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Practice Summary & Implementation Guidance

Medical Home Community Team

The Medical Home Community Team (MHCT) provides intensive, "home-grown" and high-quality home-visiting services to especially vulnerable and marginalized black and brown Philadelphian children and their families, centered on social determinants of health (SDoH) risks. The team works collaboratively with the referred child's pediatric medical home and in equal partnership with MHCT families to address the impacts of racial and health inequities.

Location	Topic Area	Setting
Philadelphia, PA	Service Coordination/Integration	Community

Population Focus	NPM	Date Added
CYSHCN	NPM 11: Medical Home NPM 12: Transition	April 2021

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Section 1: Practice Summary

PRACTICE DESCRIPTION

The Medical Home Community Team (MHCT) was established in 2017 through Title V funding from the Philadelphia Department of Public Health, Division of Maternal, Child and Family Health (MCFH). MHCT is a "home-grown" home-visiting program, offered by the Health Promotion Council (HPC), a non-profit organization and affiliate of Public Health Management Corporation (PHMC). HPC's mission is to promote health, and prevent and manage chronic diseases, especially among vulnerable populations, through community-based outreach, education, and advocacy. MHCT serves Philadelphia families whose children primarily receive care in Pennsylvania American Academy of Pediatrics' (PA-AAP) certified medical homes. As provided in the structure of the medical home model, these pediatric clinics aim to provide fuller access to wellness that incorporates the child(ren) and whole family's unique health challenges and barriers (American Academy of Pediatrics, 2020).

MHCT engages its collaborators, MCFH and the Medical Home Program (MHP), for guidance, initiation of connections and certification of pediatric medical homes. MHCT, MCFH and MHP meet bi-monthly to discuss program trends, barriers and progress as well as receive updates about policies and city- and state- level decisions that will ultimately affect Philadelphia's children. Currently, MHCT has partnerships with 17 pediatric medical homes, at various levels of the certification process, serving all neighborhoods of Philadelphia.

Each pediatric medical home partner is connected to the referral source mechanism, which maximizes opportunities for the MHCT to develop relationships with the pediatric medical home providers, together identify appropriate families with complex needs, and provides continuity for families between their pediatric medical home, and their own communities and homes. During the introductory meeting, MCFH leaders, MHCT staff, MHP staff and medical home providers talk about the intended impact of MHCT for the practice and the clients. MHCT leads the discussion and seeks information about the unique ways that SDoH and inequities in the provision of services show up for the pediatric medical home's clients and families.

In this initial meeting and subsequent conversations, MHCT consistently impresses the importance of ongoing collaboration as critical to program outcomes and, importantly, improving the lives of referred children and families. The needs, goals and progress of the family are regularly (at least monthly) shared with the child's medical home in order to build awareness around the systemic challenges faced by the child(ren) receiving care at their clinic, build the capacity of the medical home staff to meet the needs of those children and provide a stronger bridge of support in the relationship of the caregiver and pediatric medical home. MHCT requires providers to discuss MHCT aims and services with families who would benefit from our services before making a referral. As a part of this

process, MHCT requires written or verbal consent from each family member that they have received information about MHCT and are interested in enrollment.

MHCT uses an integrated, collaborative model, by directly engaging pediatric medical homes to identify and reach Philadelphia families with highly complex social-medical needs and who are most marginalized by inequitable systems in the provision of services (i.e., criminal justice, health care, child welfare systems, Supplemental Nutrition Assistance Program, Social Security Income). MHCT primarily serves black and brown parents and their children, with and without special healthcare needs, ages 0-21 years old in Philadelphia County. Since its inception, the MHCT has successfully served 80-100 Philadelphian families per year, often exceeding target goals. Family size of MHCT families is highly variable; a single parent household has on average, between 3-7 children. MHCT relevantly focuses on the association of medical health and SDoH in the children's home environment, in coordination with the pediatric medical home. Services are dependent on the family's need and can include individualized health education for every family member, coaching and skill-building, referrals to community-based organizations, linkages and coordination with behavioral health, mental health, and other social service and community organizations.

