing HMG phone that is currently housed at the Department of Education and transfer it to the expanded centralized access entity once established. This number should have statewide reach and have the capability to route locally.

A6. Process to access CAP must be easy, with as few steps as possible, for families and professionals.

A7. Include evening and weekend hours.

A8. If web-based, provide American Indian specific connections through a drop-down menu like the MNSURE website provides.

Infrastructure

A9. Issue a Request for Proposal (RFP) for an established entity to partner with the State of Minnesota to provide a centralized access point with statewide reach.

A10. The statewide phone number and website should connect to local/regional networks and services.

A11. Centralized Access Point should have accreditation standards to high quality experiences and customer service

A12. Have clear written policies and procedures for data base management, intake, assessment, referral and follow-up processes and must include a definition of care coordination services

[1] National Equity Project. "Targeted Universalism". June 22, 2011. Accessed on July 6, 2015, http://blog.nationalequityproject.org/2011/06/22/targeted-universalism/

A13. Local and regional networks will work with the CAP to update local resources and services into a searchable statewide database. If possible, this database should connect to or use existing databases that have been developed.

A14. Professionals and parents should be able to access resource information based on their or the family's specific needs. Care coordination should be offered based on the varying needs of consumers.

A15. The CAP is one mechanism, yet not the only mechanism for families and professionals to make or receive referrals. Self, professional and community referrals are also an option.

Staffing

A16. Staff must meet minimum educational and professional qualifications. This includes knowledge of child development; and/or supervision by qualified staff. It is important that staffing qualifications allow flexibility in training, mentoring and supervision to meet community needs).

A17. Staff must complete and participate in ongoing training to carry out intake/assessment, referral, and coordination services.

A18. Staff must be well-paid and well-supported through ongoing reflective supervision.

Intake and Coordination Services

A19. HMG links all families and professionals to existing services that support healthy child development.

A20. CAP provides the infrastructure for information sharing, referral to services, and limited care coordination activities.

A21. CAP will include a searchable statewide database for care coordinators and staff, families and professionals to use.

A22. The Centralized Access Point staff should have the capacity to make referral to a comprehensive array of services that support the family and child through a multi-generational approach (refer to Orange County list).

A23. The Centralized Access Point staff should assign a 'case number" so follow-up can occur, A "case number" will enable a search feature so that a family or case coordinator can track service history.

A24. Services provided may include:

- a family assessment to determine the most appropriate referrals to make,
- inventory of current services family is already receiving,
- active referrals and warm hand-offs,
- and follow-up.

A25. Services may include a plan for offering developmental, social-emotional and risk assessment screening for young children at some point in the future.

A26. If a release of information is in place, information about result of referrals can be shared with CAP staff and the child's primary care or other early learning or early childhood provider.

A27. HMG coordination of services does not replace care coordination services offered through health care homes/primary care and other county and school district providers.

Other Recommendations

A28. HMG needs to identify the agency or organization that will lead marketing, messaging, and branding.

A29. HMG should be implemented concurrently and statewide. It is not recommended that HMG be implemented incrementally.

A30. The data system should identify *gaps in services and barriers to accessing services*, which will inform the CAP.

A31. HMG should use a Quality Improvement Framework: Data should be used to inform system improvement.

Healthcare Provider Outreach

Target audiences

B1. Primary audiences for outreach:

a. Primary care clinics serving children, including Tribal clinics and Indian Health Services
b. Primary care providers (physicians, nurse practitioners, physician assistants), clinic administrators, and other clinic staff (nursing staff, care coordinators, interpreters)
c. Healthcare training programs
d. Providers of pre-and post-natal care

B2. Providers working with children and families with greater need but less access to primary care:

a. Organizations and staff who work with: homeless and highly mobile, foster care, domestic violence shelters, refugees, immigrants, undocumented workers, children with incarcerated parents, children living in health care provider shortage areas, and others
b. Mental health and chemical dependency providers who work with parents of young children
c. Urgent Care and Emergency Departments
d. Public health nurses.

B3. Secondary Audience: Other healthcare providers who work with young children outside the primary care setting:

a. Medical specialists who diagnose and treat developmental or behavioral concerns
b. Other health providers that work with young children and families (dentists, community health workers, occupational therapists, physical therapists, speech therapists, others).

Methods of outreach

B4. Partner with organizations that provide outreach, training or other support to healthcare providers:

a. State professional academies to seek endorsement, identify healthcare provider champions, and formalize their regional and statewide role (Such as the Minnesota Academies of the American Academy of Pediatrics, Family Medicine, Nurse Practitioners, and Physician Assistants)
b. Higher education institutions to reach healthcare professionals before they enter practice
c. State Medicaid and health insurance plans and the Minnesota Council of Health Plans for training, outreach, and coding/billing/reimbursement assistance
d. State and local departments of health, human services and education for use and development of training materials (much of which already exists).

