

July 23, 2021

MATERNAL AND CHILD HEALTH BUREAU (MCHB)  
SPECIAL PROJECTS OF REGIONAL AND NATIONAL SIGNIFICANCE (SPRANS)

FINAL REPORT AND ABSTRACT

PROJECT IDENTIFICATION

Project Title: Healthy Tomorrows Partnership for Children Program Community Connections

Project Number: H17MC29433

Project Director: Alison Gee

Grantee Organization: Parents as Teachers National Center

Address: 2228 Ball Drive, St. Louis, MO 63146

Phone Number: 314 432-4330

E-mail Address: info@parentsasteachers.org

Home Page: www.parentsasteachers.org

Project Period: 03/01/2016 – 02/28/2021

Total Amount of Grant Awarded: \$249,997

Narrative

1) PURPOSE OF PROJECT AND RELATIONSHIP TO SSA TITLE V MATERNAL AND CHILD HEALTH (MCH) PROGRAMS: Briefly describe the major purpose(s) of the project and the needs and problems it addressed. Indicate the program priority under which the project was funded. Explain the relationship to the State Title V MCH Program and state/local AAP chapter(s).

Major Purpose. The purpose of the Healthy Tomorrows Partnership for Children Community Connections project was to improve the health and development of children in Greene County, Missouri so they are ready to learn upon entry to school. The project responded to the health needs of underserved, at-risk families from pregnancy through kindergarten by: 1) building an interdisciplinary

collaboration between maternal child health (MCH) providers and the Parents as Teachers (PAT) evidence-based home visiting program, 2) improving parents' ability to navigate the health system, and 3) increasing access to preventive health care and health insurance.

Needs and problems addressed. The primary need/problem addressed by the Community Connections project are the high rates of children in Greene County (the county of focus for the project) entering kindergarten not prepared due to poverty, lack of access to quality health care and early education, and disparities in health and wellness.<sup>1</sup>

Program priority under which the project was funded. Healthy Tomorrows Partnership for Children Program

Relationship to Title V. The 2010 Title V Missouri Needs Assessment originally identified fourteen priorities to improving maternal child health. The identified priorities include the need to:

- *Enhance primary/preventive health care access for MCH populations, particularly the uninsured, health care education services and support to navigate the complexities associated with health care access;*
- *Create conditions conducive to the development of healthy, empowered and educated children in an effort to stop the cycle of adverse life course experiences that are adversely impacting the health and well-being of children, women and families;*
- *Educate parents, particularly from at-risk families, on parenting skills and early childhood development;*
- *Enhance coordination between various programs/agencies to support comprehensive healthy lifestyle programs with a goal to build healthy communities and healthy populations.*

The fourteen MCH priority needs were consolidated into ten priorities while keeping their focus on the importance of a comprehensive system rather than a fragmented approach to improving maternal child

---

<sup>1</sup> Dixon, D., Duncan Fallone, M., and Martin, J. Readiness for Kindergarten II, 2010 Kindergarten Readiness Study 2011

health. However, despite this recognized and acknowledge need for a comprehensive approach, traditional “silos” remain in the delivery of health services for children. When this project began, this was particularly true in Greene County where Parents as Teachers and the MCH community remained segregated, creating redundancies and inefficiencies, in serving children. *Community Connections* addressed the priorities above.

Relationship to State AAP Chapter. The State AAP chapter representative served on the advisory board for this project. AAP chapter members and representatives have been updated on and involved in the program’s progress throughout the duration. One of the members is a provider at one of our partners (i.e. is implementing the medical model herself), as well as a representative.

2. GOALS AND OBJECTIVES: Describe the goals and objectives of the project and show how they relate to the item above.

The overarching goal of the *Community Connections* project is to improve the health and development of underserved children in Greene County so they are ready to learn. The underlying goals, objectives and corresponding activities were as follows:

**Goal 1: Enhance partnerships and collaboration between the MCH community and Parents as Teachers.**

**Objective 1: Increase Awareness and Knowledge**

**Objective 2: Facilitate Integration of Home Visiting into MCH Systems** so that a Parents as Teachers/MCH community partnership becomes a standard practice in serving at-risk families and children.