When medical home providers submit a referral via fax or email, the referral form highlights discrepancies with appointment/medical adherence, the child's recent diagnosis and current SDoH risks. The program manager (PM) next contacts the family within 48 business hours to schedule a date and time for intake (in-person or virtual) for enrollment. During the intake, the PM collects detailed information including, but not limited to, financial challenges, early intervention, special education (e.g., IEPs), history of trauma, parental depression and other mental health challenges, parents with intellectual disabilities, access to healthcare, transportation challenges, language and literacy barriers, and housing. The needs assessment is conversational in nature to establish a relationship and build rapport, often extending 3 hours duration. During the initial intake, the PM gauges caregiver desire and ability to work together on the matters discussed. The intake conversation allows the PM to gain a deeper understanding of the complexities and barriers faced by the family uniquely as well as using a racial and health equity lens broadly.

Next, the PM carefully and purposefully assigns a Community Patient Navigator (CPN) or Community Health Nurse (CHN) to the family, based on the identified needs and mutual fit. MHCT personnel are professionally trained, well-rounded as well as grounded, and uniquely equipped and prepared to provide advocacy and guidance to MHCT families. MHCT personnel reflect and represent the families they serve and have similar lived experiences in their personal and professional lives. The team is comprised of 1 FTE PM with masters level preparation and 10+ years of experience in the social services sector; 1 FTE CPN with public health bachelors level preparation and 10+ years of experience in parent engagement; 1 FTE Bilingual CPN with social work bachelors preparation and 30+ years of case management and care coordination expertise; and, 1 FTE CHN with a license in practical nursing and 25+ experience in nursing care for black and brown individuals. All MHCT staff, who are black and brown parents and grandparents from Philadelphia, seek out and receive over 40 hours of training in topics relevant to racial and health equity within service provision, including the utilization of the language translation/interpretation line. Each staff member carries a standard case load of 10 – 15 families at a time, which allows for meeting the unique needs of each family, using family-tailored intervention techniques and a health equity lens.

The CPN and CHN address the needs identified during the intake assessment to develop an intervention plan with the family. The intervention plan details goals and objectives established by the family and is combined with the medical home provider's recommendations. MHCT informs the medical home's understanding of their patients and patient needs through consistent engagement and communication with the referring medical home throughout the family's enrollment period. The length of time a CPN/CHN works with a family is flexible and based on the complexity of the needs, goals and ability/availability of the caregiver as the leader of goal/program completion. Follow-up assessments happen in-person at month 3, month 6, and month 9, and additional goals may be created at that time. MHCT supports families until they are well-connected to appropriate services and care, better able to navigate through the health and social systems in Philadelphia and demonstrate a readiness for discharge. During the intervention, the CPN/CHN acts as a coach, motivator, care coordinator and social worker to assist families with the completion of their goals. Parents engage with their assigned CHN/CPN or the PM freely, and there is ongoing communication via phone, Zoom, e-mail and in-person meetings. MHCT, as part of its core responsibility, recognizes that quality engagement and frequent communication is necessary to optimizing program completion and sustaining trusted relationships with black and brown families.

References:

American Academy of Pediatrics. (updated: 2020, May). What is Medical Home?. https://medicalhomeinfo.aap.org/overview/Pages/Whatisthemedicalhome.aspx

CORE COMPONENTS & PRACTICE ACTIVITES

The core components of MHCT include: ongoing collaboration with MCFH and the PA-AAP's Medical Home Program (MHP), reciprocal partnerships with Philadelphia based pediatric medical homes to extend access and reach to especially vulnerable and marginalized black and brown families, uniquely tailored service provision to families experiencing racial and health inequities centered on social determinants of health (SDoH) risks, highly trained and prepared staff members, and investment in driving quality and trusted relationships with the referred child and family members.