B5. Healthcare provider outreach should build on existing state, regional and local infrastructure such as: Child and Teen Checkups (C&TC), the Interagency Early Intervention Committees (IEIC), Head Start/Early Head Start, Minnesota Initiative Foundations (MIF), Early Childhood Initiatives (ECI), Minnesota Organization on Fetal Alcohol Syndrome, Oral health zone, Reach Out and Read, Early Childhood Mental Health system, and State Health Improvement Program (SHIP).

B6. Work with health systems and clinic networks to spread information about HMG using existing infrastructures (electronic health record, marketing, health system leadership).

B7. Utilize existing connections to health care providers such as Health Care Home, Reach Out and Read, Accountable Communities for Health, and clinical quality collaboratives.

B8. Conduct a widespread, statewide marketing campaign in multiple formats that will reach both providers and families simultaneously with aligned messaging.

B9. Include healthcare provider tab on the HMG website that includes a “toolbox” of early childhood resources, links to request training or technical assistance, or a downloadable icon or app.

B10. Identify Healthcare Provider Champions to help spread the word through peer to peer learning and direct training. As capacity allows, these champions can help to “open the door” and endorse non-clinician HMG messengers as knowledgeable, credible, and resourceful.

a. Engage and formalize roles of healthcare provider champions at the state (professional academies), regional (healthcare system) and local (clinic) levels.
b. Engage healthcare champions within Tribal health clinics, Federally Qualified Health Centers, and other settings to more effectively reach children at higher risk for health inequities.

Training methods

B12. When possible, HMG training strategies should help meet healthcare providers’ requirements for continuing education credits, Maintenance of Certification (MOC), quality improvement, cultural and linguistic competency, and established national or state clinical measures.

B13. In-person regional training strategies may include: Co-sponsored trainings with a health system; state, regional and local meetings and conferences; and others.

B14. Provide web-based training opportunities such as e-learning modules or webinars (recorded, brief web-based modules with enduring continuing medical education are most likely to be used).

B15. Provide HMG training materials (PowerPoint slides, talking points, and brochures) to organizations already conducting outreach to healthcare providers.

B16. Individuals providing HMG outreach to healthcare providers should be knowledgeable about services and benefits, and clinic flow and processes, and developmental and social-emotional surveillance. They also should be from a credible organization and ideally represent the diversity of the population being served.

Training messages

B17. Educate providers about the Help Me Grow (HMG) system's purpose and capabilities, including:

a. A clear understanding of what will happen after referral of a family to HMG, and the quality of the services available.
b. HMG offers a reliable mechanism to ensure their children and families receive referrals and connections to an array of quality community programs and services outside of the healthcare system that support healthy development.
c. HMG will support and promote well child preventive care for every family.
d. HMG offers a connection to services that already exist in the community and is not the direct provider of those services.
e. HMG provides a referral process that is easy, understandable, integrated with the electronic Health Record to the degree possible and reliable for providers and families.
f. HMG offers ways for providers to meet state and national clinic measures, improve quality of care and outcomes, and meet continuing education and MOC requirements.

B18. Provide information about developmental and social-emotional surveillance, screening and referral. Key messages include:

a. Promotion of developmental and social-emotional surveillance and screening, referral and follow-through - in the context of family, community and culture.
b. Recognition of the impact of oral health, hearing, vision, sleep, nutrition, basic needs, family mental health, and health inequities on child development.
c. *Early referral* to the HMG system is a way for providers and families to proactively access resources and services, and to identify next steps for *all levels* of developmental and social-emotional concerns.

B19. Emphasize the system's commitment to reciprocal communication and decision-making with healthcare providers and families. Key messages include:

a. HMG will ensure children are referred back to their primary care provider for medical evaluation when appropriate, regardless of referral source.
b. HMG will respect the trusted relationship between healthcare providers and families and work collaboratively with and through that relationship.
c. HMG will communicate, with parent permission, what referrals are made to other service providers, along with the information necessary to follow-up with that service provider
d. HMG will communicate, with parent permission, the outcome of their referral to the Help Me Grow system, whether the child was connected to services, or whether gaps or barriers existed.

Evaluation

B20. Establish baseline measures (with existing state data), to help track improvements made via the HMG System.

B21. Establish process and outcome evaluation measures, such as:

a. Numbers reached through outreach efforts, how and by whom.
b. Pre- and post-training surveys to measure satisfaction, knowledge and change in practice.
c. Healthcare provider surveys assessing the use of HMG and satisfaction with services and follow-up communication.
d. Local outreach staff evaluation of support from professional academies, healthcare champions, and others.
e. Use of the HMG training curriculum for local outreach, such as number of hits, downloads, or assessment via survey.
f. Assessment of how families heard about HMG via the HMG intake process.
g. Family survey to assess satisfaction with HMG system and referred services.
h. Increase in statewide standardized developmental and social-emotional screening rates.
i. Increase in referrals to HMG.
j. Increase in referrals (through HMG) to services that support healthy development.
k. Track population demographics and characteristics to assess who is being reached and who is missing, including racial/cultural/ethnic groups, refugees, immigrants, families experiencing poverty or homelessness, children of incarcerated parents, and children in foster care.
l. Conduct cost-benefit analysis of the de-medicalization of childhood developmental and behavioral concerns (when appropriate).