**Goal 2: Improve parents’ ability to navigate the complexities of the healthcare system so they can respond to the health needs of their children.**

**Objective 1: Increase Understanding of Preventative Health and Health Resources**

**Objective 2: Increase Parental Health Literacy**

**Goal 3: Improve connections to prevention health care systems and health insurance for underserved families and children.**

**Objective 1: Increase the Number of Eligible Families Accessing Health Insurance**

**Objective 2: Increase the Number of Children with an Established Medical Home**

3. METHODOLOGY: Briefly describe the program activities used to attain goals/objectives and comment on innovation, cost, and other characteristics of the methodology.

Briefly, the main program activities included:

- Building upon an existing community-wide initiative in Greene County – Every Child Promise – to work strategically and across sectors in the community to improve kindergarten readiness.
- Intentionally connect home visiting (PAT) with MCH/Pediatric primary care settings.
- Piloting integration approaches in various settings.
- Developing training/resources and a community blueprint for integrations and coordination of home visiting and MCH/pediatric services

One key innovation was the flexible way in which integration approaches were rolled out and piloted.

We worked with the partner agencies in ways that best served their purposes while simultaneously advancing project goals. We learned from each implementation pilot what approaches work and shared them with all the partners. Pilot sites included:

- A federally qualified health center - Jordan Valley Community Health Care Center
- A NICU – Cox South Hospital NICU
- A Pediatric Clinic – Cox Northside Pediatric Clinic
- A nurse home visiting program - Greene County Health Department
- A community hospital – Ozark Community Hospital

Implementation costs were kept to a minimum because the main expense (the salaries of the PAT

parent educators that worked in/with the pediatric settings) was already covered by the Springfield School District's PAT budget.

Another innovation was the use of the **Capability Maturity Model Integration (CMMI)** tool to assess the Community Connections Program and track growth over time. CMMI is a tool typically used in the business world to enable organizations to measure, build, and improve capabilities to improve overall performance. A long-time Greene County resident and stakeholder suggested this might be an innovative tool to help the program assess its capabilities over time through an initial baseline assessment and subsequent point in time assessments. More details can be found in the Evaluation and Results sections of this report.

4. EVALUATION: Briefly describe the evaluation methods used to assess the effectiveness of the project in attaining goals/objectives.

#### Family/Service delivery outcome evaluation

As standard practice, PAT programs collected data on its services to families. This information includes service delivery information (number of visits, information provided on visits), family and child demographics, health history and screening records. This information provides vital information on how the program is being implemented, and also helps inform the outcome evaluation. In addition, qualitative data is collected from families including Parent Satisfaction surveys.

#### Implementation evaluation

To assess the quality of the overall implementation of the medical model, a tool called the Capability Maturity Model Integration (CMMI) was used. CMMI is a process level improvement training and appraisal program. CMMI can be used to guide process improvement across a project, division, or an entire organization. CMMI defines the following maturity levels for processes: Initial, Managed, Defined, Quantitatively Managed, and Optimizing. CMMIs were conducted 3 times over the course of

the project (Baseline, Year 3, and Year 5). Progress over time was tracked.

5. RESULTS/OUTCOMES: Summarize the major results. Highlight any health status outcomes, systems changes, lessons learned and outcomes, which have potential for transfer and replication. Provide the number of individuals identified by racial and ethnic group who were served.

Family/Child Outcomes

In the aggregate, over the entire project period, 371 families and 516 families participated in the medical model services.

One of the project objectives was to increase the number of eligible families accessing health insurance. Year 3 was the first year this data was collected. Below are year 5 data and, for comparison purposes, the previously reported Year 3 and 4 data.