Core Components & Practice Activities

Core Component	Activities	Operational Details
Ongoing collaboration with MCFH and MHP	• Meet as a collective bi-monthly; frequent emails, phone calls and meetings throughout program period • Identify non-Medical Home (MH) clinics in Philadelphia	• Provides opportunity to jointly brainstorm MHCT successes, challenges and opportunities • Work with MCFH and MHP to identify criteria and referral

	who may be a good fit for the MH model • Jointly conduct collaboration/introductory meetings with new MH partners to discuss referral mechanism • Participate in MHP & MCFH internal/external meetings	mechanism for new medical homes • MHP establishes/introduces MHCT to new partner; MHCT determines date of in-person meeting and invites MHP & MFCH • Helps to solidify a deeper collaboration
Reciprocal partnerships with Philadelphia-based pediatric medical homes to extend access and reach to especially vulnerable and marginalized black and brown families	• MH partners share information about MHCT as option for caregiver/family and receive written/verbal consent to refer • Establish a mechanism to accept patient referrals, operating seven days per week • Co-develop methods for addressing problems families typically encounter when working within systems and limited availability of resources • Identify/link potential community service providers to bridge identified gaps • Provide information about community resources for practice staff • Communicate regularly with MH provider about enrolled family including goals	• Creates choice for families and helps to avoid some of the paternalistic nature of referrals to home-visiting programs • Accept and respond to provider referrals within 48 business hours of receipt • Each referral is discussed between MHCT and MH provider including the limitations of systems and resource availability • MHCT staff correspond with resources relevant to family's needs and shares contact information with provider • Provide regional resource guides regularly to MH providers. • Provide monthly reports via email; frequent meetings via phone and email
Uniquely tailored service provision to families experiencing racial and health inequities centered on SDoH risks	• Conduct family needs assessment with each referred patient during home visits • Develop family-led goal plan	• Assess family health literacy needs of patients • Utilize information learned during needs assessment and referral to build joint plan

	• Collaborate with family and MH provider to accomplish goals from plan	• Provide referrals/linkages and education; ensure referral follow-up; assistance with navigating services
Highly trained and prepared staff members	• Hire staff reflective of the community served • Hire staff with varied experiences and backgrounds • Required/provide relevant training • Conduct bi-monthly team meetings and encourage attend at home-visiting collaboration meetings across the region of service • Provide supervision at minimum once monthly; PM should be available to staff frequently	• Prioritize familiarity with community and personal attributes over formal credentials; interventions are led by relationships • Recognizes communities served are not monoliths and enrollment may occur at different points in their/the child's development • Require trainings such as motivational interviewing, mandated reporter training, using in-person and over the phone interpretation. • Provide opportunities for multi-disciplinary approach • Ongoing supervision/discussion identifying best practices
Investment in driving quality and trusted relationships with the referred child and family members	• Lead trauma-informed interventions	• Listen and engage family members; develop relationships that center collaboration, choice, self-agency, and empowerment

HEALTH EQUITY

Reverend Dr. Martin Luther King, Jr., in 1966 stated, "of all the forms of inequality, injustice in health [care] is the most shocking and inhumane." Over three decades later and the Robert Wood Johnson Foundation (RWJF) echoes Dr. King Jr's sentiments, further defining health equity as "…everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health

such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and health care" (RWJF, 2017). Yet, it is well known that health disparities exist, and disproportionately impact black and brown families across the lifespan, contributing to excess morbidity and premature death. It is also well known that black and brown families disproportionately experience systemic inequities (in healthcare, legal, workforce, for example), and that patterns of racism persist and are often reinforced in policy and public health practice. Evidence persists that preconceived beliefs about the behavior and health of black and brown folks leads to unequal treatment and discrimination in the healthcare setting, fuels distrust and creates toxic stress (Burgess, D. J., et al, 2004). A research study that looked at individuals who experienced discrimination in the health care setting found they were less likely to seek medical help when necessary or follow provider recommendations on lifestyle changes, medications or follow-up appointments (Oswald, D. P., et al., 2011). The content and quality of the MHCT intervention promote health equity by encouraging the conditions where black and brown families have what they need to live healthier lives.

In truth, home visiting programs are not created, replicated, or sustained equally. For example, even though the MHCT successfully secured local funding as responsive to the request for proposals (i.e., a pilot program serving 80-100 families per year), and has exceeded these annual goals, funding for the MHCT is at disparately high risk of being cut, as priorities shift toward other evidence based approaches and "population-level" public health planning. This reductionist approach, and dated public-health/biomedical model, designed to focus on numbers alone, is not new, catalyzes unhealthy competition between - and siloes - home visiting agencies, necessarily disadvantages the MHCT program, threatens the job security of an already disadvantaged workforce, and ultimately undermines the values underlying the MHCT (to provide intensive, quality home-visiting programming to the most marginalized families across Philadelphia) and further denigrates the families that the MHCT serves.

