



Site Team Aim Statements

Atlanta (updated Jan. 2017)

The goal of the Strong4Life Provider Co-Op (Care Collaboration for Obesity Prevention) program is to increase the efficiency and effectiveness of the healthy lifestyle counseling provided to high-risk children and their families. The purpose of this pilot project is to test the feasibility, acceptability and impact of a model to improve communication and collaboration between children's care providers, specifically WIC nutritionists and primary health care providers (PCPs).

- Pilot and test (Health-E-Goal system) a web based communication process for sharing behavior change goals set at the WIC clinic with Physician's office.
- Test the *feasibility and usefulness* of this type of information sharing between care providers
 - **80%** of participating PCPs and WIC nutritionists will utilize, or report their intention to utilize, the electronic data sharing (Health-e-Goal system) to improve patient care.
 - **80%** of participating PCPs and WIC nutritionists/CPAs will report on the usefulness of the electronic data sharing system (Health-e-Goal) and perceived benefit to their patients/clients.
- Increase physicians' knowledge about WIC and increase referrals to WIC clinic.
 - Participating PCPs will increase their referrals to WIC by **50%**.

Boston (updated Jan. 2017)

OUR GOAL:

To implement comprehensive pediatric asthma population health programs in community health centers to address social, environmental, and medical risks by connecting children and families with clinical and community resources.

OBJECTIVES:

- Build an "enhanced registry" i.e. we will build on/ improve their current registry systems/list of asthma patients.
- Use continuous quality improvement strategies (PDSA cycles) to implement changes in clinic workflows and sustain skills developed in this work
- Engage with care coordination and management systems in CHCs to better understand and link community partnerships to address families' social needs
- Identify specific community partners that will provide follow up data to ensure patients receive services following referral

Plans to achieve Aim

- Strengthening our functioning as a team:
 - Increase communication between CHC partners and convene in-person meetings/learning sessions for CHCs facilitated by BCH primary care asthma action team.
- Improving the quality and quantity of our data:
 - Increase asthma population tracking through full registry development
 - Develop relationships with cross-sector partners share data about services provided and future service needs of families



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- Enhancing our improvement and change management skills:
 - Continue exploring systems that keep the family/patient driving the care plans and leveraging supports from across the primary care team
 - Develop clinic systems that track referral and outcomes to community partners and link to registry development work

Central Coast (updated Jan. 2017)

Global Aim: Improve patient and community health outcomes by assessing individual needs and empowering families through intervention, information, and integrated services that address behavioral, legal, and financial factors.

Specific Aim: Design and prototype care for children ages 0-5 years old and their families based on identified financial, legal, or behavioral risk needs.

Cincinnati (updated Oct. 2016)

- Increase the % of families screened and stratified for risk related to social determinants of health at well-child visits under age 5* and offered care bundles associated with their level of risk with options for referral to an on-site Parent Coach and/or off-site community services by January 31, 2017
- Target – 95% of eligible families* screened and stratified for risk

Columbus (updated Jan. 2017)

Greater than 75% of children ages 3 to 10 years living in the Healthy Neighborhoods Healthy Families zone and receiving services from two or more partners will be compliant with well-child checks.

Greater than 90% of children ages 9 months to 10 years living in the Healthy Neighborhoods Healthy Families zone and receiving services from two or more partners will be enrolled in an age appropriate literacy intervention.



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Dallas (updated Oct. 2016)

AIM: To provide a coordinated bundle of care through partnership with Children's Health Pediatric Group Clinic's (CHPG), the Promotora Asthma Management Program, and local service agencies

Why?: Families in west Dallas are disproportionately affected with asthma and our CHPG clinic, Promotora's and community partner can assist in addressing a majority of the social determinants of health affecting our families.

Measures:

- To establish a baseline of family well-being plans that will be put into practice by family and partners
- Family well-being plans will have at least three components that families and partners will work toward addressing
- Increase number of services families are using with community partner
- Increase number of families who report positive experiences with well-being plan

Promotora's will be key to the success of home education, monitoring families connection with community partner to improve well-being and working with families to improve well-being

Harlem (updated Jan. 2017)

The NYP-Columbia University Medical Center (NYP-CUMC), in collaboration with Northern Manhattan Perinatal Project:

- Will focus on the child behavior and maternal depression aspects of our social determinants screen

Our goals are to:

- Continue to screen ~ **75%** of children and their families with the Survey of Well Being of Young Children
- Assign risk levels to **50%** of families screened (NOTE: We could potentially use the families who are co-managed with NMPP as the denominator, but by definition, those are Level 2-3 families and we would also like to create bundles of care for Level 1 families. See below)

We will achieve this by:

- Creating (and piloting) a stepped (levels 1 – 3) parenting bundle for families of children 0 – 5 years, and a parenting curriculum for the pediatric resident trainees at the Charles Rangel Community Health Center
- Creating (and piloting) a stepped (levels 1 – 3) maternal health bundle, which will include coaching for Level 1 mothers who report risk for depression on the SWYC, (or otherwise) and referrals to NMPP for Level 2 – 3 mothers.
- Hiring a Community health worker to help accomplish these goals with our families



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East Palo Alto (updated Oct. 2016)

Intends to:

- Pilot a version of peer group coaching (for 5-6 families of 2 year olds) and parent-child centering playgroups (for 5-6 families of 0-1 yr olds).
- Understand needs and structuring of possible services bundles for families in the coaching / playgroup pilots
- Develop a shared vision, strategy and timeline for rolling out a continuous, group-based model of support for parents - starting prenatally and lasting throughout the child's experience in school. This strategy will include protocols for offering coaching support for families that are shared across organizations as well as families that are not shared.

By: 1/31/17 for: Families with children 0-3 in the East Palo Alto and East Menlo Park (Belle Haven) communities who are eligible for services from any of the partnering agencies, but who are currently not connected to those services.

Because: We believe that by working together, we can achieve a world where all children and families own their own life outcomes that include health and education outcomes, receive life coaching support centered around their particular needs, and are ready to succeed in school, health and life.

Long Beach (updated Jan. 2017)

By October 2017, The Children's Clinic and its' agency partners will decrease the number of patients/families experiencing food insecurity by addressing food access concerns of at least 25 patients/families (n~25) receiving services or resources by agency partners.

By January 2018, The Children's Clinic and its' agency partners will incorporate food access strategies to address social isolation of patients/families receiving services or resources by agency partners.

OBJECTIVES

1. Screen a minimum of 25 patients and their families experiencing food insecurity.
2. Assign asset/risk levels to 100% of patients and their families.
3. Provide a service or refer 80% of those patients and their families.

Milwaukee (updated Jan. 2017)

Improved integration, utilization, and coordination of medical, early childhood education, and social needs specifically, by:

- By December 2017, to increase the percentage of families referred (from early education center and primary care) to the CHW's community health navigator for co-management.
- By December 2017, increase the percentage of families who attain both the compliance goals and a minimum of one family-identified goal.
- By December 2017, establish bi-monthly co-management meetings and identify (technology-supported) processes to communicate patient/family updates to all care providers.



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Yonkers (updated Oct. 2016)

Aim to: Screen all children and adolescents for Adverse Childhood Experiences (ACEs) and resilience; transform the current health care model by offering community-centered integrated primary medical and behavioral health services.

What we will accomplish by January 2017: Becoming a fully integrated trauma informed health center by including all providers at the site.