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Practice Summary & Implementation Guidance

Family, Youth and Community Engagement in all MCH/CYSHCN Programs using the Community

This practice outlines an annual process for local programs, that receive Title V funding, to assess their engagement with family, youth and community members, and provides a method to enhance their practice of engagement throughout the year.

Cutting-Edge | **Emerging** | Promising | Best

Location	Topic Area	Setting
Wisconsin	Family/Youth Engagement	Community

Population Focus	NPM	Date Added
Cross-Cutting/Systems Building	N/A.	October 2020

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Section 1: Practice Summary

PRACTICE DESCRIPTION

Evidence from AMCHP's 2016 Family Engagement study identified several benefits of family engagement. Ninety-four percent of MCH programs found that family engagement increased awareness and understanding of family issues and needs. In addition, 75% of CYSHCN programs found that family engagement improved planning and policies resulting in services more directly responsive to family needs.

This practice outlines an annual process for local programs, that receive Title V funding, to assess their engagement with family, youth and community members, and provides a method to enhance their practice of engagement throughout the year. This annual process repeats so programs can continue to improve their engagement over time.

The Community Engagement Assessment Tool (CEAT) is a health equity strategy which can be used in all Maternal and Child Health Programs focused on Women/Maternal, Perinatal/Infant, Child, Adolescent, and Children and Youth with Special Health Care Needs. The tool guides MCH-funded programs to implement practice changes to enhance family, youth and community engagement. This tool specifically aligns with the Foundational Practices for Health Equity tool that was developed as part of the Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality.

CORE COMPONENTS & PRACTICE ACTIVITES

The annual process for local MCH-funded programs implementing the project is to:

- Complete the Community Engagement Assessment Tool (CEAT) with representatives from the population they serve.
- Develop an action plan focusing on one indicator from the CEAT.
- Implement the action plan to support at least one practice change to enhance family, youth and community engagement.

The CEAT includes 14 indicators across six components of engagement, as identified in the table below. Please see the complete version of the tool in Appendix A, the simplified version in Appendix B and our driver diagram in Appendix C.

Core Components & Practice Activities

Core Component	Activities	Operational Details
Family, Youth and Community Partnership		
Respectful, Trusting Relationships Between Staff and the People They Serve	Build relationships	Agencies train program staff members to develop trusting relationships with the people they serve. There is a clear plan and efforts to improve access to services and overcome anything that gets in the way.
Family, Youth and Community Members Working in a Cooperative Way and Having Shared Goals	Build trust and work collaboratively	Programs embed engagement so that those they serve are a vital part of the program's success. The program works to identify and use the strengths of community members. It designs programming to meet the needs of its community. The program schedules opportunities at times that work for community members. The program teaches those they serve how to look for and use services that best fit their strengths, needs and cultures.
A Commitment to Social Support Systems Within the Program and Larger Community	Build community networks	Programs build networks of opportunities within the community they serve. Working with community members, programs design services that work for the community. Program staff members are present in the community. Program staff members identify local champions to help make change in their own programs.
Culture of Inclusion and Equity		
A Commitment to Health Equity	Value and promote health equity	Program staff members understand that social and economic conditions impact health. Program staff members receive training on Adverse Childhood Experiences and Trauma Informed Care. Program staff member's interactions with the people they serve are respectful and thoughtful. Policies and practices reflect this commitment. Program staff members respect the breadth of cultures which include, but are not limited to, race, ethnicity, sexual preference, and ability.
Program Environment		

Cultural and Language-Based Responsiveness	Respond to cultural characteristics	The program's activities and services respond to the cultural characteristics represented in the people they serve. Community members take part in making sure written and visual materials are appropriate and effective.
A System of Regular Communication with Families, Youth and Communities	Maintain open communication	The program maintains open communication with the population they serve. Communications are regular, frequent, clear and positive. Programs encourage open communication and help develop an exchange of ideas.
A Welcoming and Inviting Setting	Design space that reflects the values of the community served	Programs design their environments, both physical and online, with input from community members. They focus on the strengths and successes of the community. Their spaces reflect the languages and cultures of the people they serve.
Program Leadership		
Family, Youth and Community Engagement as a Shared Priority	Value engagement	Agencies make sure that all program staff members share the value of engagement. This value is clear in all written and verbal communications. The leadership of the program leads by example. Decisions about the use of program resources increases engagement.
Increasing Success in Engaging Families, Youth and Communities	Commit to engagement	Program leaders, managers, and staff members have a solid commitment to engagement with the people they serve. They set policies and goals that support engagement with all aspects of work. The program uses resources to support those who are giving their personal lived experience and knowledge to benefit the program.
Group Decision-Making	Support partnership with community members	Programs have systems in place that support partnership with the people they serve. People served by the program take part in making decisions that affect the program as a whole. The program is open and honest about their needs and concerns. Recommendations from community members and partners are fully considered.