Despite mounting and dishearteningly obvious systemic inequities about the MHCT's value add in the home visiting funding and ecosystem, the MHCT team (and internal partners), are unified in its philosophy that black lives matter, and that serving the most marginalized black and brown families benefits us all. The MHCT addresses discrimination and inequities throughout its approach by providing intensive and uniquely tailored case interventions that focus on, first and foremost, a recognition and validation that racial inequities exist across most systems (i.e., educational, healthcare, legal) that MHCT and virtually all black and brown families engage with daily. The MHCT is equipped to focus on highlighting family/caregivers' strengths as a buffer and asset for navigating bias as part of its standard intervention. As mentioned previously, MHCT uses a trauma- informed approach to address the needs identified during the assessments in order to increase their agency in talking to providers and being consumers of their healthcare – thus providing advocacy and also a continuity of care across systems. Ongoing communication with the family allows MHCT to understand the ways inequities show up in the home environment and family dynamic which allows us to make necessary intervention adjustments. In addition, the MHCT holds community-based programs and individual providers accountable for discriminatory actions, advocates on behalf of our clients, and encourages, supports and prepares our clients to connect to these experiences in driving informed decision-making on their and their family's behalf, while offering techniques and strategies for speaking up when it happens.

Although the MHCT has good and longstanding partnerships with individual providers of many medical home practices, oftentimes a social worker or care manager, or the practice itself, seems disconnected from the standards of their AAP certification - namely to be a family-centered, comprehensive, coordinated, compassionate and culturally effective primary provider. As a small team of predominantly black and brown workers, developing strong partnerships with pediatric medical homes has been, at times, a laborious process in part due to implicit and explicit bias providers have related to devaluing partnerships with the black and brown home visiting workforce and the needs of families served through them. In many of the referrals MHCT receives (from most of our pediatric medical home partners), black and brown caregivers are labeled as "bad" or non-compliant mothers, which creates more barriers for families who are referred because of value judgements of providers, who do not acknowledge or treat families as equal partners. Providers often assume that families are in need of "education" - a paternalistic stance, that impedes quality healthcare and prohibits access for families to quality care coordination and services. This is one reason that MHCT cultivates relationships and engagement with pediatric medical homes ongoing and as part of standard practice. Our engagement with the pediatric medical home creates a pathway of access for families and provides educational opportunities for the providers to better serve their families. MHCT maintains a laser focus on equitable solutioning and serving the most marginalized families across Philadelphia, and therefore continues outreach to engage its most unyielding pediatric medical home partners.

MHCT caregivers, children and families are plagued with intersecting individual and systemic level barriers and trauma - mental, physical and behavioral health conditions, combatting negative SDoH regularly, including housing insufficiency and instability, and food insecurity, all amidst grappling with the multi-layered effects of poverty, racism, sexism, and the persistent policing of black and brown bodies and minds in the healthcare and educational sectors (USA Nurses in Health Services Research, 2017). MHCT holds systems accountable for the treatment and service they are responsible for providing to our families and the quality of those services, including educational, early intervention and therapeutic supports. MHCT addresses health disparities to improve health outcomes that promote health equity. MHCT serves to directly diminish said barriers by addressing, with intentional focus, the related SDoH, including healthcare and education access and quality, economic stability and emotional wellness, while navigating parenting as a black and brown caregiver in Philadelphia. MHCT relies on the reciprocal relationship with families and medical home providers to encourage continuity of care, improve the coordination of care for families and mitigate bias in patient-provider communication.

References:

Robert Wood Johnson Foundation (2017). What Is Health Equity? And What Difference Does a Definition Make? https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html.

Burgess, D. J., et al. (2004). Why do providers contribute to disparities and what can be done about it? Journal of general internal medicine, 19(11), 1154–1159.