Accomplishments. Currently only 1% of the medical model children are uninsured (compared to 2% of children in the overall PAT program and compared to 2% of medical model children uninsured last year). Sixteen (16%) of medical model guardians are uninsured compared with 13% of guardians in overall PAT program; lower than the baseline of 25%. Overall, the percentage of uninsured guardians in medical model families has decreased over 3 years while the percent of uninsured overall PAT program guardians has increased over time. We believe this is due to gaining more access to higher needs families as our medical partnerships grow and collaboration becomes stronger. Parent educators are actively working with the families to help them get both the children and guardians insured.

Year 5 data (March 2020 – February 2021)

<b>Medical/Medical Affiliate Families:</b>	<b>Program Wide (All Springfield PAT Families):</b>
<u>Guardians (115 total)</u>	<u>Guardians (1538 total)</u>
No Insurance: 18 guardians (16%)	No Insurance: 204 guardians (13%)
Medicaid: 59 guardians (51%)	Medicaid: 319 guardians (21%)
Private/Other: 38 guardians (33%)	Private/Other: 1015 guardians (66 %)
<u>Children (165 total)</u>	<u>Children (1953 total)</u>
No Insurance: 2 children (1%)	No Insurance: 39 children (2%)

Medicaid: 136 children (83%)	Medicaid: 833 children (43%)
Private/Other: 27 children (16%)	Private/Other: 1081 children (55%)

Year 4 data (March 2019 – February 2020)

<b>Medical/Medical Affiliate Families:</b>	<b>Program Wide (All Springfield PAT Families):</b>
<u>Guardians</u>	<u>Guardians</u>
No Insurance: 23 guardians (21%)	No Insurance: 253 guardians (15%)
Medicaid: 61 guardians (56%)	Medicaid: 328 guardians (20%)
Private/Other: 25 guardians (23%)	Private/Other: 1098 guardians (65%)
<u>Children</u>	<u>Children</u>
No Insurance: 3 children (2%)	No Insurance: 77 children (3%)
Medicaid: 138 children (87%)	Medicaid: 1024 children (43%)
Private/Other: 18 children (11%)	Private/Other: 1305 children (54%)

Baseline data collected Year 3 (May 2018 – November 2018)

<b>Medical/Medical Affiliate Families:</b>	<b>Program Wide (All Springfield PAT Families):</b>
<u>Guardians</u>	<u>Guardians</u>
No Insurance: 15 guardians (25%)	No Insurance: 73 families (5%)
Medicaid: 23 guardians (39%)	Medicaid: 304 families (23%)
Private/Other: 21 guardians (6%)	Private/Other: 948 families (72%)
<u>Children</u>	
No Insurance: 3 children or 3%	
Medicaid: 75 children or 82%	
Private/Other: 14 children or 15%	

A second objective is to increase the number of children with an established medical home.

Year 3 was the first year this data was collected. Below is year 5 data and, for comparison purposes, the previously reported Year 3 and 4 data.

Accomplishments. As in Years 3 and 4, all Medical Model participating families continue to have a medical home for their children, but so do 98% of all Springfield PAT program children.

The percentage of guardians from the Medical Model group that lack a medical home increased slightly from Year 4 (up from 4% to 9%) but is still well below the baseline (27%). The percentage of

Medical Model affiliate families with a medical home is still slightly greater than the percentage of all Springfield PAT families that do (91% vs. 88%) although the gap has narrowed.

Year 5 data (March 2020 – February 2021)

<b>Medical/Medical Affiliate Families:</b>	<b>Program Wide (All Springfield PAT Families):</b>
<u>Medical Home – Guardians (Total = 115)</u>	<u>Medical Home – Guardians (Total = 1538)</u>
105 guardians with a medical home (91%)	1353 guardians with a medical home (88%)
10 guardians with NO medical home (9%)	185 guardians with NO medical home (12%)
<u>Medical Home – Children</u>	<u>Medical Home - Children</u>
165 children with a medical home (100%)	1914 children with a medical home (98%)
0 children with NO medical home (0%)	39 children with NO medical home (2%)

Year 4 data (March 2019 – February 2020)

