CHANGE IDEA: Partner with community service providers to improve care coordination for families with complex medical, behavioral, and social needs.

STEP 1: GET READY (TASKS)

A. Convene a small team of providers, care coordinators, and administrative staff to improve referral communication and follow-up with one key behavioral health agency partner.
B. Contact your infant mental health association or state mental health system to identify local mental health clinicians trained in early childhood evidence-based treatment.
C. Communicate with other programs that receive a high volume of your referrals, such as libraries with quality playgroups, dental and vision care, local schools, peer navigators, and public health programs.
D. Define roles and responsibilities. Designate a referral coordinator at the health center and a contact person at the behavioral health agency.
E. Select a simple communication method to pilot (e.g., shared referral tracking spreadsheet, secure email template).
F. Schedule a brief training to introduce the communication process and expectations.

STEP 2: PLAN AND PRACTICE

Co-design a short workflow to improve visibility and follow-up on referrals sent to the behavioral health agency.

SAMPLE PROCESS:

A. The referral coordinator enters a referral into a shared spreadsheet and sends a secure message to the agency contact.
B. The behavioral health agency acknowledges the referral within 2 business days and updates the spreadsheet when the patient is contacted or scheduled.
C. The referral coordinator checks the spreadsheet every 2-3 days and follows up if no update is received within 5 business days.
D. Pilot this process with referrals from one care coordinator for 2 weeks.

STEP 3: REVIEW AND REFINE

Hold a review huddle with staff and the community partner to assess:

A. Number of referrals acknowledged within 2 days
B. Number of patients scheduled
C. Barriers to timely communication or tracking
D. Usability for both organizations

Use feedback to identify pain points (e.g., need for clearer fields, privacy concerns, time burden) and adjust the workflow.

STEP 4: EXPAND

If successful, expand the workflow to additional care coordinators or providers. Consider adding a second community behavioral health partner. Continue short weekly huddles to address issues and reinforce consistent use.

STEP 5: SUSTAIN

Review implementation data and gather feedback from staff and partner contacts. Refine the communication tool or process as needed, such as:

A. Simplifying spreadsheet layout
B. Standardizing message templates
C. Integrating into electronic health record workflows
D. Updating referral workflows and providing refresher training

Embed the process into routine operations by:

A. Including it in standard operating procedures for care coordination and referrals
B. Training new staff on workflow expectations
C. Regularly reviewing referral follow-up metrics to ensure accountability
D. Celebrating improvements in referral success and partnership strength