Oswald, D. P., et al. (2011). Disparities in the Clinical Encounter: Virginia's African American Children with Special Health Care Needs. ISRN pediatrics, 2011, 273938.

USA Nurses in Health Services Research. (2020, August). Nurses should oppose police violence and unjust policing in healthcare. International Journal of Nursing Studies.

U.S. Department of Health & Human Services Office of Minority Health. (2011). National Stakeholder Strategy for Achieving Health Equity Manual.

EVIDENCE OF EFFECTIVENESS

Below is a brief data analysis conducted by My-Phuong Huynh, the Lead Epidemiologist at MCFH, analyzing one fiscal year of data, July 1, 2019 – June 30, 2020. As mentioned, discharge from MHCT generally occurs at month 3 or 6. As part of this data glimpse, there were 46 successful discharges with completed discharge assessments. Outcomes demonstrate improvement in the areas of Transition to Adulthood, Emergency Room Visits, Missed Appointments and Family Empowerment.

Transition to Adulthood

Annually, about 15% of MHCT enrollees are children above the age of 14 (about 12 – 15 children each year). Between July 1, 2019 – June 30, 2020, five children reported having a successful transition from pediatric to adult provider. Of the five, two transitioned without a formal transition plan in place at the start of the program. This demonstrates that even during a fiscal year impacted by COVID-19, MHCT was able to assist CYSHCN and their families with a transition to adult care.

Emergency Room Visits

Between July 1, 2019 – June 30, 2020, there were 37 caregivers who reported their child(ren) did not have any emergency room visits in the past three months. Thirteen of them had previously reported having a visit in the past year at the start of the program. MHCT is dedicated to improving connections to pediatric medical homes to increase primary care utilization and decrease emergency room (ER) visits (use of ER vs contacting child's pediatrician). Much of the intervention centers on improving the relationship between provider and the family: as the relationship and engagement improves, the chances that families perceive a need to rely on the ER for ongoing care decreases and deliberation about ongoing care is shared and equal. The table below provides a glimpse into the shift in ER attendance while enrolled in MHCT.

Table 1: Emergency Room Visits (n=46)

	End of MCHT			
Start of MHCT		Yes	No	Unknown
	Yes	3	13	2
	No	3	22	1
	Unknown	0	2	0
	Total	6	37	3

Missed Appointments

Between July 1, 2019 – June 30, 2020, there were 30 caregivers who reported their child(ren) did not miss any medical appointments in the past three months. Of the 30, three had reported missing

medical appointment before MHCT services. The table below has information regarding the 46 families who completed discharge paperwork. There were 9 who previously reported not missing an appointment at the start of the program but reported missing appointments at the end which can be attributed to appointment cancellations or rescheduling due to COVID-19.

Table 2: Missed Appointments (n=46)

	End of MCHT			
Start of MHCT		Yes	No	Unknown
	Yes	3	3	0
	No	9	26	2
	Unknown	1	1	1
	Total	13	30	3

Family Empowerment

During enrollment and follow up, the MHCT team administered the Family Empowerment scale, per guidance from the Research and Evaluation Group (REG), an ongoing collaborator with HPC. The Family Empowerment scale has 12 items that assess the caregiver's ability to lead and navigate on the behalf of their family. The table below shows the differences between families at enrollment and at follow up during fiscal year 2020 (July 1, 2019 – June 30, 2020). Limitation: we were unable to run a complete analysis to determine statistical significance; however, we believe the data alone do display an impact.

Table 3: Family Empowerment

	Intake		**Follow Up**	
	Count	**Percent**	**Count**	**Percent**
My family has the ability to negotiate, communicate and encourage each other to give and express their opinions.	29	63.04	41	89.13
As a parent/caregiver I am able to manage my children's' challenging behaviors.	24	52.17	29	63.04
My family is able to get along with one another.	29	63.04	41	89.13
I make an effort to learn new ways to help my family grow and develop.	34	100	44	95.65
I have a good understanding of my child(ren)'s health diagnosis.	30	65.22	40	86.96
I am able to advocate for my family's healthcare needs.	33	71.74	43	93.48
I am able to motivate my family members to make healthy choices.	29	63.04	33	71.74
I pay attention to the needs of other family members.	29	63.04	42	91.30
When dealing with challenging situations involving my family, I am able to focus on the positive.	27	58.70	34	73.91
I can handle personal frustrations that come with providing care for my child(ren).	30	65.22	39	84.78

I have people to turn to when I need help, advice, or just someone to listen.	26	56.52	37	80.43
I am able to manage my time well.	20	43.48	28	60.87

***Those who replied "agree" or "strongly agree" to the statements above

Note: This dataset was restricted to only child who had a complete follow up form (n=46).