<b>Medical/Medical Affiliate Families:</b>	<b>Program Wide (All Springfield PAT Families):</b>
<u>Medical Home – Guardians</u>	<u>Medical Home - Guardians</u>
105 guardians with a medical home (96%)	1461 guardians with a medical home (86%)
4 guardians with NO medical home (4%)	235 guardians with NO medical home (14%)
<u>Medical Home – Children</u>	<u>Medical Home - Children</u>
159 children with a medical home (100%)	2358 children with a medical home (98%)
0 children with NO medical home (0%)	48 children with NO medical home (2%)

Year 3 baseline data (May 2018 – November 2018)

<b>Medical/Medical Affiliate Families:</b>	<b>Program Wide (All Springfield PAT Families):</b>
<u>Medical Home - Guardians</u>	<u>Medical Home – Guardians</u>
37 guardians with a medical home (73%)	1017 Guardians with a medical home (83%)
14 guardians with NO medical home (27%)	208 Guardians with NO medical home (17%)
<u>Medical Home – Children</u>	<u>Medical Home – Children</u>
92 children with a medical home (100%)	1216 Children with a medical home (92%)
0 children with NO medical home (0%)	108 Children with NO medical home (8%)

Immunization rates continue to trend higher for the Medical Model children than for the full

PAT model children (93% vs 83% fully immunized), pretty consistent with last year (90% vs 83%).

### Implementation evaluation

In year one (after several months of implementation), an outside consultant conducted a process evaluation using the Capability Maturity Model. This work had five objectives:

- Capture organizational knowledge of existing capabilities
- Generate a baseline to use in measuring progress over time
- Identify improvements that will support new partnerships
- Determine possible replication to other related programs
- Share ideas and processes across partners

The consultant and his team interviewed key stakeholders including external partners, the evaluation team, the implementation team, and project management. The findings from this evaluation proved the project team had been working towards integration. The consultant found that, across partners in *Community Connections*: goals and objectives had been clarified, important terms had been clearly defined, access to health care providers and integration of community stakeholders into the process had been determined, and communication across the team appeared to be seamless.

In Year 3 of the project, the evaluator and the program stakeholders (PATNC, SPS PAT management, medical providers, advisory board, and medical model Parent Educators) met to conduct a second periodic checkpoint, using the CMMI. The purpose of this checkpoint was to provide a current state assessment of the general program and its services, as well as an update to the specific activities and results from the original 2017 baseline assessment.

This checkpoint showed improvement in nearly all areas. Additionally, the project team began work with new providers and in new care settings, while fine-tuning the relationships and activities

with existing partners. Some of these experiments were unsuccessful, but all provided learning opportunities that will strengthen existing or future partnerships.

In a checkpoint, practices are assessed as Satisfied, Partially Satisfied, or Deficient.

- Satisfied and Deficient are binary scores indicating a CMMI practice is met or not met.
- A Partially Satisfied score has a wide range – filling the gap from Deficient to Satisfied.

There were major improvements in the areas of Requirements, Service Delivery, Project Management and Measurement & Analysis. This outcome shows that the team has a much clearer understanding of the goals and objectives, the importance of the project to the stakeholders, and the way to actually deliver value to the stakeholders. While many of the practices assessed as Partially Satisfied in 2017 remain as Partially Satisfied, significant improvements were made in these areas.

The remaining, unaddressed area dealt with configuration management practices – the tools and storage methods used for data, documents, and templates. The team agreed to delay changes and decisions in this area until the key processes and practices were more defined, as the new processes might dictate the use of specific systems or repositories.

The final benefit of a checkpoint is to use the shared understanding to drive the next phase of actions and improvements.

A third and final CMMI periodic checkpoint was conducted in February 2021 at the end of the project. Overall, the assessment revealed the following strengths:

- The Handbook provides a standard approach for completing the common parts of the medical model activities.
- The program team has identified specific skills and attributes which make a good Medical Model Parent Educator.