Support for Developing New Skills	Improve community member leadership skills	Programs improve the leadership abilities of the people they serve through training, coaching, and teaching. They offer opportunities to learn and practice advocacy on issues of importance. Programs invite the people they serve to co-lead support groups or training sessions with program staff.
Professional Development		
High-Quality Training for All Staff	Train staff	Agencies train program staff on topics such as engagement, racial equity, and diversity. The program invites community members to join in these training events. They further improve learning by holding discussions with everyone's input.
Career Pathways and Leadership Opportunities	Build bridge from community member to agency staff	Programs collaborate with family, youth, and community members to learn from shared knowledge. Programs invite people to shadow program activities. Community members take part in the hiring process and help make the hiring decision. Programs encourage community members to apply for open positions. Program staff members reflect the diversity of the people served.
Continuous Improvement		
Data About Engagement Efforts and Results Driving Decision-Making	Date drives decisions	Program staff members partner with family, youth and community members to decide what data is important. They also discuss how to collect data, how to use data to make program decisions, and how to share results with the community. Data collected by the program includes engagement success and impact.

HEALTH EQUITY

The daunting issues related to health equity can only be addressed when authentic relationships with the people being served are fostered and valued by the organizations doing the work. If we maintain a system of doing work 'for' people, rather than 'with' people, the disparities will continue to dominate. Once our programs break down the barriers between programs and the people they serve, we can begin real and honest dialogs concerning the needs of the people we serve. Only by creating

relationships that lead to partnerships with the people being served can we identify and build a sustainable system of support that addresses the real challenges and barriers inherent in SDoH. By making this paradigm shift, and receiving the necessary support for success, our local programs can begin to address SDoH and have real impact on the lives of all of our citizens throughout the state.

EVIDENCE OF EFFECTIVENESS

While this program is only in its second pilot year, we have seen some promising evaluation results. Our aim is to have programs that complete the assessment indicate that they are making progress or have embedded the concepts of engagement in 75% of at least three of the 14 indicators. Currently we are at 69%.

Our first process measure is the percent of programs that have a total score (sum of all indicators) greater than 35. Our goal is 75% and after our second year, our results are at 88%. Our second process measure is the percent of programs that self-assess overall work in the categories of Discuss, Involve or Partner. Our goal is 60% and after our second year, our results are at 50% (a marked increase over our first year data that was 14%). Our balancing measure tracks the unintended negative consequence of MCH professionals believing that family, youth, and community engagement did not complement their other MCH contracted activities. Our goals were no more than 20% and our latest data was a result of 8%.

Section 2: Implementation Guidance

STAKEHOLDER EMPOWERMENT & COLLABORATION

We identified the following stakeholders to provide lived experience feedback and direction:

- Local Programs supporting Title V National Performance Measures/State Performance Measures
- MCH Advisory Committee
- Family, youth, and community members in pilots

Since piloting this project in 2019, we have held quarterly learning communities with all of the programs involved in the project and received their candid experience and feedback having used our tools and methods. We also held individual interviews with each partner in the first-year pilot. This past summer, our MCH interns conducted key informant interviews with the community members involved in the first-year pilot program to learn about the lasting impact of this work.

We sought out these stakeholders to provide their expertise, resources and infrastructure, which aligned directly with our project.

- UW Center for Patient Partnership
- UW Population Health Institute
- MCHB—Division of Workforce Development
- The Evidence Center
- MCH Navigator
- MCH Workforce Development Center
- MCH Advocacy Organizations

The staff from the UW Center for Patient Partnership and UW Population Health Institute were able to offer a review of our approach with recommendations. The national stakeholders reviewed our work and provided comments, suggestions, resources and infrastructure.

REPLICATION

This practice has not yet been replicated.

INTERNAL CAPACITY

We formed a team that was responsible for developing and implementing this project. On this team we included representation from our MCH program, CYSHCN program, Adolescent Health program, and our Family to Family Health Information Center along with our MCH Health Equity Coordinator and Quality Improvement Director. This team contained diverse perspectives that helped ensure that the project could be implemented in a variety of local settings. As the project expanded, so has this team. We now include representation from each program involved in the project to ensure common messaging and understanding. Our implementation team members met at least monthly and had very dynamic, challenging and robust discussions. We challenged each other to push our thoughts and processes further than any of us individually imagined we would. This team participated in all decision making throughout the process. We had our Quality Improvement Director on this team to monitor our measures and challenge us to create change activities throughout the process.

In addition to the implementation team, we had a state team that met periodically for support and endorsement. That team included our epidemiologist, MCH Director, and CYSHCN Medical Director. The oversight state senior leadership team added perspectives that we did not have on our implementation team. They were able to challenge or support our designs and provided large-scale feedback on our plans for implementation. This team met every 2-3 months.