Alignment with Relevant Title V Performance Measures

As a comparison, we have provided data based on the Title V performance measures. Data is from July 1, 2019 – December 31, 2019.

Title V Performance Measure 2: % of primary caregivers enrolled in HV that are screened for depression

- 100% (36/36) of primary caregivers were enrolled in MHCT and screened for depression.

Title V Performance Measure 4: % of caregivers screened for IPV using a validated tool

- 100% (36/36) of primary caregivers were enrolled in MHCT and screened for IPV using a validated tool.

Title V Performance Measure 5: % of caregivers w/ positive screens for IPV who received referral information

- 100% (36/36) of primary caregivers who had positive screenings for IPV were provided referrals.

Section 2: Implementation Guidance

STAKEHOLDER EMPOWERMENT & COLLABORATION

MHCT engages its collaborators, MCFH and MHP, for guidance, initiation of connections and certification of medical homes. MHCT, MCFH and MHP meet bi-monthly to discuss program trends, barriers and progress as well as receive updates about policies and city- and state- level decisions that will ultimately affect Philadelphia's children. Currently, MHCT has partnerships with 17 pediatric medical homes, at various levels of the certification process, serving all neighborhoods of Philadelphia. Five of those practices were identified and referred by MHCT to MHP for onboarding to become certified pediatric medical homes. MHCT partnerships generally occur through an introduction and connection initiated by MHP, led by Dr. Renee Turchi, a longstanding MHCT collaborator with 15+ years of experience overseeing pediatric medical homes.

The MHCT considers itself a co-equally empowered stakeholder with the individuals and families we serve across Philadelphia County. MHCT stakeholders have varying degrees of engagement, involvement and input as part of the MHCT. The table highlights MHCT stakeholders, and outlines reasons in brief for the partnership.

Stakeholders	Reason for partnership

Referred children and families	Equal collaborators. To provide uniquely tailored home-visiting services to families centered on social determinants of health (SDoH) risks to address the direct impact of health and racial inequities
Philadelphia Department of Public Health	Funding source and development/ongoing guidance for the MHCT
Pennsylvania American Academy of Peds Medical Home Program staff	Ongoing guidance, certification of medical homes and initiation of medical home/MHCT partnership
MHCT staff	To provide quality support services to referred families/children by acting as motivators, care coordinators and advocates during the intervention.
Pediatric Medical Home Practices (17 Philadelphia practices)	Identifies/refers families for MHCT to serve; participates in ongoing engagement with MHCT to build capacity and better support the needs of patient populations
Language Line	To provide interpretation/translation during calls and in-person visits
Community Agencies/Partners	To provide a warm handoff/solid connection to MHCT families and partnered medical homes to services including, legal, local housing agencies, local benefits officers (with advanced vetting from MHCT personnel)
Research & Eval Group at PHMC	Intermittent partnership to assess health equity model, infrastructural operation and design planning

REPLICATION

This practice has not been replicated in any other locations.

INTERNAL CAPACITY

MHCT has received invaluable guidance and support from its collaborators, MCFH, MHP and REG who have helped to shape the program into its current form. Key MHCT staff includes: Director, PhD (0.05 FTE) who manages contracts, oversees fiscal matters (e.g., invoicing), and accountability with more than ten years of administrative experience managing and leading programming, including HPC's home visiting and patient navigation programs. Assistant Director, LSW, MPH (0.15 FTE) who oversees project deliverables, ensure data monitoring and storage are secure, and communicate regularly with MCFH to track progress and any barriers encountered and brings 10 years as of experience in family-centered care and program development while working directly with individuals to coordinate health services. Day-to-day project decisions are made by the Program Manager, MSW (1.0 FTE) with 8 years of experience in home visiting, care for CYSHCN, and systems support and service provider collaboration. The program manager works closely with MHI and MCFH to meet determined objectives and deadlines. The PM also oversees the CHN and two CPNs. The Community Health Nurse, LPN (1.0 FTE), with up-to-date licensure in Pennsylvania, has extensive experience in community/clinical settings and home visiting. The CHN is responsible for providing home visits, working closely with families and medical providers, making appropriate referrals for supportive