- The team did a wonderful job transitioning from actual to virtual visits with families and developing methods of interactions with providers.
- The team quickly adjusted to working in a virtual manner for team activities.
- The Medical Model team effectively focused on sharing Lessons Learned, which was critical in the shift from physical to virtual visits. This was performed through staff meetings, brown-bag lunches, and person-to-person conversations. Ideas were captured and shared across the team.
- The Medical Model team meets with the SPS team at least once a month to review the data entered and activities performed. This time is used to discuss the effectiveness of the processes and bring up any questions or learning opportunities.

The tool highlights a number of areas that are partially met but where there are opportunities for improvement as the initiative continues.

## 8. PRODUCTS:

A variety of products resulted from the project. They are listed below. The Project Director is the primary contact person for all of them.

Publications. Jupka, K., Kapp, J., Young, A., Riley, M., Carroll, D, Kemner, A., & Schootman, M. (2018). Operationalizing Population Health Management in Practice. Missouri Medicine, 115:6, 533-536.

Conference presentation. 2018 PAT International Conference

Group meeting plans. Members of the project team have developed a series of health focused Group Connections for this project to ensure an even greater health focus during Group Connections delivered to Springfield PAT families. These Group Connections address health-related topics and are designed with the goal of building social connections between our high needs families, serving as a parenting peer support group. Group Connections topics were selected based on feedback from the participating

pediatricians and on the needs of the families. Topics for the Group Connections have included:

- Medicaid enrollment and incentives (presented by a Medicaid representative)
- Immunizations (presented by an MCH partner)
- Positive Discipline (presented by an MCH partner)
- WIC (partnering with WIC for a group meeting at the grocery store where a WIC dietitian helps parents shop with their WIC vouchers)

Products. During the course of the Community Connections initiative, we came to realize there is no one ‘blueprint’ for integrating home visiting with MCH or pediatric care. The Blueprint comprises four documents we believe can help support replication of a medical model in other communities at various levels of integration and collaboration dependent on local circumstances.

The Blueprint includes:

- 1) PATNC Health Integration Guide
- 2) Community Connections Case Study
- 3) Community Connections Community Readiness Assessment Tool
- 4) Community Connections Handbook

The Health Integration Guide is a document initially drafted at a time when the potential for significant expansion of healthcare was anticipated. With a change in administration, that potential was stalled. The guide references several different programs across the country where PAT has been integrated in a health or behavioral health setting.

The detailed Case Study documents the history behind the Medical Model program in Greene County, the implementation models, challenges, and lessons learned over the five-year program. The Case Study is an excellent companion to this final report, going into greater depth on the overall implementation of the project.

As a companion to the Case Study, a Community Readiness Assessment Tool was developed to evaluate a community's resources to support this program. It can also be used to assist a community evolve to be better prepared for the program, to mitigate implementation risks, or even to prevent an inappropriate implementation in a community.

Additionally, the Community Connections Handbook consists of policies, procedures and documents for providers and parent educators who have supported the specific implementation in Greene County, and could be used by local PAT programs and MCH/pediatric medical providers within other communities as a guide for replication of the medical model. The Handbook is more of a "how-to" guide and is informed by the Greene County experience. These documents will be made available to affiliates across the PAT field through the website portal and will be marketed to state leaders and affiliates through the PAT newsletter. We will also work to connect interested affiliates with the Springfield program as well as other affiliates that are bringing home visiting and health providers together.

9. **DISSEMINATION/UTILIZATION OF RESULTS:** Describe action taken to share information/findings/products/resources with others within and outside the State.

The documents produced will be made available to affiliates across the PAT field through the PAT website portal and will be marketed to state leaders and affiliates through the PAT newsletter, webinars, and workshop presentations. We will also work to connect interested affiliates with the Springfield program as well as other affiliates that are bringing home visiting and health providers together.

10 **FUTURE PLANS/SUSTAINABILITY:** Describe plans for continuing the activities initiated by the project and future funding. Include anticipated results and both the short and long-term impact of the project.