Community and Family Outreach

Staffing

C1. A HMG Liaison position be established at the state level and connected to the centralized access point to:

a. Coordinate work at the regional and local level
b. Assist in organizing data
c. Manage and coordinate existing resource identification
d. Manage and coordinate outreach efforts
e. Create, enhance and maintain an effective feedback loop between state, regional and local resources

Marketing

C2. Develop marketing and outreach plan for the expanded Help Me Grow system that will:

a. Communicate with families (particularly those with the greatest need and least access), including:
    - Child development info
    - Why HMG? Easy access & one point of entry that meets a family's specific needs in a culturally, sensitive matter

- How does it work? Online, in person or phone number
- What information do I need to share to get started?
- What resources and information will be available to me?

b. Communicate with community Members:
- Child development info
- Why? Easy access & one point of entry that meets a family's specific needs in a culturally, sensitive matter
- How? To connect families
- How? To be included or update their services
- What? How to do a family referral, how to do outreach to the family, and what information to provide to the central intake database.

c. Communicate with service agencies or providers:
- Child Development info
- Why? Easy access & one point of entry that meets a family's specific needs in a culturally, sensitive matter
- How? To connect families
- How? To be included or update their services
- What is the role in the HMG Minnesota System?
- What is the benefit to their children and families to be included?

Family Engagement

C3. Establish a formal and resourced process to engage parents. This process encourages parent leadership opportunities, to gather parent input on how to better meet the needs of children ages prenatal to age 8.

C4. Track and monitor pertinent HMG data and return on investment within the system.

a. HMG needs to demonstrate that it is effectively reaching families, community members, and providers.
b. HMG needs to demonstrate that it is making a difference in lives of children and their families, ages prenatal to 8 years.

Data System

D1. Use/purchase the Star Data System that was developed by another HMG affiliate state.

D2. Collect enough data to ensure that we can identify what disparities exist for access to the HMG system (specifically, data on income, race/ethnicity, language status, geography, and maternal education).

D3. Include assessment of family conditions that we know impact child development if they go unaddressed.

D4. Find the balance between the need for information to know if HMG system is working and asking so much that we actually push away families needing help and professionals making referrals. To this end, we recommend that the intake process:

a. Use an open interview process (i.e. ask more open-ended questions and then specific follow up questions as needed) to collect data as this is more family-friendly.

b. Either learn from the intake processes already developed by other HMG affiliates or pilot the interview process with parents and referral sources to help identify where the balance is between collecting "enough" information and being intrusive/burdensome to parents/families.

D5. Enter screening data when available from providers/families and eventually include developmental screenings into the intake process.

D6. Create a system in which families provide information once. This will ensure that families don't have to give the same information over and over again. Request consent from families to share intake and referral information (and eventually screening data) with:

a. Primary care providers (including contact information for who referrals were made to);
b. Referral sources (including who referrals were made to);
c. And programs that children and families are referred to in order to create efficiencies in intake for the families.

D7. Reconnect with families to determine if services were received and whether they met the needs of the children and families. Identify gaps and barriers to receiving services.

D8. Referral process should connect with electronic health records of primary care systems to make referral processes easy and effective for primary care providers.

D9. Build the data system to allow for eventual connections with other systems that may provide population and child-level outcome data such as the Social Services Information System and the Minnesota Automated Reporting Student System, the Early Childhood Longitudinal Data System (as examples).

D10. Establish a plan for a continuous quality improvement process.

Tribal Specific Recommendations

E1. Include a tribal drop down option similar to the MNSure website on the Help Me Grow website for American Indian specific connections.

E2. Intake staff should be specifically trained for working with American Indian populations.

E3. HMG staff should include an American Indian liaison.

E4. Assign a "Case number" so that follow up can occur (search feature) with same case worker, or that a different provider is able to access the information.

Additional Recommendations from Leadership Team

F1. Establish HMG in statute along with a plan to secure state funding for HMG sustainability as well as pursue opportunities to braid/blend funding for greater sustainability. Such as:

a. Part C
b. Health plans
c. Medicaid administrative funds

d. Foundations- big and small
e. Title 5
f. Part B
g. Corporations
h. Minnesota Initiative foundations
i. State agency dollars
j. Children's Trust Fund
k. MDC fee
l. Any service provider that invests resources in reaching their desired population
m. Other corporations – good press for them to invest
n. Fiscal note and new state funding to do this
o. Judicial system and crime prevention activity
p. Department of Employment and Economic Development – future workforce

F2. Current HMG features that are working well should be maintained and integrated into expansion.

F3. The leadership team could serve as steering and advisory group for implementation/continuous quality improvement process.

F4. Continue to have the Minnesota Children's Cabinet provide project management across MDE, DHS and MDH.