services, working with families to navigate social service systems, and working directly with pediatric and adult medical providers to ensure smooth transitions to adult care. Community Patient Navigator, BSW (1.0 FTE) performs home visits, builds relationships with the families, conducts follow-up needs assessments, and work with families to navigate social service systems. This CPN has more than 25 years of experience providing parental support, education, and involvement in programming to families of CYSHCN and primarily works with families who receive services in Spanish. Community Patient Navigator, BPH (1.0 FTE) performs the same services as CPN above and has 7 years of experience working with marginalized caregivers in Philadelphia, including providing health education, and care and service coordination. Administrative Assistant, BA (0.05 FTE) provides administrative support to the MHCT. The AA has 10 years of experience providing assistance to public health programs in Philadelphia.

PRACTICE TIMELINE

The following tables offers a recommended timeline for developing an MHCT program. The timeline addresses 3 main phases, including: Planning/Pre-Implementation, Implementation, and Sustainability. The major activities of the project are outlined below. Responsible parties include: Medical Home Community Team (MHCT), Philadelphia Department of Public Health Division of Maternal, Child and Family Health (MCFH), Health Promotion Council (HPC), the Research and Evaluation Group at Public Health Management Corporation (REG), and pediatric medical homes (MHs).

Phase: Planning/Pre-Implementation		
Activity Description	**Time Needed**	**Responsible Party**
Develop partnership with PA-AAP MHP and MCFH; Jointly establish communication mechanism/frequency agreement	ongoing	MHCT, MCFH, MHP
Develop and finalize MHCT referral systems, needs assessments, intervention plans and forms; determine intake procedures	2 months	Created by MHCT & REG; reviewed by MCFH, MHP
Hire for all vacant program positions	4 months	MHCT, HPC

Provide internal training for all staff (i.e., data entry, project operations, HIPAA compliance, shadowing visits)	1 month	MHCT, HPC
Encourage staff development and collaboration; provide mapping for external trainings including, Motivational Interviewing and set bi-monthly team meetings	ongoing	MHCT (Program Manager)
Develop/update intervention materials, including, regional resource guide	2 months; ongoing	MHCT

Phase: Implementation		
Activity Description	**Time Needed**	**Responsible Party**
Engage and begin partnership development with identified medical homes; develop referral mechanism	1 month; ongoing	MHCT, MHP, MCFH
Engage adult providers for transition planning	ongoing	MHCT (Program Manager)
Begin identifying and engaging potential new medical homes	ongoing	MHCT, MHP
Identify and engage community service providers and resources to be linked with families and medical homes	ongoing	MHCT, MHs
Receive referrals from MH and work alongside referred families to identify needs and goals for case management via intake	ongoing	MHCT, MHs
Provide intervention including empowerment, trauma-informed care, linkages and referring families to services	3 to 6 months; ongoing	MHCT, MHs

Phase: Sustainability		
Activity Description	**Time Needed**	**Responsible Party**
Collaborate to further refine/develop database, needs assessments and other tools for data collection	6 months; ongoing	MHCT, REG, MCFH
Monitor data entry and analyze data/feedback for required reporting and outcomes	ongoing	MHCT, REG, MCFH
Diversify portfolio, identifying funding opportunities including, Managed Care Organizations value- based payments	ongoing	MHCT, HPC

PRACTICE COST

The following table is reflective of one fiscal year of MHCT service provision. The total budget amount for one year is approximately $390,000. Below outline approximate figures for someone aiming to replicate the program.