The Springfield School District, which, in the past year, hired a new Executive Director of Elementary Learning and a new Director of Early Childhood, under which PAT falls, has indicated they intend to continue this program so long as their home visiting allocation from the Department of Elementary and Secondary Education (DESE) continues. DESE funding for PAT is an annual General Revenue appropriation that has been in place since 1984; it is a popular, bipartisan program not threatened with cuts.

The program continues to enhance and build upon the partnerships and collaborations between the MCH community and Parents as Teachers and will keep the PEs embedded with the different providers.

## Annotation and Key Words List

### ANNOTATION

The purpose of the Healthy Tomorrows Partnership for Children Community Connections project was to improve the health and development of children in Greene County, Missouri so they are ready to learn upon entry to school. The project responded to the health needs of underserved, at-risk families from pregnancy through kindergarten by: 1) building an interdisciplinary collaboration between maternal child health (MCH) providers and the Parents as Teachers (PAT) evidence-based home visiting program, 2) improving parents' ability to navigate the health system, and 3) increasing access to preventive health care and health insurance. Main project activities consisted of piloting efforts to intentionally connect home visiting (PAT) with several different MCH/Pediatric primary care settings, evaluating the outcomes of the pilots, and developing training/resources and a community blueprint for integrations and coordination of home visiting and MCH/pediatric services for other programs/communities to use to guide replication.

Project outcomes for families who received the medical model services included small reductions in the percentages of children uninsured, increases over time in the percentage of medical model families with a medical home, and higher immunization rates for medical model children.

Primary product is a "blueprint" document to be used as a replication guide, consisting of PATNC Health Integration Guide, the Community Connections Case Study, the Community Connections Community Readiness Assessment Tool, and the Community Connections Handbook

KEY WORDS: Families and Children, Medical Home, Access to Health Insurance, Pediatrics, NICU, Nurses, Home Visiting, Early Childhood Development/School Readiness, Health Literacy  
Improved Access to Primary Care, Maternal and Child Health

## ABSTRACT OF FINAL REPORT

### PROJECT IDENTIFICATION

Project Title: Healthy Tomorrows Partnership for Children Program Community Connections

Project Number: H17MC29433

Project Director: Alison Gee

Grantee Organization: Parents as Teachers National Center      Address: 2228 Ball Drive, St. Louis, MO 63146

Phone Number: 314 432-4330

E-mail Address: [info@parentsasteachers.org](mailto:info@parentsasteachers.org)

Home Page: [www.parentsasteachers.org](http://www.parentsasteachers.org)

Project Period: 03/01/2016 – 02/28/2021

Total Amount of Grant Awarded: \$ 249,997

PROGRAMS: The purpose of the Healthy Tomorrows Partnership for Children Community Connections project was to improve the health and development of children in Greene County, Missouri so they are ready to learn upon entry to school. The primary need/problem addressed by the Community Connections project are the high rates of children in Greene County (the county of focus for the project) entering kindergarten not prepared due to poverty, lack of access to quality health care and early education, and disparities in health and wellness.

GOALS AND OBJECTIVES: The project had 3 primary goals: 1) Enhance partnerships and collaboration between the MCH community and Parents as Teachers; 2) Improve parents' ability to navigate the complexities of the healthcare system so they can respond to the health needs of their children. 3) Improve connections to prevention health care systems and health insurance for underserved families and children.

METHODOLOGY: Briefly, the main program activities included:

- Building upon an existing community-wide initiative in Greene County – Every Child Promise – to work strategically and across sectors in the community to improve kindergarten readiness.
- Intentionally connect home visiting (PAT) with MCH/Pediatric primary care settings.
- Piloting integration approaches in various settings.

- Developing training/resources and a community blueprint for integrations and coordination of home visiting and MCH/pediatric services

One key innovation was the flexible way in which integration approaches were rolled out and piloted. We worked with the partner agencies in ways that best served their purposes while simultaneously advancing project goals.

EVALUATION: We measured family/service delivery outcomes and the quality of the overall implementation to assess the effectiveness of the project.

