

## The Bi-Monthly Broadcast

*Hello and welcome to another edition of the Bi-Monthly Broadcast! August kicks off the start of our second grant year and also happens to be National Breastfeeding Month. This issue includes information on a new resource for dads wanting to provide breastfeeding support, the importance of a medical home, and the expansion of text4baby to include messages for dads. Our contractor corner is penned this month by Amie Gatterdam with the Gallatin City-County Health Department, a partner with Thrive in the Partnership to Strengthen Families Project.*



*As always, thank you for your commitment to young families. Enjoy the rest of your summer!*

*~ Kelly Hart, Healthy Montana Teen Parent Coordinator*



## Breastfeeding Resource for Dads

The American Academy of Pediatrics website [www.healthychildren.org](http://www.healthychildren.org) has a new resource to help dads offer breastfeeding support. The resource, a "[Message for Dads](#)", offers tips on how to support mom and suggestions for dads to connect with their babies.

As the resource notes, "Many studies have shown the support of a loving partner is the most important deciding factor in whether or not a woman chooses to initiate and continue breastfeeding." With this in mind, the authors share helpful tips and suggestions such as:

- "One of the first steps you can take as the partner of a breastfeeding mother is to education yourself regarding breastfeeding's many benefits."
- "Immediately after the birth you can support your partner's decision to begin breastfeeding by helping to make her comfortable in the delivery room."
- "As you and your partner become more familiar with the routines of parenting, you can help with diaper changes, baths, and playtimes so your partner can sleep between feedings and perhaps enjoy a little time to herself. These interactions with your newborn are excellent opportunities for you to create your own unique relationship with him."

The information provided on the website comes from the 2nd edition of the New Mother's Guide to Breastfeeding, also from the American Academy of Pediatrics.

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## Contractor Corner: The Partnership to Strengthen Families Project

By Amie Gatterdam, Maternal Child Health Program Manager

The Partnership Project is an intensive home visiting program for teen/young parents with multiple challenges and children ages 0-5. The service area is Bozeman, Belgrade, Three Forks and surrounding communities. In 2013, 178 individuals participated.



The project provides parent education and support, health, mental health and quality child care services in partnership with Thrive, the Gallatin City-County Health Department, the Gallatin Mental Health Center and quality early child care centers. Home visitors from Thrive and the Health Department meet with parents in the home for

an average of 18 months. They help the parent set and achieve goals that will enhance his/her ability to provide a safe and secure environment for their children, improve the long term stability of the family and learn the fundamentals of quality parenting. The Gallatin Mental Health Center provides comprehensive behavioral healthcare that emphasizes education, treatment, advocacy and recovery with a focus on developing skills that support increased independence and improved quality of life.

Short term goals of the project are to improve attachment and bonding; parent's understanding of their child's developmental stage and what they can do to support learning and healthy development; and access to health, mental health and quality childcare services.

Long term goals are to ensure children are physically and mentally healthy; children are ready to learn; and families are self-sufficient with adequate education, employment and housing.

Outcomes of The Partnership Project include enhancing parent-child bonding; improving parent knowledge of and expectations regarding child development. Additional outcomes include increasing parents' ability to meet basic needs for family survival, healthy family functioning

(physical, mental, and socio-emotional), reduction in the incidence of child maltreatment, effective utilization of community services and support systems, and health literacy. The Partnership promotes improvements in maternal and prenatal, infant, and child health and development; increased school readiness; improved parenting related to child development outcomes; improved family socio-economic status; and greater coordination of referrals to community resources and supports.

The Partnership Project utilizes the Life Skills Progression Survey, a validated assessment tool, the nationally acclaimed Parents As Teachers home visiting program, and has participated in a National Health Literacy Study. Recent research conducted by Dr. George Haynes, MSU utilized 10 years of program data and shows statistically significantly improvements in 31 of the 43 measured areas with the most notable changes in income, education, substance abuse, well child care and relationship with the father of baby or spouse.

One of the strengths of the Partnership Project is the relationship with the referral sources in the community. Referral sources to the Partnership Project include Bozeman Deaconess Hospital, WIC, local schools, childcare providers, health and prenatal care providers, and other local human service organizations. The home visiting staff visits Bozeman Deaconess Hospital (BDH) three times per week to pick up referrals from the Nursery and Labor and Delivery Unit that have been identified as high risk for factors including drug/alcohol use, homelessness, mental illness, medically fragile infants, medically fragile mothers, resource needs and domestic violence. The home visitor then meets with the referred family at the hospital to discuss the home visiting program and other available community resources. The home visitors meet with the hospital nurses and the nursing supervisor on a regular basis to update them on available services through the home visiting program and to get feedback on their experience with referring to our program. At a recent meeting with the nursing supervisor at BDH, she suggested that

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when picking up referrals and meeting with the referred families at the hospital, the home visitors then document if the family agreed to home visiting services in their hospital chart so that the doctors and hospital staff are informed of the services in place for the family. We have implemented this practice into our referral process with the hospital and it has improved communication between the home visitors and hospital staff.

The Gallatin City-County Health Department has a home visitor who works in WIC one day a week to meet with high-risk WIC clients who could benefit from the home visiting services. These clients are directly enrolled into the home visiting program, so the retention rate is very high for these referrals. WIC is a department within the Health Department, so there is constant communication regarding the referrals WIC makes into the home visiting program. The home visiting staff shares success stories from referrals, as well as additional services being provided.