As we continue to spread the project to more local programs, we considered developing a position for a project coordinator. Since funding was not available for this, we reframed our infrastructure and required more people to take on smaller portions of the project for its ongoing success. We continue to have two leads who oversee all of the work and serve as subject matter experts for new members who join the effort.

The most important element of support we had and needed was the backing of our efforts from leadership within our MCH/CYSHCN programs. With their support, we could insert this work as a standing objective in program's work plans to ensure the attention to this effort.

PRACTICE TIMELINE

Phase: Planning/Pre-Implementation		
Activity Description	**Time Needed**	**Responsible Party**
Tools: Review the Community Engagement Assessment Tool and driver diagram. Produce an electronic version of the assessment to support community feedback designed such that a program has a link to give to community members and the program can see those responses (e.g., Survey Gizmo).	Year 1: Q1-Q2 24 hours	Implementation team IT department
Participants: Recruit/identify participating agencies/partners; Start small with a few sites across MCH program areas or focus on 1 program area (i.e., CYSHCN or adolescent health)	Year 1: Q4 24 hours	Implementation team
Support: Build a website for the project; Establish a Learning Community that convenes project participants.	Year 1: Q3 40 hours	Implementation team IT department
Data: Established measures. Identify or develop a database to document assessment entries and practice changes (e.g., REDCap).	Year 1: Q2-Q3 40 hours	Quality Improvement Director

		IT department

Phase: Implementation

Activity Description	Time Needed	Responsible Party
Tools: Provide an overview of the assessment tool and project to participants via in-person training or distance learning.	Year 2: Q1 4 hours planning 2 hour presentation	Implementation team Participating agencies/partners
Participants: Integrate project activities into work plans/objectives with participating agencies/partners.	Either Year 1: Q3/4 or Year 2: Q1 4 hours	Participating agencies/partners
Support: Assure project materials are available on the website. Provide individual technical assistance as needed. Convene Learning Community sessions to support participants to share strategies and learn from each other.	Year 2: Q1-Q4 Quarterly Learning Communities 4 hours/month Learning Community:4 hours planning; 2 hour presentation	Implementation team Participating agencies/partners
Data: Assure access to the database for project participants. Inform participants of the data measures and reporting requirements.	Q1/2 4 hours	IT department

Phase: Sustainability

Activity Description	Time Needed	Responsible Party
Tools: No additional tools	*N/A.*	*N/A.*
Participants: Spread the project to additional agencies/partners/programs.	Year 3: Q3-Q4 8 hours	Implementation team
Support: Share implemented strategies and practice changes by participants. Adjust mode of technical assistance as needed to accommodate a growing number of project participants.	Ongoing	Implementation team Participating agencies/partners
Data: Collect and analyze data on an ongoing basis.	Annually Q3 8 hours	Implementation team IT department

PRACTICE COST

There has been no additional cost required to implement this project.

LESSONS LEARNED

The greatest lesson learned was that many programs that provide services directly to families, youth and community members have not developed the type of relationship needed to ask those people to participate in an assessment process. That is, the relationship has been unidirectional and to now turn the tables and ask for feedback felt unnatural. For those programs, we encouraged them to use their first year in this project to complete the tool as a program and use it to develop those relationships with the people they serve so that when they complete the assessment again the following year, they would have people who could assist them that process.

Intentional tests of change occurred involving the assessment tool. One change added language to each indicator describing what success would look like from the perspective of family, youth and/or community members. Another change from 2019 to 2020 involved testing a version of the tool with more accessible, lower literacy level language. Participating teams, consistent with our predictions, received both changes positively.

NEXT STEPS

In 2019, this project started with seven pilot programs. Over 35 programs were engaged in 2020 until many project activities were paused as local public health department staff had to be redirected to the COVID-19 response.

In 2021, community engagement activities are included in contract work plans with CYSHCN and Adolescent Health partner agencies. Completion of the Community Engagement Assessment Tool and practice changes to enhance engagement have also been integrated into MCH activities with local and tribal health departments related to breastfeeding and health equity. Finally, programs in our Family Planning and Reproductive Health unit may participate as capacity allows.

A significant change in 2021 is that there will not be Learning Community sessions focused on community engagement. Rather than separating community engagement as a distinct activity, it will be integrated into the work of Maternal and Child Health, CYSHCN, Adolescent Health and Family Planning/Reproductive program areas. To accomplish this, we will be developing the infrastructure and support so it can be replicated across the various programs.

RESOURCES PROVIDED

- Please visit the website we created in support of this project for more resources and information.
- Community Engagement Tool Driver Diagram
- Community Engagement Assessment Tool Simplified Form

APPENDIX

- *N/A.*