Family/Service delivery outcome evaluation. PAT programs collected service delivery data (including number of personal visits, information provided on visits), family and child demographics, health history and screening records. In addition, qualitative data is collected from families including Parent Satisfaction surveys.

Implementation evaluation. To assess the quality of the overall implementation of the medical model, a tool called the Capability Maturity Model Integration (CMMI) was used. CMMI is a process level improvement training and appraisal program. CMMI can be used to guide process improvement across a project, division, or an entire organization. CMMIs were conducted 3 times over the course of the project (Baseline, Year 3, and Year 5). Progress over time was tracked.

RESULTS/OUTCOMES: There were outcomes at two levels: family/child outcomes, and implementation outcomes.

Family/Child Outcomes. In the aggregate, over the entire project period, 371 families and 516 families participated in the medical model services.

Accomplishments. By project end, only 1% of the medical model children were uninsured (compared to 2% of children in the overall PAT program and compared to 2% of medical model children uninsured last year).

Sixteen (16%) of medical model guardians were uninsured compared with 13% of guardians in overall PAT program; lower than the baseline of 25%. Overall, the percentage of uninsured guardians in medical model

families decreased over 3 years while the percent of uninsured overall PAT program guardians increased. We believe this is due to gaining more access to higher needs families as our medical partnerships grow and collaboration becomes stronger. Parent educators are actively working with the families to help them get both the children and guardians insured.

At project end, all Medical model participating families had a medical home for their children, but so did 98% of all Springfield PAT program children.

The percentage of guardians from the Medical Model group with a medical home was 91% at project end; slightly greater than the percentage of all Springfield PAT families (88%).

Immunization rates continue to trend higher for the Medical Model children than for the full PAT model children (93% vs 83% fully immunized), pretty consistent with last year (90% vs 83%).

Implementation evaluation. A process evaluation using the Capability Maturity Model Integration was conducted at three time points over the course of the project. The CMMI work had five objectives:

- Capture organizational knowledge of existing capabilities
- Measuring progress over time
- Identify improvements that will support new partnerships
- Determine possible replication to other related programs
- Share ideas and processes across partners

By the third and final CMMI periodic checkpoint, conducted at the end of the project, the assessment revealed the following strengths:

- The Handbook provides a standard approach for completing the common parts of the medical model activities.
- The program team has identified specific skills and attributes that make a good Medical Model Parent Educator.

- The team did a wonderful job transitioning from actual to virtual visits with families, developing methods of interactions with providers, and adjusting to working in a virtual manner for team activities.
- The Medical Model team effectively focused on sharing Lessons Learned, which was critical in the shift from physical to virtual visits. This was performed through staff meetings, brown-bag lunches, and person-to-person conversations.

The tool highlights a number of areas where there are still opportunities for improvement as the initiative continues.

**PUBLICATIONS/PRODUCTS:** A variety of products resulted from the project. The Project Director is the primary contact person for all of them. The products include: a) a journal article; b) a conference presentation (at the 2018 PAT International Conference); a series of health-focused Group Meeting plans designed to build social connections between families, build connections with MCH partners and other health and well-being resources (e.g. WIC), and inform parents about health-related topics and, most significantly, d) a document we call a Blueprint for integrating home visiting with MCH or pediatric care consisting of a) PATNC Health Integration Guide; b) Community Connections Case Study; c) Community Connections Community Readiness Assessment Tool and d) Community Connections Handbook.

**DISSEMINATION/UTILIZATION OF RESULTS:** Products developed will be shared throughout the PAT Network and in particular with any PAT affiliates interested in replicating the program in their community. Results will be shared through the PAT newsletter, webinars, and workshop presentations.

**FUTURE PLANS/SUSTAINABILITY:** Springfield Public School District plans to continue implementing Community Connections through their Parent as Teachers program, continuing to build upon partnerships and collaborations developed over the past 5 years. The long-term impact is on the health and well-being of the children in the community, and their school readiness.