Thrive staff meets monthly with the Professional Development Coordinator at the local child care resource and referral agency and several of the directors of local child care centers to identify quality centers and coordinate services and referrals among agencies. They also meet regularly with the Thrive Parent Liaisons located at the elementary and middle schools to ensure that they are well-versed in the services provided through the home visiting programs. The childcare providers and parent liaisons then make referrals into the program based on parents' needs and the home visitors communicate back to them the successes of those referrals.

The Health Department has placed a self-referral box in the waiting room of the local Community Health Center and the local Office of Public Assistance (OPA). A poster above the box describes the home visiting services and the referral forms provide the Health Department with contact information for the client. The home visiting staff check the self-referral boxes on a weekly basis and communicate regularly with the staff at OPA to better coordinate client services. We also attend OPA staff meetings several times a year to update them on the current services available through our home visiting program.

The home visiting staff meets regularly with many of the referral sources to gain referrals into the home visiting program. In order to maintain this referral system it is necessary to establish new and maintain existing partnerships with agencies providing services for young children and families within our community. This outreach takes place on a monthly basis at meetings focused on collaboration among community service providers. Each meeting focuses on a specific topic such as emergency housing and food programs, resources for children in the community, adult education programs, prenatal care, and home visiting services. Speakers are invited to share information on their programs and brochures are distributed to assist in the referral process. The Partnership Project staff have presented at several of these collaboration meetings to increase awareness of our home visiting program and strengthen the referral partnerships among providers.

The home visiting staff is focusing on receiving referrals earlier in the pregnancy, preferably in the first or second trimester. Staff recently met with two administrators at Bozeman Deaconess Hospital to discuss strategies for receiving these earlier referrals. While we are currently receiving the majority of our referrals from the hospital at the birth of the child, we can make a bigger impact on the family if we receive these referrals for home visiting services during pregnancy. We plan on doing this by reaching out to the prenatal providers in the community. In an effort to ensure that all prenatal providers receive education and guidance on making referrals to our home visiting programs, staff from the Health Department and Thrive plan on developing an outreach schedule to identify which prenatal providers need to be contacted and which staff from both agencies will be initiating and scheduling that contact. Other methods of strengthening our referral system and gaining new referrals include participation in community meetings and events, such as the Inter-agency Council, Project Homeless Connect, the Special Education Parent Teacher Association Expo, and the Cleft Palate Clinic. Additionally, we hope to gain more referrals and strengthen our referral system by utilizing social media outlets, including Facebook and the Thrive and Health Department's websites to write blogs highlighting our home visiting programs.



## A Look at Medical Homes

The concept of a medical home was developed by the American Academy of Pediatrics (AAP) to provide comprehensive care to children with special needs. The concept has expanded to focus on all patients, regardless of age or needs. The AAP describes a medical home:

### WHAT IS A FAMILY-CENTERED MEDICAL HOME?



A family-centered medical home is not a building, house, hospital, or home healthcare service, but rather an approach to providing comprehensive primary care.

In a family-centered medical home the pediatric care team works in partnership with a child and a child's family to assure that all of the medical and non-medical needs of the patient are met.

Through this partnership the pediatric care team can help the family/patient access, coordinate, and understand specialty care, educational services, out-of-home care, family support, and other public and private community services that are important for the overall health of the child and family.

The American Academy of Pediatrics (AAP) developed the medical home model for delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children and youth, including children and youth with special health care needs.



### LINKS FOR MORE INFO:

American Academy of Pediatrics:

[www.medicalhomeinfo.org](http://www.medicalhomeinfo.org)

Patient-Centered Primary Care Collaborative:

<http://www.pcpcc.org/about/medical-home>

U.S. Department of Health and Human Services, Health Information Technology:

<http://www.hrsa.gov/healthit/toolbox/Childrenstoolbox/BuildingMedicalHome/whyimportant.html>

### Thinking about expectant and parenting teens:

The Office of Adolescent Health has a power point on their website entitled “The Medical Home and Bright Futures—What does that have to do with teenage sexuality and pregnancy anyway” by Thomas Tonniges, MD, FAAP that can be found [here](#).

## Text4baby - 4 Dads 2!



Text4baby, the free mobile information service for maternal and child health, has announced a new series of text messages for expectant fathers and fathers with babies under the age of one. These messages provide dads important information and tips on improving child health and safety, ways to engage with their babies, and how to support a mother's health. New messages also reinforce how mothers can support fathers in their role as a parent. To sign up for these free text messages, text BABY (or BEBE for messages in Spanish) to 511411.

**Dads Matter**

# UPCOMING TRAINING OPPORTUNITIES

\*Have training opportunities to share? Send them to [Khart2@mt.gov](mailto:Khart2@mt.gov) \*

## September

National Indian Child Welfare Association—Positive Indian Parenting, ICWA Basics, Advanced ICWA

September 8-10, 2014

Portland, OR

<http://www.nicwa.org/training/institutes/>

## October

Montana DPHHS- *Helping Children to Eat and Grow Well* (Ellyn Satter Institute)

October 9, 2014

Billings, MT

<http://www.dphhs.mt.gov/hcsd/childcare/cacfp/index.shtml>

Healthy Teen Network Annual National Conference *Synergy: Achieving More Together*

October 21-24, 2014

Austin, TX

<http://www.healthyteennetwork.org/>

## December

National Indian Child Welfare Association—Positive Indian Parenting, ICWA Basics, Advanced ICWA

December 1-3, 2014

San Diego, CA

<http://www.nicwa.org/training/institutes/>

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