Budget			
Activity/Item	Brief Description	Quantity	Total
Salaries and Fringe Benefits	Administrative/Client-facing Staff Salaries; FICA, insurances	4.25 FTE	$275,000
Staff Development	External trainings for MHCT staff	$375 per PM, CHN, CPN	$1,500

Consultant Expenses	Database fees, PHMC REG (Language services provided by MFCH)	Data: $20k; REG: $30k	$50,000 (start-up)
Communications	Telephone base, copying, cellular, computer, out-of-office networking	Based on FTE	$19,500
Office Supplies	Necessary supplies for the office and remote working including printers		$2,000
Client Supplies	Client Emergency Fund to address family's needs		$5,000
Staff Travel	Public transportation passes; Mileage	4 passes X 12 months; mileage	$2,500
Client Transportation	Day passes or Tokens for public transportation		$500
Other Operating Expenses	Indirect costs, including rent		$34,000
		Total Amount:	$390,000

LESSONS LEARNED

Since its inception, MHCT dedicated efforts to develop effective partnerships with medical home practices/providers alongside MHP. Over four years, MHCT has amassed 17 partnerships with medical homes to the encouragement of MFCH. Given MHCT is a small team, the Program Manager single-handedly became responsible for organizing referrals and holding medical home partner consultations for those 17 practices. The recommendation would be that a team the size of MHCT

would add partners much slower to ensure high-quality collaborative relationships and create balance for the Program Manager.

MHCT was able to adjust programming to virtual services somewhat seamlessly during the COVID-19 pandemic. MHCT staff worked to overcome barriers to reaching families over the phone and virtually by offering flexibility of meeting times, including evenings and weekends, and editing assessments/data collection to ensure caregiver safety and avoid protected-health-information-sharing concerns. This newer method of MHCT service delivery will continue to be offered alongside in-person home visits in the future as this created new avenues for serving caregivers with significant time limitations.

As mentioned, MHCT has a small team of predominantly black and brown workers, operating with minimum true infrastructure to effectively perform. Developing strong partnerships with pediatric medical homes has been an arduous process due to implicit and explicit bias providers carry in serving black, brown and "poor" families and related devaluing of partnerships with a primarily black and brown home-visiting workforce. There are significant examples to share that include medical homes that border affluent neighborhoods in Philadelphia, staffed by primarily white providers who had never referred a family despite having been onboarded to MHCT within the first year of funding. MHCT put forth many efforts to collaborate with these practices for the sake of black and brown families who should have access to and given the choice to accept/deny all resources, services and programs available.

MHCT was developed with a deep understanding of the systemic and structural inequities and the ways they operate. We recognized that competition with other home visiting programs, funding barriers and limited definitions of 'evidence' further exacerbate inequities and disparities and block access to families in great need of services. The recommendations for agencies intending to replicate MHCT is to have an integrated evaluation conducted in real time to ongoingly clarify health equity components and expand intentional assessment of health equity as a core function of the practice (i.e., in workforce, engaging families, engaging pediatric medical homes, infrastructure, reporting, framing evidence). This 'deep dive' evaluation will work to continuously improve the programmatic offering and further benefit of the communities served.

NEXT STEPS

In the future, MHCT intends to focus on scalability to increase reach and impact of the program. MHCT recognizes that quality engagement and frequent communication is necessary to optimizing program completion and sustaining trusted relationships with black and brown families. MHCT 'slows down' with families, has them connect to their strengths and understand the situations present in the family home while identifying equity issues beyond standard SDoH. This is the reason that in the future, MHCT intends to devote efforts into the cultivation of deeper relationships with fewer pediatric medical homes. In order to continue building deeper awareness around the systemic challenges faced by the child(ren) receiving care at their clinic, building the capacity of the medical home staff to meet the needs of those children and providing a stronger bridge of support in the relationship of the caregiver and pediatric medical home, MHCT will focus collaboration efforts on 7 to 10 of its 17 pediatric medical home partners and re-focus energy on making stronger partnerships

with these practices. This plan will also include a more robust evaluation that includes exploratory and expansive plan to intentionally target health equity in home visiting, including, community-stakeholder engagement, key informant interviews and an impact statement.

RESOURCES PROVIDED

- Sample regional resource guide

APPENDIX

- MHCT logic model
- MHCT Brochure
- MHCT Postcard